



Accreditation Program: Hospital



# Accreditation Participation Requirements

**APR.01.01.01**

The hospital submits information to The Joint Commission as required.

**Elements of Performance for APR.01.01.01**

1. The hospital meets all requirements for timely submissions of data and information to The Joint Commission.  
Note 1: The Joint Commission will impose the following consequences for failure to comply with this APR:
  - If the hospital does not comply with the requirement after 31 days, the hospital will be placed in Provisional Accreditation.
  - If the hospital does not comply with the requirement after 61 days, the hospital's accreditation decision will be changed from Provisional Accreditation to Conditional Accreditation.
  - If the hospital does not comply with the requirement after 91 days, the hospital's accreditation decision will be changed from Conditional Accreditation to Denial of Accreditation. In accordance with the Accreditation Committee policy, such hospitals will not be afforded any appeal.Note 2: The proposed consequences address only compliance with the requirement itself. They do not address the content of the hospital's submissions to The Joint Commission. For example, if information in a hospital's electronic application for accreditation (e-App) leads to inaccuracies in the appropriate length of the survey and a longer survey is required, the hospital will incur the additional costs of the longer survey. In addition, if there is evidence that the hospital has intentionally falsified the information submitted to The Joint Commission, the requirement at APR.01.02.01, EP 1 and its consequences will apply. (See also APR.01.02.01, EP 1)



**APR.01.02.01**

The hospital provides accurate information throughout the accreditation process.

**Rationale for APR.01.02.01**

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

**Elements of Performance for APR.01.02.01**

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

Note 1: Information may be received in the following ways:

  - Provided verbally
  - Obtained through direct observation by, or in an interview or any other type of communication with, a Joint Commission employee
  - Derived from documents supplied by the hospital to The Joint Commission
  - Submitted electronically by the hospital through a performance measurement system to The Joint Commission

Note 2: For the purpose of this requirement, falsification is defined as the fabrication, in whole or in part, 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.

**2 A****APR.01.03.01**

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

**Elements of Performance for APR.01.03.01**

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

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

**A****APR.02.01.01**

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

**Elements of Performance for APR.02.01.01**

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

**2 A**

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required


**APR.03.01.01**

The hospital fulfills requirements for Periodic Performance Review.

**Rationale for APR.03.01.01**

The Periodic Performance Review (PPR) helps hospitals incorporate The Joint Commission standards into routine daily operations. When hospitals use the PPR 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**

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| <ol style="list-style-type: none"> <li>1. <b>D</b> The hospital annually updates and transmits to The Joint Commission the full Periodic Performance Review (PPR) and its Plan of Action on any recommendations cited. (Refer also to the PPR Options section in "The Accreditation Process" (ACC) chapter.)<br/>Note: For hospitals that select Options 1, 2, or 3, the requirement to transmit the PPR and its Plan of Action to The Joint Commission may not apply in part or in whole.</li> <li>2. The hospital completing the full Periodic Performance Review (PPR) collaborates with the medical staff in completing the PPR and developing plan(s) of action.</li> <li>3. <b>D</b> The hospital exercising Option 1, 2, or 3 for the Periodic Performance Review (PPR) annually attests that, after careful consideration with legal counsel, the hospital has decided not to participate in the full PPR.</li> <li>4. <b>D</b> The hospital exercising Option 1 for the Periodic Performance Review (PPR) completes a PPR and Plan of Action.<br/>Note: The hospital does not submit this information to The Joint Commission.</li> <li>5. The hospital exercising Option 1 for the Periodic Performance Review (PPR) collaborates with the medical staff in completing the PPR and developing Plan(s) of Action.</li> <li>6. <b>D</b> The hospital exercising Option 2 for the Periodic Performance Review agrees to undergo a limited survey and then submit a Plan of Action for recommendations cited as a result of the survey.</li> <li>7. The hospital exercising Option 3 for the Periodic Performance Review agrees to undergo a limited survey.<br/>Note: The hospital does not receive a written report after the survey.</li> </ol> | <div style="display: flex; align-items: center; justify-content: flex-end;"> <div style="margin-right: 10px;">  </div> <div style="margin-right: 10px;">A</div> </div> <div style="display: flex; align-items: center; justify-content: flex-end;"> <div style="margin-right: 10px;">A</div> </div> <div style="display: flex; align-items: center; justify-content: flex-end;"> <div style="margin-right: 10px;">A</div> </div> <div style="display: flex; align-items: center; justify-content: flex-end;"> <div style="margin-right: 10px;">A</div> </div> <div style="display: flex; align-items: center; justify-content: flex-end;"> <div style="margin-right: 10px;">A</div> </div> <div style="display: flex; align-items: center; justify-content: flex-end;"> <div style="margin-right: 10px;">A</div> </div> <div style="display: flex; align-items: center; justify-content: flex-end;"> <div style="margin-right: 10px;">A</div> </div> |
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**APR.04.01.01**





The hospital selects and uses core performance measure sets and/or non-core performance measures from among those available through its listed performance measurement system.

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

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

**Elements of Performance for APR.04.01.01**

11.	The hospital selects a sufficient number of core performance measure sets and/or non-core performance measures to meet current ORYX requirements.	<b>A</b>
12.	The hospital notifies The Joint Commission of its core performance measure sets and/or non-core performance measure selections by the date requested.	<b>A</b>
17.	The hospital discusses with the surveyor how the data are used to identify, prioritize, and monitor performance improvement activities.	<b>A</b>
18.	The hospital uses each individual core measure set and/or non-core measure for at least four consecutive quarters before replacing it.	<b>A</b>
19.	Based on The Joint Commission statistical analysis, the hospital continues to use a measure if the data suggest an unstable pattern of performance or otherwise identifies an opportunity for improvement.	<b>A</b>
20.	For non-core measures, the hospital, based on The Joint Commission statistical analysis, selects a new measure if the data reflect stable and satisfactory performance.	<b>A</b>
21. 	The hospital notifies The Joint Commission of any changes in its core measure sets and/or non-core performance measure selections.	<b>A</b>
22.	The hospital allows the performance measurement system to submit hospital clinical data to The Joint Commission at least four times a year.	<b>A</b>
23.	The hospital resolves data quality issues identified by The Joint Commission and determined by the performance measurement system to be the hospital's responsibility.	<b>A</b>
24.	For the most recent 12-month reporting period, the hospital achieves and sustains an acceptable level of performance, as defined by quarterly Joint Commission statistical analysis, for each core measure within a measure set and/or each non-core measure before it discontinues its use of such a measure set.	<b>A</b>
26.	The hospital ensures that hospital-specific aggregate data for its selected core and/or non-core measures are submitted by its selected performance measurement system(s) to The Joint Commission four times a year, in accordance with time lines established by The Joint Commission.	<b>A</b>

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required


**APR.05.01.01**

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

**Rationale for APR.05.01.01**

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

**Elements of Performance for APR.05.01.01**

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

**A****APR.06.01.01**

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

**Elements of Performance for APR.06.01.01**

1. The hospital does not use Joint Commission employees to provide any accreditation-related consulting services.  
Note: Consulting services include, but are not limited to, the following:
  - Helping the hospital to meet Joint Commission standards
  - Helping the hospital to complete its Periodic Performance Review (PPR)
  - Assisting the hospital in remediating areas identified in its PPR as needing improvement
  - Conducting mock surveys
  - Providing the hospital with consultation to address Priority Focus Process information

**A****APR.07.01.01**

The hospital accepts the presence of Joint Commission surveyor management staff or a Board of Commissioners member in the role of observer of an on-site survey.

**Elements of Performance for APR.07.01.01**

1. The hospital allows Joint Commission surveyor management staff or a member of the Board of Commissioners to observe the on-site survey.  
Note: The observer will not participate in the on-site survey process, including the scoring of standards compliance. The hospital will not incur any additional survey fees because an observer(s) is present.

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**APR.08.01.01**

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

**Elements of Performance for APR.08.01.01**

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| 1. | The hospital's advertising accurately reflects the scope of programs and services that are accredited by The Joint Commission. | <b>A</b> |
| 2. | The hospital does not engage in any false or misleading advertising about its accreditation award.                             | <b>A</b> |

**APR.09.01.01**

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

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

**Elements of Performance for APR.09.01.01**

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| 1. | The hospital informs the public it serves about how to contact its management to report concerns about patient safety and quality of care.       | <b>A</b> |
| 2. | The hospital informs the public it serves about how to contact The Joint Commission to report concerns about patient safety and quality of care. | <b>A</b> |

**APR.09.02.01**

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

**Rationale for APR.09.02.01**

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

**Elements of Performance for APR.09.02.01**

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| 1. | The hospital educates its staff, medical staff, and other individuals who provide care, treatment, and services that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission.                                  | <b>A</b> |
| 2. | The hospital informs its staff and medical staff that it will take no disciplinary or punitive action because an employee, physician, or other individual who provides care, treatment, and services reports safety or quality-of-care concerns to The Joint Commission. | <b>A</b> |
| 3. | The hospital takes no disciplinary or punitive action against employees, physicians, or other individuals who provide care, treatment, and services when they report safety or quality-of-care concerns to The Joint Commission.   | <b>A</b> |

**APR.09.03.01**

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

**Elements of Performance for APR.09.03.01**

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| 1. | The hospital adheres to The Joint Commission's published guidelines for how it describes information in its Quality Report. | <b>A</b> |
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## Environment of Care

**Standard EC.01.01.01**

The hospital plans activities to minimize risks in the environment of care.

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

**Rationale for EC.01.01.01**

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

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

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

**Elements of Performance for EC.01.01.01**

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| 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.<br>Note: Deficiencies include injuries, problems, or use errors. | <b>A</b> |
| 2. | Leaders identify an individual(s) to intervene whenever environmental conditions immediately threaten life or health or threaten to damage equipment or buildings.   | <b>A</b> |
| 3. | <b>D</b> The hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the hospital's facilities. (See also EC.04.01.01, EP 15)  | <b>A</b> |
| 4. | <b>D</b> The hospital has a written plan for managing the following: The security of everyone who enters the hospital's facilities. (See also EC.04.01.01, EP 15)  | <b>A</b> |
| 5. | <b>D</b> The hospital has a written plan for managing the following: Hazardous materials and waste. (See also EC.04.01.01, EP 15)  | <b>A</b> |
| 6. | <b>D</b> The hospital has a written plan for managing the following: Fire safety. (See also EC.04.01.01, EP 15)  | <b>A</b> |
| 7. | <b>D</b> The hospital has a written plan for managing the following: Medical equipment. (See also EC.04.01.01, EP 15)  | <b>A</b> |
| 8. | <b>D</b> The hospital has a written plan for managing the following: Utility systems. (See also EC.04.01.01, EP 15)  | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard EC.02.01.01**

The hospital manages safety and security risks.

**Rationale for EC.02.01.01**

Safety and security risks are present in most health care environments. These risks affect all individuals in the organization – patients, visitors, and those who work in the hospital. It is important to identify these risks in advance so that the hospital can prevent or effectively respond to incidents. In some organizations, safety and security are treated as a single function, although in others they are treated as separate functions.

Safety risks may arise from the structure of the physical environment, from the performance of everyday tasks, or from situations beyond the hospital's control, such as the weather. Safety incidents are most often accidental. On the other hand, security incidents are often intentional. Security protects individuals and property against harm or loss. Examples of security risks include workplace violence, theft, infant abduction, and unrestricted access to medications. Security incidents are caused by individuals from either outside or inside the hospital.

**Elements of Performance for EC.02.01.01**



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| 1.             | The hospital identifies safety and security risks associated with the environment of care.<br>Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. (See also EC.04.01.01, EP 14) | <b>A</b>   |
| <b>(M)</b> 3.  | The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.   | <b>3 C</b> |
| <b>(M)</b> 5.  | The hospital maintains all grounds and equipment.  | <b>C</b>   |
| <b>(M)</b> 7.  | The hospital identifies individuals entering its facilities.<br>Note: The hospital determines which of those individuals require identification and how to do so.  | <b>C</b>   |
| 8.             | The hospital controls access to and from areas it identifies as security sensitive.  | <b>3 A</b> |
| 9. <b>(D)</b>  | The hospital has written procedures to follow in the event of a security incident, including an infant or pediatric abduction.   | <b>A</b>   |
| 10.            | When a security incident occurs, the hospital follows its identified procedures.   | <b>3 A</b> |
| <b>(M)</b> 11. | The hospital responds to product notices and recalls. (See also MM.05.01.17, EPs 1-4)  | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **(M)** indicates Measure of Success if needed; **(D)** indicates that documentation is required

## Standard EC.02.01.03

The hospital prohibits smoking except in specific circumstances.

### Elements of Performance for EC.02.01.03

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| 1.   |  The hospital develops a written policy prohibiting smoking in all buildings. Exceptions for patients in specific circumstances are defined. | <b>A</b> |
| 4.   | If the hospital decides that patients may smoke in specific circumstances, it designates smoking areas that are physically separate from care, treatment, and service areas. (See also EC.02.03.01, EP 2)                     | <b>A</b> |
|  6. | The hospital takes action to maintain compliance with its smoking policy.   | <b>C</b> |

**Standard EC.02.02.01**

The hospital manages risks related to hazardous materials and waste.

**Elements of Performance for EC.02.02.01**




1.	Ⓓ	The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation. (See also IC.02.01.01, EP 6; MM.01.01.03, EP 3)		<b>A</b>
3.	Ⓓ	The hospital has written procedures, including the use of precautions and personal protective equipment, to follow in response to hazardous material and waste spills or exposures.		<b>A</b>
4.		The hospital implements its procedures in response to hazardous material and waste spills or exposures.	3	<b>A</b>
5.	Ⓜ	The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.		<b>C</b>
6.		The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of radioactive materials.	3	<b>A</b>
7.	Ⓜ	The hospital minimizes risks associated with selecting and using 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).	3	<b>C</b>
8.	Ⓜ	The hospital minimizes risks associated with disposing of hazardous medications. (See also MM.01.01.03, EPs 1-3)	3	<b>C</b>
9.	Ⓜ	The hospital 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, glutaraldehyde, ethylene oxide, vapors generated while using cauterizing equipment and lasers, and gases such as nitrous oxide.		<b>C</b>
10.		The hospital monitors levels of hazardous gases and vapors to determine that they are in safe range. Note: Law and regulation determine the frequency of monitoring hazardous gases and vapors as well as acceptable ranges.	3	<b>A</b>
11.	Ⓓ	For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and material safety data sheets required by law and regulation.		<b>A</b>
12.		The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. Footnote: 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.		<b>A</b>

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **Ⓜ** indicates Measure of Success if needed; **Ⓓ** indicates that documentation is required

## Standard EC.02.03.01

The hospital manages fire risks.

### Elements of Performance for EC.02.03.01

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| <p><b>M</b> 1. The hospital minimizes the potential for harm from fire, smoke, and other products of combustion.</p> <p>2. If patients are permitted to smoke, the hospital takes measures to minimize fire risk. (See also EC.02.01.03, EP 4)</p> <p>4. The hospital maintains free and unobstructed access to all exits.<br/>Note: This requirement applies to all buildings classified as business occupancy. The "Life Safety" (LS) chapter addresses the requirements for all other occupancy types.</p> <p>9. <b>D</b> The hospital has a written fire response plan.</p> <p>10. The written fire response plan describes the specific roles of staff and licensed independent practitioners at and away from a fire's point of origin, including when and how to sound fire alarms, how to contain smoke and fire, how to use a fire extinguisher, and how to evacuate to areas of refuge. (See also EC.02.03.03, EP 5)</p> | <p> <b>C</b></p> <p> <b>A</b></p> <p> <b>A</b></p> <p><b>A</b></p> <p><b>A</b></p> |
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## Standard EC.02.03.03

The hospital conducts fire drills.

### Elements of Performance for EC.02.03.03

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| <p>1. The hospital conducts fire drills once per shift per quarter in each building defined as a health care occupancy by the Life Safety Code. The hospital conducts quarterly fire drills in each building defined as an ambulatory health care occupancy by the Life Safety Code. (See also LS.01.02.01, EP 11; LS.02.01.70, EP 4; LS.03.01.70, EP 6)<br/>Note 1: Evacuation of patients during drills is not required.<br/>Note 2: In leased or rented facilities, drills need be conducted only in areas of the building that the hospital occupies.</p> <p>2. The hospital conducts fire drills every 12 months from the date of the last drill in all freestanding buildings classified as business occupancies and in which patients are seen or treated.<br/>Note: In leased or rented facilities, drills need be conducted only in areas of the building that the hospital occupies.</p> <p>3. When quarterly fire drills are required, at least 50% are unannounced.</p> <p><b>M</b> 4. Staff who work in buildings where patients are housed or treated participate in drills according to the hospital's fire response plan.<br/>Note: When drills are conducted between 9:00 p.m. and 6:00 a.m., the hospital may use alternative methods to notify staff instead of activating the building's fire alarm system.</p> <p>5. <b>D</b> The hospital critiques fire drills to evaluate fire safety equipment, fire safety building features, and staff response to fire. The evaluation is documented. (See also EC.02.03.01, EP 10)</p> | <p><b>A</b></p> <p><b>A</b></p> <p><b>A</b></p> <p><b>C</b></p> <p><b>A</b></p> |
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**Standard EC.02.03.05**





The hospital maintains fire safety equipment and fire safety building features.

Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below.

However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

**Elements of Performance for EC.02.03.05**

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| 1.   |  At least quarterly, the hospital tests supervisory signal devices (except valve tamper switches). The completion date of the tests is documented.<br>Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).  | <b>A</b>   |
| 2.   |  Every 6 months, the hospital tests valve tamper switches and water-flow devices. The completion date of the tests is documented.<br>Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).   | <b>A</b>   |
|  3.   |  Every 12 months, the hospital tests duct detectors, electromechanical releasing devices, heat detectors, manual fire alarm boxes, and smoke detectors. The completion date of the tests is documented.<br>Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2). | <b>C</b>   |
|  4.   |  Every 12 months, the hospital tests visual and audible fire alarms, including speakers. The completion date of the tests is documented.<br>Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).  |  <b>C</b> |
| 5.   |  Every quarter, the hospital tests fire alarm equipment for notifying off-site fire responders. The completion date of the tests is documented.<br>Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).   | <b>A</b>   |
|  6.   |  For automatic sprinkler systems: Every week, the hospital tests fire pumps under no-flow conditions. The completion date of the tests is documented.<br>Note: For additional guidance on performing tests, see NFPA 25, 1998 edition.   | <b>C</b>   |
|  7. |  For automatic sprinkler systems: Every 6 months, the hospital tests water-storage tank high- and low-water level alarms. The completion date of the tests is documented.<br>Note: For additional guidance on performing tests, see NFPA 25, 1998 edition (Section 6-3.5).                           | <b>C</b>   |
|  8. |  For automatic sprinkler systems: Every month during cold weather, the hospital tests water-storage tank temperature alarms. The completion date of the tests is documented.<br>Note: For additional guidance on performing tests, see NFPA 25, 1998 edition (Section 6-3).                          | <b>C</b>   |
|  9. |  For automatic sprinkler systems: Every 12 months, the hospital tests main drains at system low point or at all system risers. The completion date of the tests is documented.<br>Note: For additional guidance on performing tests, see NFPA 25, 1998 edition (Section 9-2.6).                      | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

10. **D** For automatic sprinkler systems: Every quarter, the hospital inspects all fire department water supply connections. The completion dates of the inspections are documented. **A**  
Note: For additional guidance on performing tests, see NFPA 25, 1998 edition (Section 9-7.1).
11. **D** For automatic sprinkler systems: Every 12 months, the hospital tests fire pumps under flow. The completion date of the tests is documented. **3 A**  
Note: For additional guidance on performing tests, see NFPA 25, 1998 edition.
- M** 12. **D** Every 5 years, the hospital conducts water-flow tests for standpipe systems. The completion date of the tests is documented. **C**  
Note: For additional guidance on performing tests, see NFPA 25, 1998 edition.
13. **D** Every 6 months, the hospital inspects any automatic fire-extinguishing systems in a kitchen. The completion dates of the inspections are documented. **A**  
Note 1: Discharge of the fire-extinguishing systems is not required.  
Note 2: For additional guidance on performing inspections, see NFPA 96, 1998 edition.
14. **D** Every 12 months, the hospital tests carbon dioxide and other gaseous automatic fire-extinguishing systems. The completion date of the tests is documented. **A**  
Note: Discharge of the fire-extinguishing systems is not required.
- M** 15. **D** At least monthly, the hospital inspects portable fire extinguishers. The completion dates of the inspections are documented. **C**  
Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory.  
Note 2: Inspections involve a visual check for the presence and correct type of extinguisher, broken parts, full charge, and ease of access.  
Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10, Standard for Portable Fire Extinguishers, 1998 edition (Sections 1-6, 4-3, and 4-4).
- M** 16. **D** Every 12 months, the hospital performs maintenance on portable fire extinguishers. The completion date of the maintenance is documented. **C**  
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, 1998 edition (Sections 1-6, 4-3, and 4-4).
- M** 17. **D** The hospital conducts hydrostatic tests on standpipe occupant hoses 5 years after installation and every 3 years thereafter. The completion date of the tests is documented. **C**  
Note: For additional guidance on hydrostatic testing, see NFPA 1962, 1998 edition (Section 2-3), and NFPA 25, 1998 edition.
- M** 18. **D** The hospital operates fire and smoke dampers 1 year after installation and then at least every 6 years to verify that they fully close. The completion date of the tests is documented. **C**  
Note 1: The initial test that must occur 1 year after installation applies only to dampers installed on and after January 1, 2008.  
Note 2: For additional guidance, see NFPA 80 Standard for Fire Doors and Other Opening Protectives, 2007 edition (Section 19.4.1.1) and NFPA 105, 2007 edition (Section 6.5.2).

- |          |     |          |   |          |
|----------|-----|----------|---|----------|
| <b>M</b> | 19. | <b>D</b> | Every 12 months, the hospital tests automatic smoke-detection shutdown devices for air-handling equipment. The completion date of the tests is documented.<br>Note: For additional guidance on performing tests, see NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems, 1999 edition (Section 4-4.1). | <b>C</b> |
| <b>M</b> | 20. | <b>D</b> | Every 12 months, the hospital tests sliding and rolling fire doors for proper operation and full closure. The completion date of the tests is documented.<br>Note: For additional guidance on performing tests, see NFPA 80, 1999 edition (Section 15-3.4).   | <b>C</b> |

### Standard EC.02.04.01

The hospital manages medical equipment risks.

#### Elements of Performance for EC.02.04.01





- |          |    |  |          |
|----------|----|--|----------|
|          | 1. | The hospital solicits input from individuals who operate and service equipment when it selects and acquires medical equipment.   | <b>A</b> |
|          | 2. | <b>D</b> The hospital maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized by physical risk associated with use (including all life-support equipment) and equipment incident history. The hospital evaluates new types of equipment before initial use to determine whether they should be included in the inventory. (See also EC.02.04.03, EPs 1 and 3)   | <b>A</b> |
| <b>M</b> | 3. | <b>D</b> The hospital identifies the activities, in writing, for maintaining, inspecting, and testing for all medical equipment on the inventory. (See also EC.02.04.03, EPs 2 and 3)<br>Note: Hospitals may use different strategies for different items as appropriate. For example, strategies such as predictive maintenance, reliability-centered maintenance, interval-based inspections, corrective maintenance, or metered maintenance may be selected to ensure reliable performance. | <b>C</b> |
|          | 4. | <b>D</b> The hospital identifies, in writing, frequencies for inspecting, testing, and maintaining medical equipment on the inventory based on criteria such as manufacturers' recommendations, risk levels, or current hospital experience. (See also EC.02.04.03, EPs 2 and 3)   | <b>A</b> |
|          | 5. | The hospital 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.  | <b>A</b> |
|          | 6. | <b>D</b> The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment.  | <b>A</b> |



**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; indicates situational decision rules apply; indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

## Standard EC.02.04.03

The hospital inspects, tests, and maintains medical equipment.

### Elements of Performance for EC.02.04.03



- |                                 |   |   |
|---------------------------------|---|---|
| <p><b>(M)</b> 1.</p>            | <p>Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2)</p>   | <p> <b>C</b></p> |
| <p>2. <b>(D)</b></p>            | <p>The hospital inspects, tests, and maintains all life-support equipment. These activities are documented. (See also EC.02.04.01, EPs 3 and 4; PC.02.01.11, EP 2)</p>  | <p> <b>A</b></p> |
| <p><b>(M)</b> 3. <b>(D)</b></p> | <p>The hospital inspects, tests, and maintains non-life-support equipment identified on the medical equipment inventory. These activities are documented. (See also EC.02.04.01, EPs 2-4 and PC.02.01.11, EP 2)</p>               | <p><b>C</b></p>   |
| <p>4. <b>(D)</b></p>            | <p>The hospital conducts performance testing of and maintains all sterilizers. These activities are documented. (See also IC.02.02.01, EP 2)</p>  | <p> <b>A</b></p> |
| <p>5. <b>(D)</b></p>            | <p>The hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented.</p>  | <p> <b>A</b></p> |
| <p>14. <b>(D)</b></p>           | <p>For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The dates of these activities are documented.</p> | <p><b>A</b></p>   |



**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **(M)** indicates Measure of Success if needed; **(D)** indicates that documentation is required

## Standard EC.02.05.01


The hospital manages risks associated with its utility systems.

### Elements of Performance for EC.02.05.01

- |                      |  |  |
|----------------------|--|--|
| 1.                   | The hospital designs and installs utility systems that meet patient care and operational needs. (See also EC.02.06.05, EP 1)   | <b>A</b>   |
| 2. <b>D</b>          | The hospital maintains a written inventory of all operating components of utility systems or maintains a written inventory of selected operating components of utility systems based on risks for infection, occupant needs, and systems critical to patient care (including all life-support systems). The hospital evaluates new types of utility components before initial use to determine whether they should be included in the inventory. (See also EC.02.05.05, EPs 1, 3-5)  | <b>A</b>   |
| <b>M</b> 3. <b>D</b> | The hospital identifies, in writing, inspection and maintenance activities for all operating components of utility systems on the inventory. (See also EC.02.05.05, EPs 3 - 5; EC.02.05.09, EP 1)<br>Note: Hospitals may use different approaches to maintenance. For example, activities such as predictive maintenance, reliability-centered maintenance, interval-based maintenance, corrective maintenance, or metered maintenance may be selected to ensure dependable performance.   | <b>C</b>   |
| 4. <b>D</b>          | The hospital identifies, in writing, the intervals for inspecting, testing, and maintaining all operating components of the utility systems on the inventory, based on criteria such as manufacturers' recommendations, risk levels, or hospital experience. (See also EC.02.05.05, EPs 3-5)   | <b>A</b>   |
| 5.                   | The hospital minimizes pathogenic biological agents in cooling towers, domestic hot-and cold-water systems, and other aerosolizing water systems.  |  <b>A</b> |
| 6.                   | In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration efficiencies.<br>Note: Areas designed for control of airborne contaminants include spaces such as operating rooms, special procedure rooms, delivery rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, pulmonary or laryngeal tuberculosis), patients in "protective environment" rooms (for example, those receiving bone marrow transplants), laboratories, pharmacies, and sterile supply rooms. For further information, see Guidelines for Design and Construction of Hospitals and Health Care Facilities, 2001 edition, published by the American Institute of Architects. |  <b>A</b> |
| 7. <b>D</b>          | The hospital maps the distribution of its utility systems.   | <b>A</b>   |
| 8.                   | The hospital labels utility system controls to facilitate partial or complete emergency shutdowns.   | <b>A</b>   |
| 9. <b>D</b>          | The hospital has written procedures for responding to utility system disruptions.  | <b>A</b>   |
| 10.                  | The hospital's procedures address shutting off the malfunctioning system and notifying staff in affected areas.  | <b>A</b>   |
| 11.                  | The hospital's procedures address performing emergency clinical interventions during utility system disruptions.   | <b>A</b>   |
| 12.                  | The hospital's procedures address how to obtain emergency repair services.   | <b>A</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required






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

 A

### Standard EC.02.05.03

The hospital has a reliable emergency electrical power source.

#### Elements of Performance for EC.02.05.03









1. The hospital provides emergency power for the following: 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, 1999 edition (Section 13-3.3).  A
2. The hospital provides emergency power for the following: Exit route and exit sign illumination, as required by the Life Safety Code.  A
3. The hospital provides emergency power for the following: Emergency communication systems, as required by the Life Safety Code.  A
4. The hospital provides emergency power for the following: Elevators (at least one for nonambulatory patients). A
5. The hospital provides emergency power for the following: 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.  A
6. The hospital provides emergency power for the following: Areas in which loss of power could result in patient harm, including operating rooms, recovery rooms, obstetrical delivery rooms, nurseries, and urgent care areas.  A





### Standard EC.02.05.05

The hospital inspects, tests, and maintains utility systems.

Note: At times, maintenance is performed by an external service. In these cases, hospitals are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.

#### Elements of Performance for EC.02.05.05

-  1.  The hospital tests utility system components on the inventory before initial use. The completion date of the tests is documented. (See also EC.02.05.01, EP 2) C
3.  The hospital inspects, tests, and maintains the following: Life-support utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2-4)  A
4.  The hospital inspects, tests, and maintains the following: Infection control utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2-4)  A
-  5.  The hospital inspects, tests, and maintains the following: Non-life-support utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2-4) C

KEY: A indicates scoring category A; C indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard EC.02.05.07**



The hospital inspects, tests, and maintains emergency power systems.



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





**Rationale for EC.02.05.07**

Emergency electrical power supply systems may fail during a power disruption, leaving the hospital unable to deliver safe care, treatment, and services to patients. Testing these systems for sufficient lengths of time at regular frequencies increases the likelihood of detecting reliability problems and reduces the risk of losing this critical resource when it is most needed.

**Elements of Performance for EC.02.05.07**

- |   |   |
|---|---|
| <p><b>M</b> 1. <b>D</b> At 30-day intervals, the hospital performs a functional test of battery-powered lights required for egress for a minimum duration of 30 seconds. The completion date of the tests is documented.</p>  | <p><b>C</b></p>   |
| <p><b>M</b> 2. <b>D</b> Every 12 months, the hospital either performs a functional test of battery-powered lights required for egress for a duration of 1 1/2 hours; or the hospital replaces all batteries every 12 months and, during replacement, performs a random test of 10% of all batteries for 1 1/2 hours. The completion date of the tests is documented.</p>  | <p><b>C</b></p>   |
| <p>3. <b>D</b> Every quarter, the hospital performs a functional test of stored emergency power supply systems (SEPSS) for 5 minutes or as specified for its class (whichever is less). The hospital performs an annual test at full load for 60% of the full duration of its class. The completion dates of the tests are documented.</p> <p>Note 1: Non-SEPSS battery backup emergency power systems that the hospital has determined to be critical for operations during a power failure (for example, laboratory equipment or electronic medical records) should be properly tested and maintained in accordance with manufacturer's recommendations.</p> <p>Note 2: 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.</p> <p>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, Standard on Stored Electrical Energy Emergency and Standby Power Systems, 1996 edition.</p> | <p><b>A</b></p>   |
| <p>4. <b>D</b> Twelve times a year, at intervals of not less than 20 days and not more than 40 days, the hospital tests each emergency generator for at least 30 continuous minutes. The completion dates of the tests are documented.</p>  | <p> <b>A</b></p> |
| <p>5. The emergency generator tests are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature. If the hospital does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 4, then it must test each emergency generator once every 12 months using supplemental (dynamic or static) loads of 25% of nameplate rating for 30 minutes, followed by 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 2 continuous hours.</p>   | <p> <b>A</b></p> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required



- |             |   |  |
|-------------|---|--|
| 6. <b>D</b> | Twelve times a year, at intervals of not less than 20 days and not more than 40 days, the hospital tests all automatic transfer switches. The completion date of the tests is documented.   |  <b>A</b> |
| 7. <b>D</b> | At least once every 36 months, hospitals with a generator providing emergency power for the services listed in EC.02.05.03, EPs 5 and 6, test each emergency generator for a minimum of 4 continuous hours. The completion date of the tests is documented.<br>Note: For additional guidance, see NFPA 110, 2005 edition, Standard for Emergency & Standby Power Systems. |  <b>A</b> |
| 8.          | The 36-month 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.  |  <b>A</b> |
| 9.          | If a required emergency power system test fails, the hospital implements measures to protect patients, visitors, and staff until necessary repairs or corrections are completed.  |  <b>A</b> |
| 10.         | If a required emergency power system test fails, the hospital performs a retest after making the necessary repairs or corrections.  | <b>A</b>   |



### Standard EC.02.05.09

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

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

#### Elements of Performance for EC.02.05.09

- |             |   |  |
|-------------|---|--|
| 1. <b>D</b> | In time frames defined by the hospital, the hospital inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets. These activities are documented. (See also EC.02.05.01, EP 3) |  <b>A</b> |
| 2. <b>D</b> | The hospital tests piped medical gas and vacuum systems for purity, correct gas, and proper pressure when these systems are installed, modified, or repaired. The completion date of the tests is documented.   |  <b>A</b> |
| 3.          | The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.   | <b>A</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

## Standard EC.02.06.01

The hospital establishes and maintains a safe, functional environment.

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

### Elements of Performance for EC.02.06.01


<b>M</b>	1.	Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.	<b>C</b>
	4.	The hospital provides space for recreation and social interaction for patients who remain in the care of the hospital for more than 30 days.	<b>A</b>
<b>M</b>	5.	The hospital provides storage space to meet patient needs.	<b>C</b>
	6.	When the hospital provides care for more than 30 days, it provides outside areas for patient use, suitable to the patient's age, physical or mental condition, or other factors.	<b>A</b>
	11.	Lighting is suitable for care, treatment, and services.	<b>C</b>
	13.	The hospital maintains ventilation, temperature, and humidity levels suitable for the care, treatment, and services provided.	<b>A</b>
<b>M</b>	18.	Interior spaces accommodate the use of equipment, such as wheelchairs, necessary to the activities of daily living.	<b>C</b>
<b>M</b>	20.	Areas used by patients are clean and free of offensive odors.	<b>C</b>
	23.	The hospital provides emergency access to all locked and occupied spaces.	<b>3 A</b>
<b>M</b>	26.	The hospital keeps furnishings and equipment safe and in good repair.	<b>C</b>

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

## Standard EC.02.06.05

The hospital manages its environment during demolition, renovation, or new construction to reduce risk to those in the organization.

### Elements of Performance for EC.02.06.05

- |    |   |  |
|----|---|--|
| 1. | When planning for new, altered, or renovated space, the hospital uses one of the following design criteria:<br>- State rules and regulations<br>- Guidelines for Design and Construction of Hospitals and Health Care Facilities, 2001 edition, published by the American Institute of Architects<br>When the above rules, regulations, and guidelines do not meet specific design needs, use other reputable standards and guidelines that provide equivalent design criteria.<br>(See also EC.02.05.01, EP 1) | <b>A</b>   |
| 2. | When planning for demolition, construction, or renovation, the hospital conducts a preconstruction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services.<br>Note: See LS.01.02.01 for information on fire safety procedures to implement during construction or renovation.   | <b>A</b>   |
| 3. | The hospital takes action based on its assessment to minimize risks during demolition, construction, or renovation.   |  <b>A</b> |




## 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 and licensed independent practitioners can describe or demonstrate methods for eliminating and minimizing physical risks in the environment of care. (See also HR.01.04.01, EP 1) | <b>C</b> |
|  | 2. Staff and licensed independent practitioners can describe or demonstrate actions to take in the event of an environment of care incident. (See also HR.01.04.01, EP 1)                  | <b>C</b> |
|  | 3. Staff and licensed independent practitioners can describe or demonstrate how to report environment of care risks. (See also HR.01.04.01, EP 1)  | <b>C</b> |

## Standard EC.04.01.01

The hospital collects information to monitor conditions in the environment.

### Elements of Performance for EC.04.01.01

- |              |   |          |
|--------------|---|----------|
| 1.           | The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:<br>- Injuries to patients or others within the hospital's facilities<br>- Occupational illnesses and staff injuries<br>- Incidents of damage to its property or the property of others<br>- Security incidents involving patients, staff, or others within its facilities<br>- Hazardous materials and waste spills and exposures<br>- Fire safety management problems, deficiencies, and failures<br>- Medical or laboratory equipment management problems, failures, and use errors<br>- Utility systems management problems, failures, or use errors<br>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.<br>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. | <b>A</b> |
| <b>M</b> 3.  | Based on its process(es), the hospital reports and investigates the following: Injuries to patients or others in the hospital's facilities. (See also EC.04.01.03, EP 1)  | <b>C</b> |
| <b>M</b> 4.  | Based on its process(es), the hospital reports and investigates the following: Occupational illnesses and staff injuries. (See also EC.04.01.03, EP 1)  | <b>C</b> |
| <b>M</b> 5.  | Based on its process(es), the hospital reports and investigates the following: Incidents of damage to its property or the property of others. (See also EC.04.01.03, EP 1)  | <b>C</b> |
| <b>M</b> 6.  | Based on its process(es), the hospital reports and investigates the following: Security incidents involving patients, staff, or others within its facilities. (See also EC.04.01.03, EP 1)  | <b>C</b> |
| <b>M</b> 8.  | Based on its process(es), the hospital reports and investigates the following: Hazardous materials and waste spills and exposures. (See also EC.04.01.03, EP 1)   | <b>C</b> |
| <b>M</b> 9.  | Based on its process(es), the hospital reports and investigates the following: Fire safety management problems, deficiencies, and failures. (See also EC.04.01.03, EP 1)  | <b>C</b> |
| <b>M</b> 10. | Based on its process(es), the hospital reports and investigates the following: Medical/laboratory equipment management problems, failures, and use errors. (See also EC.04.01.03, EP 1)   | <b>C</b> |
| <b>M</b> 11. | Based on its process(es), the hospital reports and investigates the following: Utility systems management problems, failures, or use errors. (See also EC.04.01.03, EP 1)   | <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

12.	The hospital conducts environmental tours every six months in patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks. (See also EC.04.01.03, EP 1)	<b>A</b>
<b>M</b> 13.	The hospital conducts annual environmental tours in nonpatient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate risks in the environment. (See also EC.04.01.03, EP 1)	<b>C</b>
14.	The hospital uses its tours to identify environmental deficiencies, hazards, and unsafe practices. (See also EC.02.01.01, EP 1; EC.04.01.03, EP 1)	<b>A</b>
15.	Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness. (See also EC.01.01.01, EPs 3-8; EC.04.01.03, EP 1)	<b>3 A</b>

**Standard EC.04.01.03**

The hospital analyzes identified environment of care issues.

**Elements of Performance for EC.04.01.03**

1.	Representatives from clinical, administrative, and support services participate in the analysis of environment of care data. (See also EC.04.01.01, EPs 3-6 and 8-15; EC.04.01.05, EP 3)	<b>A</b>
<b>M</b> 2.	The hospital uses the results of data analysis to identify opportunities to resolve environmental safety issues. (See also EC.04.01.05, EP 1)	<b>C</b>
3.	Annually, representatives from clinical, administrative, and support services recommend one or more priorities for improving the environment of care.	<b>A</b>

**Standard EC.04.01.05**

The hospital improves its environment of care.

**Elements of Performance for EC.04.01.05**

<b>M</b> 1.	The hospital takes action on the identified opportunities to resolve environmental safety issues. (See also EC.04.01.03, EP 2)	<b>C</b>
<b>M</b> 2.	The hospital evaluates changes to determine if they resolved environmental safety issues.	<b>C</b>
3.	The hospital reports performance improvement results to those responsible for analyzing environment of care issues. (See also EC.04.01.03, EP 1; EM.03.01.03, EP 15)	<b>A</b>

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required



# Emergency Management

**Standard EM.01.01.01**

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

Note: An emergency is an unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand for the organization's services. Emergencies can be either human-made or natural (such as an electrical system failure or a tornado), or a combination of both, and they exist on a continuum of severity. A disaster is a type of emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

**Rationale for EM.01.01.01**

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

**Elements of Performance for EM.01.01.01**

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| 1. | The hospital's leaders, including leaders of the medical staff, participate in planning activities prior to developing an Emergency Operations Plan.  | <b>A</b> |
| 2. | <b>D</b> The hospital conducts a hazard vulnerability analysis (HVA) to identify potential emergencies that could affect demand for the hospital's services or its ability to provide those services, the likelihood of those events occurring, and the consequences of those events. The findings of this analysis are documented. (See also EM.03.01.01, EP 1; IC.01.06.01, EP 4)<br>Note 1: Hospitals have flexibility in creating either a single HVA that accurately reflects all sites of the hospital, or multiple HVAs. Some remote sites may be significantly different from the main site (for example, in terms of hazards, location, and population served); in such situations a separate HVA is appropriate.<br>Note 2: If the hospital identifies a surge in infectious patients as a potential emergency, this issue is addressed in the "Infection Prevention and Control" (IC) chapter. | <b>A</b> |
| 3. | <b>D</b> The hospital, together with its community partners, prioritizes the potential emergencies identified in its hazard vulnerability analysis (HVA) and documents these priorities.<br>Note: The hospital determines which community partners are critical to helping define priorities in its HVA. Community partners may include other health care organizations, the public health department, vendors, community organizations, public safety and public works officials, representatives of local municipalities, and other government agencies.  | <b>A</b> |
| 4. | The hospital communicates its needs and vulnerabilities to community emergency response agencies and identifies the community's capability to meet its needs. This communication and identification occur at the time of the hospital's annual review of its Emergency Operations Plan and whenever its needs or vulnerabilities change. (See also EM.03.01.01, EP 1)   | <b>A</b> |

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| 5. | The hospital uses its hazard vulnerability analysis as a basis for defining mitigation activities (that is, activities designed to reduce the risk of and potential damage from an emergency).<br>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.   | <b>A</b> |
| 6. | The hospital uses its hazard vulnerability analysis as a basis for defining the preparedness activities that will organize and mobilize essential resources. (See also IM.01.01.03, EPs 1-4)  | <b>A</b> |
| 7. | The hospital's incident command structure is integrated into and consistent with its community's command structure.<br>Note: The incident command structure used by the hospital should provide for a scalable response to different types of emergencies.<br>Footnote: The National Incident Management System (NIMS) is one of many models for an incident command structure available to health care organizations. The NIMS provides guidelines for common functions and terminology to support clear communications and effective collaboration in an emergency situation. The NIMS is required of hospitals receiving certain federal funds for emergency preparedness. | <b>A</b> |
| 8. | <b>D</b> The hospital keeps a documented inventory of the resources and assets it has on site that may be needed during an emergency, including, but not limited to, personal protective equipment, water, fuel, and medical, surgical, and medication-related resources and assets. (See also EM.02.02.03, EP 6)   | <b>A</b> |

**Standard EM.02.01.01**



The hospital has an Emergency Operations Plan.


Note: The hospital's Emergency Operations Plan (EOP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, EM.02.02.09, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This "all hazards" approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the Plan's response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.

**Rationale for EM.02.01.01**

A successful response effort relies on a comprehensive and flexible Emergency Operations Plan that guides decision making at the onset of an emergency and as an emergency evolves. Although the Emergency Operations Plan can be formatted in a variety of ways, it must address response procedures that are both applicable to the hospital's likely emergencies and adaptable in supporting key areas (such as communications and patient care) that might be affected by emergencies of different causes.

**Elements of Performance for EM.02.01.01**

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| 1.   | The hospital's leaders, including leaders of the medical staff, participate in the development of the Emergency Operations Plan.  | <b>A</b> |
| 2.    | <p>The hospital develops and maintains a written Emergency Operations Plan that describes the response procedures to follow when emergencies occur. (See also EM.03.01.03, EP 5)</p> <p>Note: The response procedures address the prioritized emergencies but can also be adapted to other emergencies that the hospital may experience. Response procedures could include the following:</p> <ul style="list-style-type: none"> <li>- Maintaining or expanding services</li> <li>- Conserving resources</li> <li>- Curtailing services</li> <li>- Supplementing resources from outside the local community</li> <li>- Closing the hospital to new patients</li> <li>- Staged evacuation</li> <li>- Total evacuation</li> </ul> | <b>A</b> |
| 3.   | <p>The Emergency Operations Plan identifies the hospital's capabilities and establishes response procedures for when the hospital cannot be supported by the local community in the hospital's efforts to provide communications, resources and assets, security and safety, staff, utilities, or patient care for at least 96 hours.</p> <p>Note: Hospitals are not required to stockpile supplies to last for 96 hours of operation.</p>  | <b>A</b> |
| 4.  | The hospital develops and maintains a written Emergency Operations Plan that describes the recovery strategies and actions designed to help restore the systems that are critical to providing care, treatment, and services after an emergency.  | <b>A</b> |

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| 5. | The Emergency Operations Plan describes the processes for initiating and terminating the hospital's response and recovery phases of an emergency, including under what circumstances these phases are activated.<br>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. | <b>A</b>   |
| 6. | The Emergency Operations Plan identifies the individual(s) who has the authority to activate the response and recovery phases of the emergency response.  | <b>A</b>   |
| 7. | The Emergency Operations Plan identifies alternative sites for care, treatment, and services that meet the needs of the hospital's patients during emergencies.   | <b>A</b>   |
| 8. | If the hospital experiences an actual emergency, the hospital implements its response procedures related to care, treatment, and services for its patients.   |  <b>A</b> |

**Standard EM.02.02.01**

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

**Rationale for EM.02.02.01**

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

**Elements of Performance for EM.02.02.01**

1.	The Emergency Operations Plan describes the following: How staff will be notified that emergency response procedures have been initiated.	<b>A</b>
2.	The Emergency Operations Plan describes the following: How the hospital will communicate information and instructions to its staff and licensed independent practitioners during an emergency.	<b>A</b>
3.	The Emergency Operations Plan describes the following: How the hospital will notify external authorities that emergency response measures have been initiated.	<b>A</b>
4.	The Emergency Operations Plan describes the following: How the hospital will communicate with external authorities during an emergency.	<b>A</b>
5.	The Emergency Operations Plan describes the following: How the hospital will communicate with patients and their families, including how it will notify families when patients are relocated to alternative care sites.	<b>A</b>
6.	The Emergency Operations Plan describes the following: How the hospital will communicate with the community or the media during an emergency.	<b>A</b>
7.	The Emergency Operations Plan describes the following: How the hospital will communicate with suppliers of essential services, equipment, and supplies during an emergency.	<b>A</b>
8.	The Emergency Operations Plan describes the following: How the hospital will communicate with other health care organizations in its contiguous geographic area regarding the essential elements of their respective command structures, including the names and roles of individuals in their command structures and their command center telephone numbers.	<b>A</b>
9.	The Emergency Operations Plan describes the following: How the hospital will communicate with other health care organizations in its contiguous geographic area regarding the essential elements of their respective command centers for emergency response.	<b>A</b>
10.	The Emergency Operations Plan describes the following: How the hospital will communicate with other health care organizations in its contiguous geographic area regarding the resources and assets that could be shared in an emergency response.	<b>A</b>
11.	The Emergency Operations Plan describes the following: How and under what circumstances the hospital will communicate the names of patients and the deceased with other health care organizations in its contiguous geographic area.	<b>A</b>

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

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| 12. | The Emergency Operations Plan describes the following: How, and under what circumstances, the hospital will communicate information about patients to third parties (such as other health care organizations, the state health department, police, the FBI). | <b>A</b> |
| 13. | The Emergency Operations Plan describes the following: How the hospital will communicate with identified alternative care sites.   | <b>A</b> |
| 14. | The hospital establishes backup systems and technologies for the communication activities identified in EM.02.02.01, EPs 1-13.   | <b>A</b> |
| 17. | The hospital implements the components of its Emergency Operations Plan that require advance preparation to support communications during an emergency.  | <b>A</b> |

**Standard EM.02.02.03**

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

**Rationale for EM.02.02.03**

The hospital that continues to provide care, treatment, and services to its patients during emergencies needs to determine how resources and assets (that is, supplies, equipment, and facilities) will be managed internally and, when necessary, solicited and acquired from external sources such as vendors, neighboring health care providers, other community organizations, state affiliates, or a regional parent company. The hospital should also recognize the risk that some resources may not be available from planned sources, particularly in emergencies of long duration or broad geographic scope, and that contingency plans will be necessary for critical supplies. This situation may occur when multiple hospitals are vying for a limited supply from the same vendor.

**Elements of Performance for EM.02.02.03**

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| 1. | The Emergency Operations Plan describes the following: How the hospital will obtain and replenish medications and related supplies that will be required throughout the response and recovery phases of an emergency, including access to and distribution of caches that may be stockpiled by the hospital, its affiliates, or local, state, or federal sources.  | <b>A</b> |
| 2. | The Emergency Operations Plan describes the following: How the hospital will obtain and replenish medical supplies that will be required throughout the response and recovery phases of an emergency, including personal protective equipment where required.  | <b>A</b> |
| 3. | The Emergency Operations Plan describes the following: How the hospital will obtain and replenish nonmedical supplies that will be required throughout the response and recovery phases of an emergency.   | <b>A</b> |
| 4. | The Emergency Operations Plan describes the following: How the hospital will share resources and assets with other health care organizations within the community, if necessary.<br>Note: Examples of resources and assets that might be shared include beds, transportation, linens, fuel, personal protective equipment, medical equipment, and supplies.  | <b>A</b> |
| 5. | The Emergency Operations Plan describes the following: How the hospital will share resources and assets with other health care organizations outside the community, if necessary, in the event of a regional or prolonged disaster.<br>Note: Examples of resources and assets that might be shared include beds, transportation, linens, fuel, personal protective equipment, medical equipment, and supplies. | <b>A</b> |
| 6. | The Emergency Operations Plan describes the following: How the hospital will monitor quantities of its resources and assets during an emergency. (See also EM.01.01.01, EP 8)  | <b>A</b> |
| 9. | The Emergency Operations Plan describes the following: The hospital's arrangements for transporting some or all patients, their medications, supplies, equipment, and staff to an alternative care site(s) when the environment cannot support care, treatment, and services. (See also EM.02.02.11, EP 3)   | <b>A</b> |





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| 10. | The Emergency Operations Plan describes the following: The hospital's arrangements for transferring pertinent information, including essential clinical and medication-related information, with patients moving to alternative care sites. (See also EM.02.02.11, EP 3) | <b>A</b> |
| 12. | The hospital implements the components of its Emergency Operations Plan that require advance preparation to provide for resources and assets during an emergency.  | <b>A</b> |

### Standard EM.02.02.05

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

#### Elements of Performance for EM.02.02.05

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| 1.  | The Emergency Operations Plan describes the following: The hospital's arrangements for internal security and safety.   | <b>A</b> |
| 2.  | The Emergency Operations Plan describes the following: The roles that community security agencies (for example, police, sheriff, National Guard) will have in the event of an emergency.     | <b>A</b> |
| 3.  | The Emergency Operations Plan describes the following: How the hospital will coordinate security activities with community security agencies (for example, police, sheriff, National Guard). | <b>A</b> |
| 4.  | The Emergency Operations Plan describes the following: How the hospital will manage hazardous materials and waste.   | <b>A</b> |
| 5.  | The Emergency Operations Plan describes the following: How the hospital will provide for radioactive, biological, and chemical isolation and decontamination.                                | <b>A</b> |
| 7.  | The Emergency Operations Plan describes the following: How the hospital will control entrance into and out of the health care facility during an emergency.                                  | <b>A</b> |
| 8.  | The Emergency Operations Plan describes the following: How the hospital will control the movement of individuals within the health care facility during an emergency.                        | <b>A</b> |
| 9.  | The Emergency Operations Plan describes the following: The hospital's arrangements for controlling vehicles that access the health care facility during an emergency.                        | <b>A</b> |
| 10. | The hospital implements the components of its Emergency Operations Plan that require advance preparation to support security and safety during an emergency.                                 | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required




**Standard EM.02.02.07**

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

**Rationale for EM.02.02.07**

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

**Elements of Performance for EM.02.02.07**

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| 2.   | The Emergency Operations Plan describes the following: The roles and responsibilities of staff for communications, resources and assets, safety and security, utilities, and patient management during an emergency.   | <b>A</b> |
| 3.   | The Emergency Operations Plan describes the following: The process for assigning staff to all essential staff functions.   | <b>A</b> |
| 4.   | The Emergency Operations Plan identifies the individual(s) to whom staff report in the hospital's incident command structure.  | <b>A</b> |
| 5.   | The Emergency Operations Plan describes how the hospital will manage staff support needs (for example, housing, transportation, incident stress debriefing).   | <b>A</b> |
| 6.   | The Emergency Operations Plan describes how the hospital will manage the family support needs of staff (for example, child care, elder care, pet care, communication).   | <b>A</b> |
|  7.   | The hospital trains staff for their assigned emergency response roles.   | <b>C</b> |
|  8.  | The hospital communicates, in writing, with each of its licensed independent practitioners regarding his or her role(s) in emergency response and to whom he or she reports during an emergency.   | <b>C</b> |
| 9.   | The Emergency Operations Plan describes how the hospital will identify licensed independent practitioners, staff, and authorized volunteers during emergencies. (See also EM.02.02.13, EP 3; EM.02.02.15, EP 3)<br>Note: This identification could include identification cards, wristbands, vests, hats, or badges. | <b>A</b> |
| 10.  | The hospital implements the components of its Emergency Operations Plan that require advance preparation to manage staff during an emergency.  | <b>A</b> |

**Standard EM.02.02.09**

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

**Rationale for EM.02.02.09**

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

**Elements of Performance for EM.02.02.09**

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| 2. | As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following: Electricity.   | <b>A</b> |
| 3. | As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following: Water needed for consumption and essential care activities.  | <b>A</b> |
| 4. | As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following: Water needed for equipment and sanitary purposes.  | <b>A</b> |
| 5. | As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following: Fuel required for building operations, generators, and essential transport services that the hospital would typically provide.                                     | <b>A</b> |
| 6. | As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following: Medical gas/vacuum systems.  | <b>A</b> |
| 7. | As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following: Utility systems that the hospital defines as essential (for example, vertical and horizontal transport, heating and cooling systems, and steam for sterilization). | <b>A</b> |
| 8. | The hospital implements the components of its Emergency Operations Plan that require advance preparation to provide for utilities during an emergency.   | <b>A</b> |

**Standard EM.02.02.11**

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

**Rationale for EM.02.02.11**

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

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

**Elements of Performance for EM.02.02.11**

2.	The Emergency Operations Plan describes the following: How the hospital will manage the activities required as part of patient scheduling, triage, assessment, treatment, admission, transfer, and discharge.	<b>A</b>
3.	The Emergency Operations Plan describes the following: How the hospital will evacuate (from one section or floor to another within the building, or, completely outside the building) when the environment cannot support care, treatment, and services. (See also EM.02.02.03, EPs 9 and 10)	<b>A</b>
4.	The Emergency Operations Plan describes the following: How the hospital will manage a potential increase in demand for clinical services for vulnerable populations served by the hospital, such as patients who are pediatric, geriatric, disabled, or have serious chronic conditions or addictions.	<b>A</b>
5.	The Emergency Operations Plan describes the following: How the hospital will manage the personal hygiene and sanitation needs of its patients.	<b>A</b>
6.	The Emergency Operations Plan describes the following: How the hospital will manage its patients' mental health service needs that occur during an emergency.	<b>A</b>
7.	The Emergency Operations Plan describes the following: How the hospital will manage mortuary services.	<b>A</b>
8.	The Emergency Operations Plan describes the following: How the hospital will document and track patients' clinical information.	<b>A</b>
11.	The hospital implements the components of its Emergency Operations Plan that require advance preparation to manage patients during an emergency.	<b>A</b>





**Standard EM.02.02.13**

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

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

**Elements of Performance for EM.02.02.13**

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| 1. | The hospital grants disaster privileges to volunteer licensed independent practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.  | <b>A</b>  |
| 2. | (D) The medical staff identifies, in its bylaws, those individuals responsible for granting disaster privileges to volunteer licensed independent practitioners.  | <b>A</b>  |
| 3. | The hospital determines how it will distinguish volunteer licensed independent practitioners from other licensed independent practitioners. (See also EM.02.02.07, EP 9)  | <b>A</b>  |
| 4. | (D) The medical staff describes, in writing, how it will oversee the performance of volunteer licensed independent practitioners who are granted disaster privileges (for example, by direct observation, mentoring, medical record review).  | <b>A</b>  |
| 5. | <p>Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:</p> <ul style="list-style-type: none"> <li>- A current picture identification card from a health care organization that clearly identifies professional designation</li> <li>- A current license to practice</li> <li>- Primary source verification of licensure</li> <li>- 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</li> <li>- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances</li> <li>- Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster</li> </ul> | <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">3</div> <b>A</b> </div> |
| 6. | During a disaster, the medical staff oversees the performance of each volunteer licensed independent practitioner.  | <b>A</b>  |
| 7. | Based on its oversight of each volunteer licensed independent practitioner, the hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue.   | <b>C</b>  |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

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

**Standard EM.02.02.15**

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

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

**Elements of Performance for EM.02.02.15**

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|----|---|---|
| 1. | The hospital assigns disaster responsibilities to volunteer practitioners who are not licensed independent practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.   | <b>A</b>  |
| 2. | ② The hospital identifies, in writing, those individuals responsible for assigning disaster responsibilities to volunteer practitioners who are not licensed independent practitioners.   | <b>A</b>  |
| 3. | The hospital determines how it will distinguish volunteer practitioners who are not licensed independent practitioners from its staff. (See also EM.02.02.07, EP 9)   | <b>A</b>  |
| 4. | ② The hospital describes, in writing, how it will oversee the performance of volunteer practitioners who are not licensed independent practitioners who have been assigned disaster responsibilities. Examples of methods for overseeing their performance include direct observation, mentoring, and medical record review.  | <b>A</b>  |
| 5. | <p>Before a volunteer practitioner who is not a licensed independent practitioner is considered eligible to function as a practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and one of the following:</p> <ul style="list-style-type: none"> <li>- A current picture identification card from a health care organization that clearly identifies professional designation</li> <li>- A current license, certification, or registration</li> <li>- Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice)</li> <li>- 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</li> <li>- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances</li> <li>- Confirmation by hospital staff with personal knowledge of the volunteer practitioner's ability to act as a qualified practitioner during a disaster</li> </ul> | <div style="display: inline-block; border: 1px solid black; padding: 2px; text-align: center;">3</div> <b>A</b> |
| 6. | During a disaster, the hospital oversees the performance of each volunteer practitioner who is not a licensed independent practitioner.   | <b>A</b>  |
| 7. | Based on its oversight of each volunteer practitioner who is not a licensed independent practitioner, the hospital determines within 72 hours after the practitioner's arrival whether assigned disaster responsibilities should continue.  | <b>C</b>  |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; ② indicates situational decision rules apply; ③ indicates direct impact requirements apply; ④ indicates Measure of Success if needed; ⑤ indicates that documentation is required

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| 8. | D | Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice) of volunteer practitioners who are not licensed independent practitioners occurs as soon as the disaster is under control or within 72 hours from the time the volunteer practitioner presents him- or herself to the hospital, whichever comes first. If primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice) for a volunteer practitioner who is not a licensed independent practitioner cannot be completed within 72 hours due to extraordinary circumstances, the hospital documents all of the following:<br>- Reason(s) it could not be performed within 72 hours of the practitioner's arrival<br>- Evidence of the volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment, or services<br>- Evidence of the hospital's attempt to perform primary source verification as soon as possible | C |
| 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.<br>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.  | C |

### Standard EM.03.01.01

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

#### Rationale for EM.03.01.01

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

#### Elements of Performance for EM.03.01.01

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| 1. | D | The hospital conducts an annual review of its risks, hazards, and potential emergencies as defined in its hazard vulnerability analysis (HVA). The findings of this review are documented. (See also EM.01.01.01, EPs 2 and 4) | A |
| 2. | D | The hospital conducts an annual review of the objectives and scope of its Emergency Operations Plan. The findings of this review are documented.   | A |
| 3. | D | The hospital conducts an annual review of its inventory. The findings of this review are documented.   | A |

**Standard EM.03.01.03**


The hospital evaluates the effectiveness of its Emergency Operations Plan.

**Rationale for EM.03.01.03**

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

**Elements of Performance for EM.03.01.03**

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| 1. | <p>As an emergency response exercise, the hospital activates its Emergency Operations Plan twice a year at each site included in the plan.</p> <p>Note 1: If the hospital activates its Emergency Operations Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises.</p> <p>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.</p> <p>Note 3: Tabletop sessions, though useful, are not acceptable substitutes for these exercises.</p> <p>Footnote: The Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA. Refer to NFPA 101-2000 for occupancy classifications.</p> | <b>A</b> |
| 2. | <p>For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital's two emergency response exercises includes an influx of simulated patients.</p> <p>Note 1: Tabletop sessions, though useful, cannot serve for this portion of the exercise.</p> <p>Note 2: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 3 and 4.</p>   | <b>A</b> |
| 3. | <p>For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital's two emergency response exercises includes an escalating event in which the local community is unable to support the hospital.</p> <p>Note 1: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 2 and 4.</p> <p>Note 2: Tabletop sessions are acceptable in meeting the community portion of this exercise.</p>   | <b>A</b> |
| 4. | <p>For each site of the hospital with a defined role in its community's response plan, at least one of the two emergency response exercises includes participation in a community-wide exercise.</p> <p>Note 1: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 2 and 3.</p> <p>Note 2: Tabletop sessions are acceptable in meeting the community portion of this exercise.</p>  | <b>A</b> |

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| 5.  | Emergency response exercises incorporate likely disaster scenarios that allow the hospital to evaluate its handling of communications, resources and assets, security, staff, utilities, and patients. (See also EM.02.01.01, EP 2)  | <b>A</b> |
| 6.  | <p>The hospital designates an individual(s) whose sole responsibility during emergency response exercises is to monitor performance and document opportunities for improvement.</p> <p>Note 1: This person is knowledgeable in the goals and expectations of the exercise and may be a staff member of the hospital.</p> <p>Note 2: If the response to an actual emergency is used as one of the required exercises, it is understood that it may not be possible to have an individual whose sole responsibility is to monitor performance. Hospitals may use observations of those who were involved in the command structure as well as the input of those providing services during the emergency.</p> | <b>A</b> |
| 7.  | During emergency response exercises, the hospital monitors the effectiveness of internal communication and the effectiveness of communication with outside entities such as local government leadership, police, fire, public health officials, and other health care organizations.   | <b>A</b> |
| 8.  | During emergency response exercises, the hospital monitors resource mobilization and asset allocation, including equipment, supplies, personal protective equipment, and transportation.   | <b>A</b> |
| 9.  | During emergency response exercises, the hospital monitors its management of the following: Safety and security.   | <b>A</b> |
| 10.   | During emergency response exercises, the hospital monitors its management of the following: Staff roles and responsibilities.  | <b>A</b> |
| 11.   | During emergency response exercises, the hospital monitors its management of the following: Utility systems.   | <b>A</b> |
| 12.   | During emergency response exercises, the hospital monitors its management of the following: Patient clinical and support care activities.  | <b>A</b> |
| 13.   | Based on all monitoring activities and observations, the hospital evaluates all emergency response exercises and all responses to actual emergencies using a multidisciplinary process (which includes licensed independent practitioners).  | <b>A</b> |
| 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.   | <b>A</b> |
| 15.   | The deficiencies and opportunities for improvement, identified in the evaluation of all emergency response exercises and all responses to actual emergencies, are communicated to the improvement team responsible for monitoring environment of care issues. (See also EC.04.01.05, EP 3)   | <b>A</b> |
| 16.   | <p>The hospital modifies its Emergency Operations Plan based on its evaluation of emergency response exercises and responses to actual emergencies.</p> <p>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.</p>   | <b>A</b> |
| 17.   | Subsequent emergency response exercises reflect modifications and interim measures as described in the modified Emergency Operations Plan.   | <b>A</b> |



## Human Resources

## Standard HR.01.01.01

The hospital has the necessary staff to support the care, treatment, and services it provides.


### Elements of Performance for HR.01.01.01

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| 28. | For hospitals that use Joint Commission accreditation for deemed status purposes: A full-time, part-time, or consulting pharmacist develops, supervises, and coordinates all the activities of the pharmacy department or pharmacy services. | <b>A</b> |
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## Standard HR.01.02.01

The hospital defines staff qualifications.











### Elements of Performance for HR.01.02.01





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| 1.  | <p>The hospital defines staff qualifications specific to their job responsibilities. (See also IC.01.01.01, EP 3)</p> <p>Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).</p> <p>Note 2: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88), under Subpart M: "Personnel for Nonwaived Testing" §493.1351-§493.1495. A complete description of the requirement is located at <a href="http://wwwn.cdc.gov/clia/regs/toc.aspx">http://wwwn.cdc.gov/clia/regs/toc.aspx</a>.</p> <p>Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital.</p> | <b>A</b>   |
| 19. | For hospitals that use Joint Commission accreditation for deemed status purposes: If blood transfusions and intravenous medications are administered by staff other than doctors of medicine or osteopathy, the staff members have special training for this duty.  |  <b>A</b> |





## Standard HR.01.02.05

The hospital verifies staff qualifications.

### Elements of Performance for HR.01.02.05

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| <p>1.  When law or regulation requires care providers to be currently licensed, certified, or registered to practice their professions, the hospital both verifies these credentials with the primary source and documents this verification when a provider is hired and when his or her credentials are renewed. (See also HR.01.02.07, EP 2)</p> <p>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.</p> <p>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.</p> <p>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.</p> | <p><b>A</b></p>   |
| <p> 2.  When the hospital requires licensure, registration, or certification not required by law and regulation, the hospital both verifies these credentials and documents this verification at time of hire and when credentials are renewed. (See also HR.01.02.07, EP 2)</p>   | <p><b>C</b></p>   |
| <p> 3.  The hospital verifies and documents that the applicant has the education and experience required by the job responsibilities.</p>  | <p><b>C</b></p>   |
| <p> 4.  The hospital obtains a criminal background check on the applicant as required by law and regulation or hospital policy. Criminal background checks are documented.</p>   | <p><b>C</b></p>   |
| <p> 5.  Staff comply with applicable health screening as required by law and regulation or hospital policy. Health screening compliance is documented.</p>   | <p><b>C</b></p>   |
| <p>6. The hospital uses the following information from HR.01.02.05, Elements of Performance 1-5, to make decisions about staff job responsibilities:</p> <ul style="list-style-type: none"> <li>- Required licensure, certification, or registration verification</li> <li>- Required credentials verification</li> <li>- Education and experience verification</li> <li>- Criminal background check</li> <li>- Applicable health screenings</li> </ul>  | <p><b>A</b></p>   |
| <p>7. Before providing care, treatment, and services, the hospital confirms that nonemployees who are brought into the hospital by a licensed independent practitioner to provide care, treatment, or services have the same qualifications and competencies required of employed individuals performing the same or similar services at the hospital.</p> <p>Note 1: This confirmation can be accomplished either through the hospital's regular process or with the licensed independent practitioner who brought in the individual.</p> <p>Note 2: When the care, treatment, and services provided by the nonemployee are not currently performed by anyone employed by the hospital, leadership consults the appropriate professional hospital guidelines for the required credentials and competencies.</p>   | <p> <b>A</b></p> |




**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required





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| 10. | Physician assistants and advanced practice registered nurses who practice within the hospital are credentialed, privileged, and re-privileged through the medical staff process or an equivalent process.<br>Note: Advanced practice registered nurses who are licensed independent practitioners are credentialed and privileged only through the medical staff credentialing and privileging process. (See also the "Medical Staff" (MS) chapter) |  <b>A</b> |
| 11. | The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the hospital is approved by the governing body.   | <b>A</b>   |
| 12. |  The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the hospital includes the following: An evaluation of the applicant's credentials. The evaluation is documented.  | <b>A</b>   |
| 13. |  The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the hospital includes the following: An evaluation of the applicant's current competence. The evaluation is documented.   | <b>A</b>   |
| 14. |  The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the hospital includes the following: Peer recommendations. The peer recommendations are documented.   | <b>A</b>   |
| 15. | The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the hospital includes the following: Input from individuals and committees, including the medical staff executive committee, in order to make an informed decision regarding requests for privileges.   | <b>A</b>   |

### Standard HR.01.02.07

The hospital determines how staff function within the organization.

#### Elements of Performance for HR.01.02.07

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| 1.   | All staff who provide patient care, treatment, and services possess a current license, certification, or registration, in accordance with law and regulation.   |  <b>A</b>  |
| 2.   | Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration and as required by law and regulation. (See also HR.01.02.05, EPs 1 and 2) |  <b>A</b> |
|  5. | Staff oversee the supervision of students when they provide patient care, treatment, and services as part of their training.  | <b>C</b>  |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

## Standard HR.01.04.01

The hospital provides orientation to staff.

### Elements of Performance for HR.01.04.01

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|----------------------|--|----------|
| 1.                   | The hospital determines the key safety content of orientation provided to staff. (See also EC.03.01.01, EPs 1-3)<br>Note: Key safety content may include specific processes and procedures related to the provision of care, treatment, and services; the environment of care; and infection control.  | <b>A</b> |
| <b>M</b> 2. <b>D</b> | The hospital orients its staff to the key safety content before staff provides care, treatment, and services. Completion of this orientation is documented. (See also IC.01.05.01, EP 6)   | <b>C</b> |
| <b>M</b> 3. <b>D</b> | The hospital orients staff on the following: Relevant hospital-wide and unit-specific policies and procedures. Completion of this orientation is documented.   | <b>C</b> |
| <b>M</b> 4. <b>D</b> | The hospital orients staff on the following: Their specific job duties, including those related to infection prevention and control and assessing and managing pain. Completion of this orientation is documented. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7; IC.02.04.01, EP 2; RI.01.01.01, EP 8)   | <b>C</b> |
| <b>M</b> 5. <b>D</b> | The hospital orients staff on the following: Sensitivity to cultural diversity based on their job duties and responsibilities. Completion of this orientation is documented.   | <b>C</b> |
| <b>M</b> 6. <b>D</b> | The hospital orients staff on the following: Patient rights, including ethical aspects of care, treatment, and services and the process used to address ethical issues based on their job duties and responsibilities. Completion of this orientation is documented.   | <b>C</b> |
| <b>M</b> 7.          | The hospital orients external law enforcement and security personnel on the following:<br>- How to interact with patients<br>- Procedures for responding to unusual clinical events and incidents<br>- The hospital's channels of clinical, security, and administrative communication<br>- Distinctions between administrative and clinical seclusion and restraint | <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

### Standard HR.01.05.03

Staff participate in ongoing education and training.

#### Elements of Performance for HR.01.05.03

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| <p><b>(M)</b> 1. <b>(D)</b> Staff participate in ongoing education and training to maintain or increase their competency. Staff participation is documented.</p> <p><b>(M)</b> 4. <b>(D)</b> Staff participate in ongoing education and training whenever staff responsibilities change. Staff participation is documented.</p> <p><b>(M)</b> 5. <b>(D)</b> Staff participate in education and training that is specific to the needs of the patient population served by the hospital. Staff participation is documented. (See also PC.01.02.09, EP 3)</p> <p><b>(M)</b> 6. <b>(D)</b> Staff participate in education and training that incorporates the skills of team communication, collaboration, and coordination of care. Staff participation is documented.</p> <p><b>(M)</b> 7. <b>(D)</b> Staff participate in education and training that includes information about the need to report unanticipated adverse events and how to report these events. Staff participation is documented.</p> <p><b>(M)</b> 8. <b>(D)</b> Staff participate in education and training on fall reduction activities. Staff participation is documented.</p> <p><b>(M)</b> 13. <b>(D)</b> The hospital provides education and training that addresses how to identify early warning signs of a change in a patient's condition and how to respond to a deteriorating patient, including how and when to contact responsible clinicians. Education is provided to staff and licensed independent practitioners who may request assistance and those who may respond to those requests. Participation in this education is documented.</p> | <p><b>C</b></p> <p><b>C</b></p> <p><b>C</b></p> <p><b>C</b></p> <p><b>C</b></p> <p><b>C</b></p> <p><b>C</b></p> <p><b>3 C</b></p> |
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## Standard HR.01.06.01

Staff are competent to perform their responsibilities.

### Elements of Performance for HR.01.06.01

1.	The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services.	A
2.	The hospital uses assessment methods to determine the individual's competence in the skills being assessed. Note: Methods may include test taking, return demonstration, or the use of simulation.	A
<b>(M)</b> 3.	An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence. Note: When a suitable individual cannot be found to assess staff competence, the hospital can utilize an outside individual for this task. Alternatively, the hospital may consult the competency guidelines from an appropriate professional organization to make its assessment.	C
<b>(M)</b> 5. <b>(D)</b>	Staff competence is initially assessed and documented as part of orientation.	<b>(3)</b> C
<b>(M)</b> 6. <b>(D)</b>	Staff competence is assessed and documented once every three years, or more frequently as required by hospital policy or in accordance with law and regulation.	C
15.	The hospital takes action when a staff member's competence does not meet expectations.	<b>(3)</b> A

## Standard HR.01.07.01

The hospital evaluates staff performance.

### Elements of Performance for HR.01.07.01

<b>(M)</b> 1.	The hospital evaluates staff based on performance expectations that reflect their job responsibilities.	C
<b>(M)</b> 2. <b>(D)</b>	The hospital evaluates staff performance once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. This evaluation is documented.	C
<b>(M)</b> 5.	When a licensed independent practitioner brings a nonemployee individual into the hospital to provide care, treatment, and services, the hospital reviews the individual's competencies and performance at the same frequency as individuals employed by the hospital. Note: This review can be accomplished either through the hospital's regular process or with the licensed independent practitioner who brought staff into the hospital.	<b>(3)</b> C



# Infection Prevention and Control

**Standard IC.01.01.01**

The hospital identifies the individual(s) responsible for the infection prevention and control program.

**Elements of Performance for IC.01.01.01**





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| 1. | The hospital identifies the individual(s) with clinical authority over the infection prevention and control program.  | <b>A</b> |
| 2. | When the individual(s) with clinical authority over the infection prevention and control program does not have expertise in infection prevention and control, he or she consults with someone who has such expertise in order to make knowledgeable decisions.  | <b>A</b> |
| 3. | The hospital assigns responsibility for the daily management of infection prevention and control activities. (See also HR.01.02.01, EP 1; LD.03.06.01, EP 3)<br>Note: Number and skill mix of the individual(s) assigned should be determined by the goals and objectives of the infection prevention and control program.  | <b>A</b> |
| 4. | <div style="display: inline-block; border: 1px solid black; border-radius: 50%; padding: 2px 5px; margin-bottom: 5px;">D</div> For hospitals that use Joint Commission accreditation for deemed status purposes: The individual with clinical authority over the infection prevention and control program is responsible for the following: <ul style="list-style-type: none"> <li>- Developing policies governing control of infections and communicable diseases</li> <li>- Implementing policies governing control of infections and communicable diseases</li> <li>- Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases</li> </ul> | <b>A</b> |

**Standard IC.01.02.01**

Hospital leaders allocate needed resources for the infection prevention and control program.

**Elements of Performance for IC.01.02.01**

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| 1. | The hospital provides access to information needed to support the infection prevention and control program. (See also IM.02.02.03, EP 2) | <b>A</b> |
| 2. | The hospital provides laboratory resources when needed to support the infection prevention and control program.                          | <b>A</b> |
| 3. | The hospital provides equipment and supplies to support the infection prevention and control program.                                    | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard IC.01.03.01**

The hospital identifies risks for acquiring and transmitting infections.

**Elements of Performance for IC.01.03.01**

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| 1. | The hospital identifies risks for acquiring and transmitting infections based on the following: Its geographic location, community, and population served. (See also NPSG.07.03.01, EP 1)   | <b>A</b> |
| 2. | The hospital identifies risks for acquiring and transmitting infections based on the following: The care, treatment, and services it provides. (See also NPSG.07.03.01, EP 1)   | <b>A</b> |
| 3. | The hospital identifies risks for acquiring and transmitting infections based on the following: The analysis of surveillance activities and other infection control data. (See also NPSG.07.03.01, EP 1; TS.03.03.01, EP 2)               | <b>A</b> |
| 4. | The hospital reviews and identifies its risks at least annually and whenever significant changes occur with input from, at a minimum, infection control personnel, medical staff, nursing, and leadership. (See also NPSG.07.03.01, EP 1) | <b>A</b> |
| 5. | ② The hospital prioritizes the identified risks for acquiring and transmitting infections. These prioritized risks are documented. (See also NPSG.07.03.01, EP 1)   | <b>A</b> |

**Standard IC.01.04.01**

Based on the identified risks, the hospital sets goals to minimize the possibility of transmitting infections.

Note: See NPSG.07.01.01 for hand hygiene guidelines.

**Elements of Performance for IC.01.04.01**

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| 1. | ② The hospital's written infection prevention and control goals include the following: Addressing its prioritized risks.  | <b>A</b> |
| 2. | ② The hospital's written infection prevention and control goals include the following: Limiting unprotected exposure to pathogens.  | <b>A</b> |
| 3. | ② The hospital's written infection prevention and control goals include the following: Limiting the transmission of infections associated with procedures.  | <b>A</b> |
| 4. | ② The hospital's written infection prevention and control goals include the following: Limiting the transmission of infections associated with the use of medical equipment, devices, and supplies. | <b>A</b> |
| 5. | ② The hospital's written infection prevention and control goals include the following: Improving compliance with hand hygiene guidelines. (See also NPSG.07.01.01, EP 1)                            | <b>A</b> |

**Standard IC.01.05.01**

The hospital has an infection prevention and control plan.



**Elements of Performance for IC.01.05.01**

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|----|---|----------|
| 1. | When developing infection prevention and control activities, the hospital uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus.  | <b>A</b> |
| 2. | ⓓ The hospital's infection prevention and control plan includes a written description of the activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.   | <b>A</b> |
| 3. | ⓓ The hospital's infection prevention and control plan includes a written description of the process to evaluate the infection prevention and control plan.   | <b>A</b> |
| 5. | ⓓ The hospital describes, in writing, the process for investigating outbreaks of infectious disease. (See also IC.02.01.01, EP 5)   | <b>A</b> |
| 6. | All hospital components and functions are integrated into infection prevention and control activities. (See also HR.01.04.01, EPs 2 and 4)  | <b>A</b> |
| 7. | The hospital has a method for communicating responsibilities about 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. (See also IC.02.01.01, EP 7)<br>Note: Information may be in different forms of media, such as posters or pamphlets. | <b>A</b> |
| 8. | The hospital identifies methods for reporting infection surveillance and control information to external organizations.   | <b>A</b> |

**Standard IC.01.06.01**

The hospital prepares to respond to an influx of potentially infectious patients.






**Elements of Performance for IC.01.06.01**



- |  |  |          |
|--|--|----------|
| 1.   | The hospital identifies resources that can provide information about infections that could cause an influx of potentially infectious patients.<br>Note: Resources may include local, state, and federal public health systems. | <b>A</b> |
| 2.   | The hospital obtains current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients.   | <b>C</b> |
| 3.   | The hospital has a method for communicating critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients.                      | <b>A</b> |
| 4.  | The hospital describes, in writing, how it will respond to an influx of potentially infectious patients. (See also EM.01.01.01, EP 2)<br>Note: One acceptable response is to decide not to accept patients.                    | <b>A</b> |
| 5.  | If the hospital decides to accept an influx of potentially infectious patients, then the hospital describes in writing its methods for managing these patients over an extended period of time.                                | <b>A</b> |
| 6.   | When the hospital determines it is necessary, the hospital activates its response to an influx of potentially infectious patients.   | <b>A</b> |

**Standard IC.02.01.01**

The hospital implements its infection prevention and control plan.

**Elements of Performance for IC.02.01.01**

- |          |     |   |   |          |
|----------|-----|---|---|----------|
|          | 1.  | The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.   |   | <b>C</b> |
| <b>M</b> | 2.  | The hospital uses standard precautions, including the use of personal protective equipment, to reduce the risk of infection.<br>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.<br>Footnote: For further information regarding standard precautions, refer to the Web site of the Centers for Disease Control and Prevention (CDC) at <a href="http://www.cdc.gov/ncidod/dhqp/">http://www.cdc.gov/ncidod/dhqp/</a> (Infection Control in Healthcare Settings).   |    | <b>C</b> |
| <b>M</b> | 3.  | The hospital implements transmission-based precautions in response to the pathogens that are suspected or identified within the hospital's service setting and community.<br>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.<br>Footnote: For further information regarding transmission-based precautions, refer to the Web site of the Centers for Disease Control and Prevention (CDC) at <a href="http://www.cdc.gov/ncidod/dhqp/">http://www.cdc.gov/ncidod/dhqp/</a> (Infection Control in Healthcare Settings). |    | <b>C</b> |
|          | 5.  | The hospital investigates outbreaks of infectious disease. (See also IC.01.05.01, EP 5)   |   | <b>A</b> |
|          | 6.  | The hospital minimizes the risk of infection when storing and disposing of infectious waste. (See also EC.02.02.01, EP 1)   |    | <b>C</b> |
| <b>M</b> | 7.  | The hospital implements its methods to communicate responsibilities for preventing and controlling infection to licensed independent practitioners, staff, visitors, patients, and families. Information for visitors, patients, and families includes hand and respiratory hygiene practices. (See also HR.01.04.01, EP 4; IC.01.05.01, EP 7)<br>Note: Information may have different forms of media, such as posters or pamphlets.  |   | <b>C</b> |
| <b>M</b> | 8.  | The hospital reports infection surveillance, prevention, and control information to the appropriate staff within the hospital.  |   | <b>C</b> |
|          | 9.  | The hospital reports infection surveillance, prevention, and control information to local, state, and federal public health authorities in accordance with law and regulation. (See also IC.03.01.01, EP 6)   |   | <b>A</b> |
| <b>M</b> | 10. | When the hospital becomes aware that it transferred a patient who has an infection requiring monitoring, treatment, and/or isolation, it informs the receiving organization.  |  | <b>C</b> |
| <b>M</b> | 11. | When the hospital becomes aware that it received a patient from another organization who has an infection requiring action, and the infection was not communicated by the referring organization, it informs the referring organization.<br>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.   |  | <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard IC.02.02.01**

The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

**Rationale for IC.02.02.01**

The Centers for Disease Control and Prevention (CDC) estimate that 46.5 million surgical procedures are performed in hospitals and ambulatory settings each year; this includes approximately 5 million gastrointestinal endoscopies.\* Each of these procedures involves contact with a medical device or surgical instrument. A major risk of all such procedures is the introduction of pathogens that can lead to infection. Additionally, many more people are at risk of developing an infection from contact with medical equipment, devices, or supplies while seeking other health services. Failure to properly clean, disinfect, or sterilize, and use or store medical equipment, devices, and supplies not only poses risks for the person seeking health services, but also carries the risk for person-to-person transmission of infections.

There are numerous steps involved in the cleaning, disinfecting, and sterilizing of medical equipment, devices, and supplies. It is critical that health care workers follow standardized practices to minimize infection risks related to medical equipment, devices, and supplies. In order to maintain a reliable system for controlling this process, organizations pay attention to the following:





- Orientation, training, and competency of health care workers who are processing medical equipment, devices, and supplies
- Levels of staffing and supervision of the health care workers who are processing medical equipment, devices, and supplies
- Standardization of process regardless of whether it is centralized or decentralized
- Reinforcing the process (for example, the use of placards which list the steps to be followed, according to manufacturers' guidelines)
- Ongoing quality monitoring

Footnote: \*[http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection\\_Nov\\_2008.pdf](http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008.pdf)

**Elements of Performance for IC.02.02.01**

- M** 1. The hospital implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical supplies and devices.
- 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.
- Footnote: For further information regarding cleaning and performing low-level disinfection of medical equipment, devices, and supplies, refer to the Web site of the Centers for Disease Control and Prevention (CDC) at <http://www.cdc.gov/ncidod/dhqp/sterile.html> (Sterilization and Disinfection in Healthcare Settings).



**3 C**





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| 2.   | The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. (See also EC.02.04.03, EP 4)<br>Note: High-level disinfection is used for items such as respiratory equipment and specula. 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.<br>Footnote: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the Web site of the Centers for Disease Control and Prevention (CDC) at <a href="http://www.cdc.gov/ncidod/dhqp/sterile.html">http://www.cdc.gov/ncidod/dhqp/sterile.html</a> (Sterilization and Disinfection in Healthcare Settings). |  <b>A</b> |
| 3.   | The hospital implements infection prevention and control activities when doing the following: Disposing of medical equipment, devices, and supplies.   |  <b>A</b> |
|  4. | The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.  | <b>C</b>   |
| 5.   | When reprocessing single-use devices, the hospital implements infection prevention and control activities that are consistent with regulatory and professional standards.  |  <b>A</b> |

### Standard IC.02.03.01

The hospital works to prevent the transmission of infectious disease among patients, licensed independent practitioners, and staff.

#### Elements of Performance for IC.02.03.01

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|--|---|----------|
|  1. | The hospital makes screening for exposure and/or immunity to infectious disease available to licensed independent practitioners and staff who may come in contact with infections at the workplace.   | <b>C</b> |
|  2. | When licensed independent practitioners or staff have, or are suspected of having, an infectious disease that puts others at risk, the hospital provides them with or refers them for assessment and potential testing, prophylaxis/treatment, or counseling. | <b>C</b> |
| 3.   | When licensed independent practitioners or staff have been occupationally exposed to an infectious disease, the hospital provides them with or refers them for assessment and potential testing, prophylaxis/treatment, or counseling.                        | <b>A</b> |
| 4.   | When patients have been exposed to an infectious disease, the hospital provides them with or refers them for assessment and potential testing, prophylaxis/treatment, or counseling.  | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard IC.02.04.01**

The hospital offers vaccination against influenza to licensed independent practitioners and staff.

**Elements of Performance for IC.02.04.01**

	1.	The hospital establishes an annual influenza vaccination program that is offered to licensed independent practitioners and staff.	<b>A</b>
<b>M</b>	2.	The hospital educates licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza. (See also HR.01.04.01, EP 4)	<b>C</b>
	3.	The hospital provides influenza vaccination at sites accessible to licensed independent practitioners and staff.	<b>A</b>
	4.	The hospital annually evaluates vaccination rates and the reasons given for declining the influenza vaccination.	<b>A</b>
	5.	The hospital takes steps to increase influenza vaccination rates.	<b>A</b>

**Standard IC.03.01.01**

The hospital evaluates the effectiveness of its infection prevention and control plan.

**Elements of Performance for IC.03.01.01**

	1.	The hospital evaluates the effectiveness of its infection prevention and control plan annually and whenever risks significantly change.	<b>A</b>
	2.	The evaluation includes a review of the following: The infection prevention and control plan's prioritized risks.	<b>A</b>
	3.	The evaluation includes a review of the following: The infection prevention and control plan's goals. (See also NPSG.07.01.01, EP 2)	<b>A</b>
	4.	The evaluation includes a review of the following: Implementation of the infection prevention and control plan's activities.	<b>A</b>
	6.	Findings from the evaluation are communicated at least annually to the individuals or interdisciplinary group that manages the patient safety program. (See also IC.02.01.01, EP 9)	<b>A</b>
	7.	The hospital uses the findings of its evaluation of the infection prevention and control plan when revising the plan. (See also LD.01.02.01, EP 4)	<b>A</b>



# Information Management

**Standard IM.01.01.01**

The hospital plans for managing information.

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**Elements of Performance for IM.01.01.01**


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|----|---|----------|
| 1. | The hospital identifies the internal and external information needed to provide safe, quality care.   | <b>A</b> |
| 2. | The hospital identifies how data and information enter, flow within, and leave the organization.  | <b>A</b> |
| 3. | The hospital uses the identified information to guide development of processes to manage information.   | <b>A</b> |
| 4. | Staff and licensed independent practitioners, selected by the hospital, participate in the assessment, selection, integration, and use of information management systems for the delivery of care, treatment, and services. | <b>A</b> |
- 


**Standard IM.01.01.03**





The hospital plans for continuity of its information management processes.

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**Elements of Performance for IM.01.01.03**


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| 1. | Ⓓ The hospital has a written plan for managing interruptions to its information processes (paper-based, electronic, or a mix of paper-based and electronic). (See also EM.01.01.01, EP 6)  | <b>A</b>   |
| 2. | The hospital's plan for managing interruptions to information processes addresses the following: Scheduled and unscheduled interruptions of electronic information systems. (See also IM.03.01.01, EP 1; EM.01.01.01, EP 6)  | <b>A</b>   |
| 3. | The hospital's plan for managing interruptions to information processes addresses the following: 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) | <b>A</b>   |
| 4. | The hospital's plan for managing interruptions to information processes addresses the following: Backup of electronic information systems. (See also EM.01.01.01, EP 6)  | <b>A</b>   |
| 5. | The hospital's plan for managing interruptions to electronic information processes is tested for effectiveness according to time frames defined by the organization.   | <b>A</b>   |
| 6. | The hospital implements its plan for managing interruptions to information processes to maintain access to information needed for patient care, treatment, and services. (See also IM.03.01.01, EP 1)  | <div style="display: inline-block; text-align: center;">  <b>A</b> </div> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard IM.02.01.01**

The hospital protects the privacy of health information.





**Elements of Performance for IM.02.01.01**

- |   |          |
|---|----------|
| 1.  The hospital has a written policy addressing the privacy of health information. (See also RI.01.01.01, EP 7) | <b>A</b> |
| 2. The hospital implements its policy on the privacy of health information. (See also RI.01.01.01, EP 7)  | <b>A</b> |
| 3. The hospital uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. (See also MM.01.01.01, EP 1; RI.01.01.01, EP 7)         | <b>A</b> |
| 4. The hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. (See also RI.01.01.01, EP 7)                                   | <b>A</b> |
| 5. The hospital monitors compliance with its policy on the privacy of health information. (See also RI.01.01.01, EP 7)  | <b>A</b> |

**Standard IM.02.01.03**

The hospital maintains the security and integrity of health information.



**Elements of Performance for IM.02.01.03**

- |   |          |
|---|----------|
| 1.  The hospital has a written policy that addresses the security of health information, including access, use, and disclosure.  | <b>A</b> |
| 2.  The hospital has a written policy addressing the integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.                                      | <b>A</b> |
| 3.  The hospital has a written policy addressing the intentional destruction of health information.  | <b>A</b> |
| 4.  The hospital has a written policy that defines when and by whom the removal of health information is permitted.<br>Note: Removal refers to those actions that place health information outside the hospital's control. | <b>A</b> |
| 5. The hospital protects against unauthorized access, use, and disclosure of health information.  | <b>C</b> |
| 6. The hospital protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.  | <b>C</b> |
| 7. The hospital controls the intentional destruction of health information.   | <b>A</b> |
| 8. The hospital monitors compliance with its policies on the security and integrity of health information.  | <b>A</b> |

**Standard IM.02.02.01**

The hospital effectively manages the collection of health information.

**Elements of Performance for IM.02.02.01**



- |             |  |  |
|-------------|--|--|
| <b>M</b>    | 1. The hospital uses uniform data sets to standardize data collection throughout the hospital.   | <b>C</b>   |
| 2. <b>D</b> | The hospital has a written policy that includes the following: <ul style="list-style-type: none"> <li>- Terminology and definitions approved for use in the hospital</li> <li>- Abbreviations, acronyms, symbols, and dose designations approved for use in the hospital</li> <li>- Abbreviations, acronyms, symbols, and dose designations prohibited from use in the hospital, which include the following:             <ul style="list-style-type: none"> <li>- U,u</li> <li>- IU</li> <li>- Q.D., QD, q.d., qd</li> <li>- Q.O.D., QOD, q.o.d, qod</li> <li>- Trailing zero (X.0 mg)</li> <li>- Lack of leading zero (.X mg)</li> <li>- MS</li> <li>- MSO4</li> <li>- MgSO4</li> </ul> </li> </ul> <p>Note: 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.</p> |  <b>A</b> |
| <b>M</b>    | 3. The hospital implements its policy regarding the terminology, definitions, abbreviations, acronyms, symbols, and dose designations permitted for use in the hospital and the abbreviations, acronyms, symbols, and dose designations prohibited from use in the hospital. <p>Note: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.</p>   |  <b>C</b> |

**Standard IM.02.02.03**

The hospital retrieves, disseminates, and transmits health information in useful formats.

**Elements of Performance for IM.02.02.03**

- |             |  |          |
|-------------|--|----------|
| 1. <b>D</b> | The hospital has written policies addressing data capture, display, transmission, and retention.   | <b>A</b> |
| <b>M</b>    | 2. The hospital's storage and retrieval systems make health information accessible when needed for patient care, treatment, and services. (See also IC.01.02.01, EP 1) | <b>C</b> |
| <b>M</b>    | 3. The hospital disseminates data and information in useful formats within time frames that are defined by the hospital and consistent with law and regulation.        | <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard IM.03.01.01**

Knowledge-based information resources are available, current, and authoritative.

**Elements of Performance for IM.03.01.01**

- |    |   |          |
|----|---|----------|
| 1. | The hospital provides access to knowledge-based information resources 24 hours a day, 7 days a week. (See also IM.01.01.03, EPs 2 and 6)                                | <b>A</b> |
| 2. | The hospital makes cooperative or contractual arrangements with another institution(s) to provide knowledge-based information resources that are not available on site. | <b>A</b> |

**Standard IM.04.01.01**

The hospital maintains accurate health information.

**Elements of Performance for IM.04.01.01**

- |    |   |          |
|----|---|----------|
| 1. | The hospital has processes to check the accuracy of health information. | <b>A</b> |
|----|---|----------|



# Leadership

**Standard LD.01.01.01**

The hospital has a leadership structure.

**Rationale for LD.01.01.01**

Every hospital has a leadership structure to support operations and the provision of care. In many hospitals this structure is formed by three leadership groups: the governing body, senior managers, and the organized medical staff. In some hospitals there may be two leadership groups, and in others only one. Individual leaders may participate in more than one group.

**Elements of Performance for LD.01.01.01**

- |    |  |          |
|----|--|----------|
| 1. | The hospital identifies those responsible for governance.  | <b>A</b> |
| 2. | The governing body identifies those responsible for planning, management, and operational activities.                            | <b>A</b> |
| 3. | The governing body identifies those responsible for the provision of care, treatment, and services. (See also NR.01.01.01, EP 3) | <b>A</b> |

**Standard LD.01.02.01**

The hospital identifies the responsibilities of its leaders.

**Rationale for LD.01.02.01**

Many responsibilities may be shared by all leaders. Others are assigned by the governing body to senior managers and the leaders of the organized medical staff. Hospital performance depends on how well the leaders work together to carry out these responsibilities.

**Elements of Performance for LD.01.02.01**

- |             |  |          |
|-------------|--|----------|
| 1.          | Senior managers and leaders of the organized medical staff work with the governing body to define their shared and unique responsibilities and accountabilities. (See also NR.01.01.01, EPs 2 and 3)   | <b>A</b> |
| 2.          | The governing body establishes a process for making decisions when a leadership group fails to fulfill its responsibilities and/or accountabilities.   | <b>A</b> |
| <b>M</b> 4. | For hospitals that use Joint Commission accreditation for deemed status purposes: The chief executive officer, medical staff, and nurse executive make certain that the hospital-wide performance improvement and training programs address problems identified by the individual responsible for infection prevention and control and that corrective action plans are successfully implemented. (See also IC.03.01.01, EP 7) | <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required




## Standard LD.01.03.01

The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

### Rationale for LD.01.03.01

The governing body's ultimate responsibility for safety and quality derives from its legal responsibility and operational authority for hospital performance. In this context, the governing body provides for internal structures and resources, including staff, that support safety and quality.

#### Elements of Performance for LD.01.03.01

- |  |   |
|--|---|
| 1.  The governing body defines in writing its responsibilities.   | A   |
| 2. The governing body provides for organization management and planning.   | A   |
| 3.  The governing body approves the hospital's written scope of services. (See also PC.01.01.01, EP 7)<br>Note: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to the "Medicare Requirements for Hospitals" appendix. | A   |
| 4. The governing body selects the chief executive responsible for managing the hospital.   | A   |
| 5. The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. (See also NR.01.01.01, EP 3)  |  A |
| 6. The governing body works with the senior managers and leaders of the organized medical staff to annually evaluate the hospital's performance in relation to its mission, vision, and goals.   | A   |
| 7. The governing body provides a system for resolving conflicts among individuals working in the hospital.   | A   |
| 8. The governing body provides the organized medical staff with the opportunity to participate in governance.  | A   |
| 9. The governing body provides the organized medical staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the organized medical staff.   | A   |
| 10. Organized medical staff members are eligible for full membership in the hospital's governing body, unless legally prohibited.  | A   |

### Standard LD.01.04.01

A chief executive manages the hospital.

#### Elements of Performance for LD.01.04.01

- |     |  |          |
|-----|--|----------|
| 1.  | The chief executive provides for the following: Information and support systems.   | <b>A</b> |
| 2.  | The chief executive provides for the following: Recruitment and retention of staff.  | <b>A</b> |
| 3.  | The chief executive provides for the following: Physical and financial assets.   | <b>A</b> |
| 5.  | The chief executive identifies a nurse leader at the executive level who participates in decision-making. (See also NR.01.01.01, EPs 3 and 4 for specific nurse leader responsibilities) | <b>A</b> |
| 11. | When the chief executive is absent from the hospital, a qualified individual is designated to perform the duties of this position.   | <b>A</b> |

### Standard LD.01.05.01

The hospital has an organized medical staff that is accountable to the governing body.

#### Elements of Performance for LD.01.05.01

- |    |   |          |
|----|---|----------|
| 1. | For hospitals that do not use Joint Commission accreditation for deemed status purposes: There is a single organized medical staff unless criteria are met for an exception to the single medical staff requirements. (Refer to the introduction to MS.01.01.01)          | <b>A</b> |
| 2. | The organized medical staff is self governing. (Refer to the bulleted list describing self governance in the Overview to the Medical Staff chapter.)  | <b>A</b> |
| 3. | The medical staff structure conforms to medical staff guiding principles.   | <b>A</b> |
| 4. | The governing body approves the structure of the organized medical staff.   | <b>A</b> |
| 5. | The organized medical staff oversees the quality of care, treatment and services provided by those individuals with clinical privileges.  | <b>A</b> |
| 6. | The organized medical staff is accountable to the governing body.   | <b>A</b> |
| 7. | For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy, or, if permitted by state law, a doctor of dental surgery or dental medicine, is responsible for the organization and conduct of the medical staff. | <b>A</b> |

### Standard LD.01.07.01

The governing body, senior managers, and leaders of the organized medical staff have the knowledge needed for their roles in the hospital or they seek guidance to fulfill their roles.

#### Elements of Performance for LD.01.07.01

- |             |   |          |
|-------------|---|----------|
| 1.          | The governing body, senior managers, and leaders of the organized medical staff work together to identify the skills required of individual leaders.  | <b>A</b> |
| <b>M</b> 2. | <p>Individual members of the governing body, senior managers, and leaders of the organized medical staff are oriented to all of the following:</p> <ul style="list-style-type: none"> <li>- The hospital's mission and vision</li> <li>- The hospital's safety and quality goals</li> <li>- The hospital's structure and the decision-making process</li> <li>- The development of the budget as well as the interpretation of the hospital's financial statements</li> <li>- The population(s) served by the hospital and any issues related to that population(s)</li> <li>- The individual and interdependent responsibilities and accountabilities of the governing body, senior managers, and leaders of organized medical staff as they relate to supporting the mission of the hospital and to providing safe and quality care</li> <li>- Applicable law and regulation</li> </ul> | <b>C</b> |
| 3.          | The governing body provides leaders with access to information and training in areas where they need additional skills or expertise.  | <b>A</b> |

### Standard LD.02.01.01

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

#### Rationale for LD.02.01.01

The primary responsibility of leaders is to provide for the safety and quality of care, treatment, and services. The purpose of the hospital's mission, vision, and goals is to define how the hospital will achieve safety and quality. The leaders are more likely to be aligned with the mission, vision, and goals when they create them together. The common purpose of the hospital is most likely achieved when it is understood by all who work in or are served by the hospital.

#### Elements of Performance for LD.02.01.01

- |    |   |          |
|----|---|----------|
| 1. | The governing body, senior managers, and leaders of the organized medical staff work together to create the hospital's mission, vision, and goals. (See also NR.01.01.01, EP 2) | <b>A</b> |
| 2. | The hospital's mission, vision, and goals guide the actions of leaders.   | <b>A</b> |
| 3. | Leaders communicate the mission, vision, and goals to staff and the population(s) the hospital serves.  | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard LD.02.02.01**



The governing body, senior managers and leaders of the organized medical staff address any conflict of interest involving leaders that affect or could affect the safety or quality of care, treatment and services.

Note: This standard addresses conflict of interest involving individual members of leadership groups. For conflicts of interest among staff and licensed independent practitioners who are not members of leadership groups, see Standard LD.04.02.01.

**Rationale for LD.02.02.01**

Conflicts of interest can occur in many circumstances and may involve professional or business relationships. Leaders create policies that provide for the oversight and control of these situations. Together, leaders address actual and potential conflicts of interest that could interfere with the hospital's responsibility to the community it serves.

**Elements of Performance for LD.02.02.01**

- |  |          |
|--|----------|
| 1.  The governing body, senior managers, and leaders of the organized medical staff work together to define in writing conflicts of interest involving leaders that could affect safety and quality of care, treatment, and services. | <b>A</b> |
| 2.  The governing body, senior managers, and leaders of the organized medical staff work together to develop a written policy that defines how conflict of interest involving leaders will be addressed.                              | <b>A</b> |
| 3. Conflicts of interest involving leaders are disclosed as defined by the hospital.   | <b>A</b> |

**Standard LD.02.03.01**

The governing body, senior managers and leaders of the organized medical staff 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 hospital and those it serves. The safety and quality of care, treatment, and services depend on open communication. Civility among leaders fosters such communication. Ideally, this will result in trust and mutual respect among those who work in the hospital.

**Elements of Performance for LD.02.03.01**

- |  |          |
|--|----------|
| 1. Leaders discuss issues that affect the hospital and the population(s) it serves, including the following:<br>- Performance improvement activities<br>- Reported safety and quality issues<br>- Proposed solutions and their impact on the hospital's resources<br>- Reports on key quality measures and safety indicators<br>- Safety and quality issues specific to the population served<br>- Input from the population(s) served<br>(See also NR.01.01.01, EP 3) | <b>A</b> |
| 2. The hospital establishes time frames for the discussion of issues that affect the hospital and the population(s) it serves.   | <b>A</b> |

## Standard LD.02.04.01

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

### Elements of Performance for LD.02.04.01

- |    |  |          |
|----|--|----------|
| 1. | Senior managers and leaders of the organized medical staff work with the governing body to develop an ongoing process for managing conflict among leadership groups.   | <b>A</b> |
| 2. | The governing body approves the process for managing conflict among leadership groups.   | <b>A</b> |
| 3. | Individuals who help the hospital implement the process are skilled in conflict management.<br>Note: These individuals may be from either inside or outside the hospital.  | <b>A</b> |
| 4. | The conflict management process includes the following:<br>- Meeting with the involved parties as early as possible to identify the conflict<br>- Gathering information regarding the conflict<br>- Working with the parties to manage and, when possible, resolve the conflict<br>- Protecting the safety and quality of care | <b>A</b> |
| 5. | The hospital implements the process when a conflict arises that, if not managed, could adversely affect patient safety or quality of care.   | <b>A</b> |

**Standard LD.03.01.01**

Leaders create and maintain a culture of safety and quality throughout the hospital.

**Rationale for LD.03.01.01**

Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the hospital. Leaders demonstrate their commitment to quality and set expectations for those who work in the hospital. Leaders evaluate the culture on a regular basis.

Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to patient care. Leaders must address disruptive behavior of individuals working at all levels of the hospital, including management, clinical and administrative staff, licensed independent practitioners, and governing body members.

**Elements of Performance for LD.03.01.01**

- |     |   |            |
|-----|---|------------|
| 1.  | Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.  | <b>A</b>   |
| 2.  | Leaders prioritize and implement changes identified by the evaluation.  | <b>A</b>   |
| 3.  | Leaders provide opportunities for all individuals who work in the hospital to participate in safety and quality initiatives.  | <b>A</b>   |
| 4.  | <b>D</b> Leaders develop a code of conduct that defines acceptable, disruptive, and inappropriate behaviors.  | <b>A</b>   |
| 5.  | Leaders create and implement a process for managing disruptive and inappropriate behaviors.   | <b>3 A</b> |
| 6.  | Leaders provide education that focuses on safety and quality for all individuals.   | <b>A</b>   |
| 7.  | Leaders establish a team approach among all staff at all levels.  | <b>A</b>   |
| 8.  | All individuals who work in the hospital, including staff and licensed independent practitioners, are able to openly discuss issues of safety and quality. (See also LD.04.04.05, EP 6) | <b>A</b>   |
| 9.  | Literature and advisories relevant to patient safety are available to all individuals who work in the hospital.   | <b>A</b>   |
| 10. | Leaders define how members of the population(s) served can help identify and manage issues of safety and quality within the hospital.   | <b>A</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

## Standard LD.03.02.01

The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

### Rationale for LD.03.02.01

Data help hospitals make the right decisions. When decisions are supported by data, hospitals are more likely to move in directions that help them achieve their goals. Successful hospitals measure and analyze their performance. When data are analyzed and turned into information, this process helps hospitals see patterns and trends and understand the reasons for their performance. Many types of data are used to evaluate performance, including data on outcomes of care, performance on safety and quality initiatives, patient satisfaction, process variation, and staff perceptions.

#### Elements of Performance for LD.03.02.01

- |    |  |          |
|----|--|----------|
| 1. | Leaders set expectations for using data and information to improve the safety and quality of care, treatment, and services.  | <b>A</b> |
| 2. | Leaders are able to describe how data and information are used to create a culture of safety and quality.  | <b>A</b> |
| 3. | The hospital uses processes to support systematic data and information use.  | <b>A</b> |
| 4. | Leaders provide the resources needed for data and information use, including staff, equipment, and information systems.  | <b>A</b> |
| 5. | The hospital uses data and information in decision making that supports the safety and quality of care, treatment, and services.<br>(See also NR.02.01.01, EPs 3 and 6; PI.02.01.01, EP 8) | <b>A</b> |
| 6. | The hospital uses data and information to identify and respond to internal and external changes in the environment.  | <b>A</b> |
| 7. | Leaders evaluate how effectively data and information are used throughout the hospital.  | <b>A</b> |

## Standard LD.03.03.01

Leaders use hospital-wide 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 hospital, and from other interested groups or individuals.

### Elements of Performance for LD.03.03.01

- |    |  |   |
|----|--|---|
| 1. | Planning activities focus on improving patient safety and health care quality.                           | A   |
| 2. | Leaders can describe how planning supports a culture of safety and quality.                              | A   |
| 3. | Planning is systematic, and it involves designated individuals and information sources.                  | A   |
| 4. | Leaders provide the resources needed to support the safety and quality of care, treatment, and services. |  A |
| 5. | Safety and quality planning is hospital-wide.  | A   |
| 6. | Planning activities adapt to changes in the environment.   | A   |
| 7. | Leaders evaluate the effectiveness of planning activities.   | A   |

**KEY:** A indicates scoring category A; C indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; M indicates Measure of Success if needed; D indicates that documentation is required

### Standard LD.03.04.01

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

#### Rationale for LD.03.04.01

Effective communication is essential among individuals and groups within the hospital, and between the hospital and external parties. Poor communication often contributes to adverse events and can compromise safety and quality of care, treatment, and services. Effective communication is timely, accurate, and usable by the audience.

#### Elements of Performance for LD.03.04.01

- |    |   |          |
|----|---|----------|
| 1. | Communication processes foster the safety of the patient and the quality of care.   | <b>A</b> |
| 2. | Leaders are able to describe how communication supports a culture of safety and quality.  | <b>A</b> |
| 3. | Communication is designed to meet the needs of internal and external users.   | <b>A</b> |
| 4. | Leaders provide the resources required for communication, based on the needs of patients, the community, physicians, staff, and management. | <b>A</b> |
| 5. | Communication supports safety and quality throughout the hospital. (See also LD.04.04.05, EPs 6 and 12)                                     | <b>A</b> |
| 6. | When changes in the environment occur, the hospital communicates those changes effectively.   | <b>A</b> |
| 7. | Leaders evaluate the effectiveness of communication methods.  | <b>A</b> |

## Standard LD.03.05.01

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

### Rationale for LD.03.05.01

Change is inevitable, and agile hospitals are able to manage change and rapidly execute new plans. The ability of leaders to manage change is necessary for performance improvement, for successful innovation, and to meet environmental challenges. The hospital integrates change into all relevant processes so that its effectiveness can be sustained, assessed, and measured.

#### Elements of Performance for LD.03.05.01

- |    |  |          |
|----|--|----------|
| 1. | Structures for managing change and performance improvements exist that foster the safety of the patient and the quality of care, treatment, and services.  | <b>A</b> |
| 2. | Leaders are able to describe how the hospital's approach to performance improvement and its capacity for change support a culture of safety and quality.   | <b>A</b> |
| 3. | The hospital has a systematic approach to change and performance improvement.  | <b>A</b> |
| 4. | Leaders provide the resources required for performance improvement and change management, including sufficient staff, access to information, and training. | <b>A</b> |
| 5. | The management of change and performance improvement supports both safety and quality throughout the hospital.   | <b>A</b> |
| 6. | The hospital's internal structures can adapt to changes in the environment.  | <b>A</b> |
| 7. | Leaders evaluate the effectiveness of processes for the management of change and performance improvement.  | <b>A</b> |



**Standard LD.03.06.01**

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

**Rationale for LD.03.06.01**

The safety and quality of care, treatment, and services are highly dependent on the people who work in the hospital. The mission, scope, and complexity of services define the design of work processes and the skills and number of individuals needed. In a successful hospital, work processes and the environment make safety and quality paramount. This standard, therefore, applies to all those who work in or for the hospital, including staff and licensed independent practitioners.



**Elements of Performance for LD.03.06.01**

- |    |  |   |
|----|--|---|
| 1. | Leaders design work processes to focus individuals on safety and quality issues.   | A   |
| 2. | Leaders are able to describe how those who work in the hospital support a culture of safety and quality.   | A   |
| 3. | Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. (See also IC.01.01.01, EP 3)<br>Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. |  A |
| 4. | Those who work in the hospital are competent to complete their assigned responsibilities.  |  A |
| 5. | Those who work in the hospital adapt to changes in the environment.  | A   |
| 6. | Leaders evaluate the effectiveness of those who work in the hospital to promote safety and quality.  | A   |

**Standard LD.04.01.01**

The hospital complies with law and regulation.

**Elements of Performance for LD.04.01.01**

- |    |   |  |
|----|---|--|
| 1. |  The hospital is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission.<br>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)<br>Footnote: For more information on how to obtain a CLIA certificate, see <a href="http://www.cms.hhs.gov/CLIA/downloads/HowObtainCLIACertificate.pdf">http://www.cms.hhs.gov/CLIA/downloads/HowObtainCLIACertificate.pdf</a> . |  A |
| 2. | The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and rules and regulations.   | A  |
| 3. | Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies.   | A  |

### Standard LD.04.01.03

The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.

#### Elements of Performance for LD.04.01.03

- |    |  |          |
|----|--|----------|
| 1. | Leaders solicit comments from those who work in the hospital when developing the operational and capital budgets. (See also NR.01.01.01, EP 3) | <b>A</b> |
| 3. | The operating budget reflects the hospital's goals and objectives.   | <b>A</b> |
| 4. | <b>D</b> The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan.                        | <b>A</b> |
| 5. | Leaders monitor the implementation of the budget and long-term capital expenditure plan.   | <b>A</b> |
| 6. | <b>D</b> An independent public accountant conducts an annual audit of the hospital's finances, unless otherwise provided by law.               | <b>A</b> |

## Standard LD.04.01.05

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

### Rationale for LD.04.01.05

Leaders at the program, service, site, or department level create a culture that enables the hospital to fulfill its mission and meet its goals. They support staff and instill in them a sense of ownership of their work processes. Leaders may delegate work to qualified staff, but the leaders are responsible for the care, treatment, and services provided in their areas.


#### Elements of Performance for LD.04.01.05

- |    |  |          |
|----|--|----------|
| 1. | Leaders of the program, service, site, or department oversee operations.   | <b>A</b> |
| 2. | Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed independent practitioner with clinical privileges.   | <b>A</b> |
| 3. | <b>D</b> The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. (See also NR.01.01.01, EP 5)<br>Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services. | <b>A</b> |
| 4. | Staff are held accountable for their responsibilities.   | <b>A</b> |
| 5. | Leaders provide for the coordination of care, treatment, and services among the hospital's different programs, services, sites, or departments. (See also NR.01.01.01, EP 1)   | <b>A</b> |
| 6. | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's emergency services are directed and supervised by a qualified member of the medical staff.  | <b>A</b> |
| 7. | For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services:<br>- Anesthesia<br>- Nuclear Medicine<br>- Respiratory care   | <b>A</b> |
| 8. | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital assigns an individual who is responsible for outpatient services.   | <b>A</b> |
| 9. | For hospitals that use Joint Commission accreditation for deemed status purposes: The anesthesia service is responsible for all anesthesia administered in the hospital.   | <b>A</b> |

### Standard LD.04.01.07

The hospital has policies and procedures that guide and support patient care, treatment, and services.

#### Elements of Performance for LD.04.01.07

- |  |  |   |
|--|--|---|
| 1.   | Leaders review and approve policies and procedures that guide and support patient care, treatment, and services. (See also NR.02.03.01, EP 1; RI.01.07.01, EP 1) | A |
|  2. | The hospital manages the implementation of policies and procedures. (See also NR.02.03.01, EP 2)   | C |


### Standard LD.04.01.11

The hospital makes space and equipment available as needed for the provision of care, treatment, and services.

#### Rationale for LD.04.01.11

The resources allocated to services provided by the hospital have a direct effect on patient outcomes. Leaders should place highest priority on high-risk or problem-prone processes that can affect patient safety. Examples include infection control, medication management, use of anesthesia, and others defined by the hospital.



#### Elements of Performance for LD.04.01.11

- |    |  |   |
|----|--|---|
| 2. | The arrangement and allocation of space supports safe, efficient, and effective care, treatment, and services. | A   |
| 3. | The interior and exterior space provided for care, treatment, and services meets the needs of patients.        | A   |
| 4. | The grounds, equipment, and special activity areas are safe, maintained, and supervised.                       | A   |
| 5. | The leaders provide for equipment, supplies, and other resources.  |  A |

### Standard LD.04.02.01

The leaders address any conflict of interest involving licensed independent practitioners and/or staff that affects or has the potential to affect the safety or quality of care, treatment, and services.


#### Elements of Performance for LD.04.02.01

- |   |          |
|---|----------|
| 1.  The leaders define conflict of interest involving licensed independent practitioners or staff. This definition is in writing.  | <b>A</b> |
| 2.  The leaders develop a written policy that defines how the hospital will address conflicts of interest involving licensed independent practitioners and/or staff.                             | <b>A</b> |
| 3. Existing or potential conflicts of interest involving licensed independent practitioners and/or staff, as defined by the hospital, are disclosed.  | <b>A</b> |
| 4. The hospital reviews its relationships with other care providers, educational institutions, manufacturers, and payers to determine whether conflicts of interest exist and whether they are within law and regulation.   | <b>A</b> |
| 5. Policies, procedures, and information about the relationship between care, treatment, and services and financial incentives are available upon request to all patients and those individuals who work in the hospital, including staff and licensed independent practitioners. | <b>A</b> |

### Standard LD.04.02.03

Ethical principles guide the hospital's business practices.

#### Elements of Performance for LD.04.02.03

- |  |          |
|--|----------|
| 1. The hospital has a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.   | <b>A</b> |
| 2. The hospital uses its process to address ethical issues or issues prone to conflict.  | <b>A</b> |
| 3. The hospital follows ethical practices for marketing and billing.   | <b>A</b> |
| 4.  Marketing materials accurately represent the hospital and address the care, treatment, and services that the hospital provides either directly or by contractual arrangement. | <b>A</b> |
| 5. Care, treatment, and services are provided based on patient needs, regardless of compensation or financial risk-sharing with those who work in the hospital, including staff and licensed independent practitioners.  | <b>A</b> |
| 6. When leaders excuse staff members from a job responsibility, care, treatment, and services are not affected in a negative way.  | <b>A</b> |
| 7. Patients receive information about charges for which they will be responsible.  | <b>A</b> |

## Standard LD.04.02.05

When internal or external review results in the denial of care, treatment, and services, or payment, the hospital makes decisions regarding the ongoing provision of care, treatment, and services, and discharge or transfer, based on the assessed needs of the patient.

### Rationale for LD.04.02.05

The hospital is professionally and ethically responsible for providing care, treatment, and services within its capability and law and regulation. At times, such care, treatment, and services are denied because of payment limitations. In these situations, the decision to continue providing care, treatment, and services or to discharge the patient is based solely on the patient's identified needs.




#### Elements of Performance for LD.04.02.05





- |    |  |          |
|----|--|----------|
| 1. | Decisions regarding the provision of ongoing care, treatment, and services, discharge, or transfer are based on the assessed needs of the patient, regardless of the recommendations of any internal or external review. | <b>A</b> |
| 2. | The safety and quality of care, treatment, and services do not depend on the patient's ability to pay.   | <b>A</b> |

**Standard LD.04.03.01**

The hospital provides services that meet patient needs.

**Elements of Performance for LD.04.03.01**

- |     |  |  |
|-----|--|--|
| 1.  | The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements.   | <b>A</b>   |
| 2.  | <p>The hospital provides essential services, including the following:</p> <ul style="list-style-type: none"> <li>- Diagnostic radiology</li> <li>- Dietary</li> <li>- Emergency</li> <li>- Medical records</li> <li>- Nuclear medicine</li> <li>- Nursing care</li> <li>- Pathology and clinical laboratory</li> <li>- Pharmaceutical</li> <li>- Physical rehabilitation</li> <li>- Respiratory care</li> <li>- Social work</li> </ul> <p>Note: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services.</p> |  <b>A</b>   |
| 3.  | <p>The hospital provides at least one of the following acute-care clinical services:</p> <ul style="list-style-type: none"> <li>- Child, adolescent, or adult psychiatry</li> <li>- Medicine</li> <li>- Obstetrics and gynecology</li> <li>- Pediatrics</li> <li>- Treatment for addictions</li> <li>- Surgery</li> </ul> <p>Note: When the hospital provides surgical or obstetric services, anesthesia services are also available.</p>  |  <b>A</b>   |
| 26. | For hospitals that use Joint Commission accreditation for deemed status purposes: Emergency laboratory services are available 24 hours a day, 7 days a week.   |  <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

### Standard LD.04.03.07

Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.

#### Rationale for LD.04.03.07

Comparable standards of care means that the hospital can provide the services that patients need within established time frames and that those providing care, treatment, and services have the required competence. Hospitals may provide different services to patients with similar needs as long as the patient's outcome is not affected. For example, some patients may receive equipment with enhanced features because of insurance situations. This does not ordinarily lead to different outcomes. Different settings, processes, or payment sources should not result in different standards of care.






#### Elements of Performance for LD.04.03.07

- |    |   |          |
|----|---|----------|
| 1. | Variances in staff, setting, or payment source do not affect outcomes of care, treatment, and services in a negative way. | <b>A</b> |
| 2. | Care, treatment, and services are consistent with the hospital's mission, vision, and goals.                              | <b>A</b> |

## Standard LD.04.03.09

Care, treatment, and services provided through contractual agreement are provided safely and effectively.

### Elements of Performance for LD.04.03.09

- |     |  |   |
|-----|--|---|
| 1.  | Clinical leaders and medical staff have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement.  | A   |
| 2.  |  The hospital describes, in writing, the nature and scope of services provided through contractual agreements.  | A   |
| 3.  |  Designated leaders approve contractual agreements.   | A   |
| 4.  | <p>Leaders monitor contracted services by establishing expectations for the performance of the contracted services.</p> <p>Note: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following:</p> <ul style="list-style-type: none"> <li>- Verify that all licensed independent practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.</li> <li>- 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.</li> </ul> | A   |
| 5.  | <p> Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services.</p> <p>Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it.</p>   | A   |
| 6.  | Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations.   | A   |
| 7.  | <p>Leaders take steps to improve contracted services that do not meet expectations.</p> <p>Note: Examples of improvement efforts to consider include the following:</p> <ul style="list-style-type: none"> <li>- Increase monitoring of the contracted services.</li> <li>- Provide consultation or training to the contractor.</li> <li>- Renegotiate the contract terms.</li> <li>- Apply defined penalties.</li> <li>- Terminate the contract.</li> </ul>   | A   |
| 8.  | When contractual agreements are renegotiated or terminated, the hospital maintains the continuity of patient care.   |  A |
| 9.  | When using the services of licensed independent practitioners from a Joint Commission–accredited ambulatory care organization through a telemedical link for interpretive services, the hospital accepts the credentialing and privileging decisions of a Joint Commission–accredited ambulatory provider only after confirming that those decisions are made using the process described in MS.06.01.03 through MS.06.01.07, excluding MS.06.01.03, EP 2. (See also MS.13.01.01, EP 1)  | A   |
| 10. | <p> Reference and contract laboratory services meet the federal regulations for clinical laboratories and maintain evidence of the same.</p> <p>Footnote: For law and regulation guidance on the Clinical Laboratory Improvement Amendments of 1988, refer to 42 CFR 493.</p>   | A   |

**Standard LD.04.03.11**

The hospital manages the flow of patients throughout the hospital.

**Rationale for LD.04.03.11**

Managing the flow of patients throughout their care is essential to prevent overcrowding, which can undermine the timeliness of care and, ultimately, patient safety. Effective management of system-wide processes that support patient flow (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care. Monitoring and improving these processes are useful strategies to reduce patient flow problems.

**Elements of Performance for LD.04.03.11**

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|----|--|----------|
| 1. | The hospital has processes that support the flow of patients throughout the hospital.  | <b>A</b> |
| 2. | The hospital plans for the care of admitted patients who are in temporary bed locations, such as the post anesthesia care unit or the emergency department.  | <b>A</b> |
| 3. | The hospital plans for care to patients placed in overflow locations.  | <b>A</b> |
| 4. | Criteria guide decisions to initiate ambulance diversion.  | <b>A</b> |
| 5. | The hospital measures the following components of the patient flow process:<br>- The available supply of patient beds<br>- The efficiency of areas where patients receive care, treatment, and services<br>- The safety of areas where patients receive care, treatment and services<br>- Access to support services | <b>A</b> |
| 6. | Measurement results are provided to those individuals who manage patient flow processes. (See also NR.02.02.01, EP 4)  | <b>A</b> |
| 7. | Measurement results regarding patient flow processes are reported to leaders.  | <b>A</b> |
| 8. | Measurement results guide improvement of patient flow processes.   | <b>A</b> |

**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**

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|----|--|----------|
| 1. | Leaders set priorities for performance improvement activities and patient health outcomes. (See also PI.01.01.01, EPs 1 and 3)   | <b>A</b> |
| 2. | Leaders give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities. (See also PI.01.01.01, EPs 4, 6-8, 11-12, and 14-15) | <b>A</b> |
| 3. | Leaders reprioritize performance improvement activities in response to changes in the internal or external environment.  | <b>A</b> |
| 4. | Performance improvement occurs hospital-wide.  | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

### Standard LD.04.04.03

New or modified services or processes are well designed.


#### Elements of Performance for LD.04.04.03





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| 1. | The hospital's design of new or modified services or processes incorporates the needs of patients, staff, and others.   | <b>A</b> |
| 2. | The hospital's design of new or modified services or processes incorporates the results of performance improvement activities.  | <b>A</b> |
| 3. | The hospital's design of new or modified services or processes incorporates information about potential risks to patients. (See also LD.04.04.05, EPs 6, 10-11)<br>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. | <b>A</b> |
| 4. | The hospital's design of new or modified services or processes incorporates evidence-based information in the decision-making process.<br>Note: For example, evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards.   | <b>A</b> |
| 5. | The hospital's design of new or modified services or processes incorporates information about sentinel events.  | <b>A</b> |
| 6. | The hospital tests and analyzes its design of new or modified services or processes to determine whether the proposed design or modification is an improvement.   | <b>A</b> |
| 7. | Leaders involve staff and patients in the design of new or modified services or processes.  | <b>A</b> |

## Standard LD.04.04.05

The hospital has an organization-wide, integrated patient safety program within its performance improvement activities.

### Elements of Performance for LD.04.04.05

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| 1.  | The hospital implements a hospital-wide patient safety program.  | A   |
| 2.  | One or more qualified individuals or an interdisciplinary group manages the safety program.  | A   |
| 3.  | The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events.   | A   |
| 4.  | All departments, programs, and services within the hospital participate in the safety program.   | A   |
| 5.  | As part of the safety program, the hospital creates procedures for responding to system or process failures.<br>Note: Responses might include continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.  | A   |
| 6.  | The hospital provides and encourages the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. (See also LD.03.01.01, EP 8; LD.03.04.01, EP 5; LD.04.04.03, EP 3; PI.01.01.01, EP 8)   | A   |
| 7.  | The hospital defines "sentinel event" and communicates this definition throughout the organization.<br>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 near miss.                          | A   |
| 8.  | The hospital conducts thorough and credible root cause analyses in response to sentinel events as described in the "Sentinel Events" (SE) chapter of this manual.  |  A |
| 9.  | The hospital makes support systems available for staff who have been involved in an adverse or sentinel event.<br>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. | A   |
| 10. | At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment. (See also LD.04.04.03, EP 3)<br>Note: For suggested components, refer to the Proactive Risk Assessment section at the beginning of this chapter.  | A   |
| 11. | To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and the results of proactive risk assessments. (See also LD.04.04.03, EP 3)  | A   |
| 12. | The hospital disseminates lessons learned from 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)   | A   |

**KEY:** A indicates scoring category A; C indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

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| 13. <b>D</b> At least once a year, the hospital provides governance with written reports on the following:   | <b>A</b> |
| <ul style="list-style-type: none"> <li>- All system or process failures</li> <li>- The number and type of sentinel events</li> <li>- Whether the patients and the families were informed of the event</li> <li>- All actions taken to improve safety, both proactively and in response to actual occurrences</li> <li>- For hospitals that use Joint Commission accreditation for deemed status purposes: The determined number of distinct improvement projects to be conducted annually</li> </ul> |          |
| 14. The hospital encourages external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.  | <b>A</b> |
| <p>Note: Examples of voluntary programs include The Joint Commission Sentinel Event Database and the U.S. Food and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated.</p>   |          |

### Standard LD.04.04.07

The hospital considers clinical practice guidelines when designing or improving processes.

#### Rationale for LD.04.04.07

Clinical practice guidelines can improve the quality, utilization, and value of health care services. Clinical practice guidelines help practitioners and patients make decisions about preventing, diagnosing, treating, and managing selected conditions. These guidelines can also be used in designing clinical processes or in checking the design of existing processes. The hospital identifies criteria that guide the selection and implementation of clinical practice guidelines so that they are consistent with its mission and priorities. Sources of clinical practice guidelines include the Agency for Healthcare Research and Quality, the National Guideline Clearinghouse, and professional organizations.

#### Elements of Performance for LD.04.04.07

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| 1. The hospital considers using clinical practice guidelines when designing or improving processes. (See also NR.02.01.01, EP 5)  | <b>A</b> |
| 2. When clinical practice guidelines will be used in the design or modification of processes, the hospital identifies criteria to guide their selection and implementation. | <b>A</b> |
| 3. The hospital manages and evaluates the implementation of the guidelines used in the design or modification of processes.   | <b>A</b> |
| 4. The leaders of the hospital review and approve the clinical practice guidelines.   | <b>A</b> |
| 5. The organized medical staff reviews the clinical practice guidelines and modifies them as needed.  | <b>A</b> |







## Life Safety

## Standard LS.01.01.01

The hospital designs and manages the physical environment to comply with the Life Safety Code.

### Elements of Performance for LS.01.01.01







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|-------------|---|--|
| 1.          | The hospital assigns an individual(s) to assess compliance with the Life Safety Code, complete the electronic Statement of Conditions (e-SOC), and manage the resolution of deficiencies.                         | <b>A</b>   |
| 2.          | <b>D</b> The hospital maintains a current electronic Statement of Conditions (e-SOC).<br>Note: The e-SOC is available to each hospital through The Joint Commission Connect™ extranet site.                       |  <b>A</b> |
| 3.          | When the hospital plans to resolve a deficiency through a Plan for Improvement (PFI), the hospital meets the time frames identified in the PFI accepted by The Joint Commission. (See also LS.01.02.01, EPs 1-14) |  <b>A</b> |
| <b>M</b> 4. | <b>D</b> For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains documentation of any inspections and approvals made by state or local fire control agencies.    | <b>C</b>   |



**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required



## Standard LS.01.02.01

The hospital protects occupants during periods when the Life Safety Code is not met or during periods of construction.

### Elements of Performance for LS.01.02.01

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| 1.          | <b>D</b> The hospital notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm or sprinkler system is out of service more than 4 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text and any exceptions, refer to NFPA 101-2000: 9.6.1.8 and 9.7.6.1) (See also LS.01.01.01, EP 3)  |  <b>A</b> |
| 2.          | The hospital posts signage identifying the location of alternative exits to everyone affected. (See also LS.01.01.01, EP 3)  |  <b>A</b> |
| 3.          | <b>D</b> The hospital has a written interim life safety measure (ILSM) policy that covers situations when Life Safety Code deficiencies cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent the hospital follows special measures to compensate for increased life safety risk. (See also LS.01.01.01, EP 3)  |  <b>A</b> |
| <b>M</b> 4. | When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Inspects exits in affected areas on a daily basis. The need for these inspections is based on criteria in the hospital's interim life safety measure (ILSM) policy. (See also LS.01.01.01, EP 3)   |  <b>C</b> |
| 5.          | When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Provides temporary but equivalent fire alarm and detection systems for use when a fire system is impaired. The need for equivalent systems is based on criteria in the hospital's interim life safety measure (ILSM) policy. (See also LS.01.01.01, EP 3)  |  <b>A</b> |
| 6.          | When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Provides additional firefighting equipment. The need for this equipment is based on criteria in the hospital's interim life safety measure (ILSM) policy. (See also LS.01.01.01, EP 3)   |  <b>A</b> |
| 7.          | When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Uses temporary construction partitions that are smoke-tight, or made of noncombustible or limited-combustible material that will not contribute to the development or spread of fire. The need for these partitions is based on criteria in the hospital's interim life safety measure (ILSM) policy. (See also LS.01.01.01, EP 3) | <b>A</b>   |
| <b>M</b> 8. | When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas and storage, excavation, and field offices. The need for increased surveillance is based on criteria in the hospital's interim life safety measure (ILSM) policy. (See also LS.01.01.01, EP 3)                         | <b>C</b>   |
| <b>M</b> 9. | When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Enforces storage, housekeeping, and debris-removal practices that reduce the building's flammable and combustible fire load to the lowest feasible level. The need for these practices is based on criteria in the hospital's interim life safety measure (ILSM) policy. (See also LS.01.01.01, EP 3)                              | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

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|-----------------------|---|--|
| 10.                   | When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Provides additional training to those who work in the hospital on the use of firefighting equipment. The need for additional training is based on criteria in the hospital's interim life safety measure (ILSM) policy. (See also LS.01.01.01, EP 3)  | <b>A</b>   |
| 11.                   | When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Conducts one additional fire drill per shift per quarter. The need for additional drills is based on criteria in the hospital's interim life safety measure (ILSM) policy. (See also EC.02.03.03, EP 1; LS.01.01.01, EP 3)  | <b>A</b>   |
| <b>M</b> 12. <b>D</b> | When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Inspects and tests temporary systems monthly. The completion date of the tests is documented. The need for these inspections and tests is based on criteria in the hospital's interim life safety measure (ILSM) policy. (See also LS.01.01.01, EP 3)   | <b>C</b>   |
| 13.                   | The hospital conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety. The need for education is based on criteria in the hospital's interim life safety measure (ILSM) policy. (See also LS.01.01.01, EP 3)  |  <b>A</b> |
| <b>M</b> 14.          | The hospital trains those who work in the hospital to compensate for impaired structural or compartmental fire safety features. The need for training is based on criteria in the hospital's interim life safety measure (ILSM) policy. (See also LS.01.01.01, EP 3)<br>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. |  <b>C</b> |

**Standard LS.02.01.10**



Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.





**Rationale for LS.02.01.10**

A building should be designed, constructed, and maintained in order to minimize danger from the effects of fire, including smoke, heat, and toxic gases. The structural characteristics of the building, as well as its age, determine the types of fire protection features that are needed. The features covered in this standard include the structure, automatic sprinkler systems, building separations, and doors.

Note: When remodeling or designing a new building, the hospital should also satisfy any requirements of other codes and standards (local, state, or federal) that may be more stringent than the Life Safety Code. Also, the Life Safety Code contains special considerations for minor and major renovation.

**Elements of Performance for LS.02.01.10**

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|----|---|--|
| 1. | Buildings meet requirements for height and construction type in accordance with NFPA 101-2000: 18/19.1.6.2.   |  <b>A</b> |
| 2. | New buildings contain approved automatic sprinkler systems, and existing buildings contain approved automatic sprinkler systems as required by the construction type. (For full text and any exceptions, refer to NFPA 101-2000: 18.3.5.1 and 19.1.6.2)   |  <b>A</b> |
| 3. | Walls that are fire rated for 2 hours (such as common walls between buildings and occupancy separation walls within buildings) extend from the floor slab to the floor or roof slab above and extend from exterior wall to exterior wall. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.2.2)   | <b>A</b>   |
| 4. | Openings in 2-hour fire-rated walls are fire rated for 1 1/2 hours. (See also LS.02.01.20, EP 3; LS.02.01.30, EP 1) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1)   | <b>A</b>   |
| 5. | Doors 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 inch. (See also LS.02.01.30, EP 2; LS.02.01.34, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1-11.4) | <b>C</b>   |
| 6. | Doors that are fire rated do not have unapproved protective plates that are higher than 16 inches above the bottom of the door. Note: Doors for hazardous rooms may have nonrated protective plates that are placed no higher than 48 inches from the bottom of the door. (For full text and any exceptions, refer to NFPA 80-1999: 2-4.5 and NFPA 101-2000: 19.3.2.1)  | <b>C</b>   |
| 7. | Doors requiring a fire rating of 3/4 hour or longer are free of coverings, decorations, or other objects applied to the door face, with the exception of informational signs. (For full text and any exceptions, refer to NFPA 80-1999: 1-3.5)  | <b>C</b>   |
| 8. | Ducts that penetrate a 2-hour fire-rated separation are protected by dampers that are fire-rated for 1 1/2 hours. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.1 and NFPA 90A-1999: 3-3.1)  | <b>A</b>   |
| 9. | The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material.<br>Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)  | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

10. The hospital meets all other Life Safety Code requirements related to NFPA 101-2000: 18/19.1.

**C**

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard LS.02.01.20**



The hospital maintains the integrity of the means of egress.





**Rationale for LS.02.01.20**


Because patients are under medical care and in many cases cannot move on their own to escape the danger of fire, buildings in which patients are cared for must be designed and maintained so patients can be protected in place or moved to safe places in the building (instead of evacuated to a place outside the building). Hospitals should make sure that a sufficient number of exits exist and that they are configured to provide protection from fire. Egress doors should not be locked in a way that restricts passage to safety. Means of egress include corridors, stairways, and doors that allow individuals to leave a building or to move between specific spaces in a building. They allow individuals to escape from fire and smoke and, therefore, are an integral part of a fire protection strategy.





Note: The Life Safety Code does permit select doors to be locked when there are clinical reasons to restrict the movement of the patient.

**Elements of Performance for LS.02.01.20**

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| 1. | Doors in a means of egress are unlocked in the direction of egress. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.4)  |  <b>A</b>   |
| 2. | Doors in a means of egress swing in the direction of egress in hospitals whose occupancy is 50 or more. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.1.4.2)  | <b>C</b>   |
| 3. | Walls containing horizontal exits are fire rated for 2 or more hours, extend from the lowest floor slab to the floor or roof slab above, and extend continuously from exterior wall to exterior wall. (See also LS.02.01.10, EP 4) (For full text and any exceptions, refer to NFPA 101-2000: 7.2.4.3.1 and 8.2.2.2)   | <b>A</b>   |
| 4. | Outside exit stairs are separated from the interior of the building by walls with the same fire rating required for enclosed stairs. The wall extends vertically from the ground to a point 10 feet or more above the top landing of the stairs or roofline (whichever is lower) and extends 10 feet or more horizontally. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.2.6.3) | <b>C</b>   |
| 5. | Doors in new buildings that are a part of horizontal exits have approved vision panels and are installed without a center mullion. (For full text and any exceptions, refer to NFPA 101-2000: 18.2.2.5.6)  | <b>C</b>   |
| 6. | When horizontal exit walls in new buildings terminate at outside walls at an angle of less than 180 degrees, the outside walls are fire-rated for 1 hour for a distance of 10 or more feet. Openings in the walls in the 10-foot span are fire-rated for 3/4 hour. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.4.3.2)   | <b>C</b>   |
| 7. | Stairs and ramps serving as a required means of egress have handrails and guards on both sides in new buildings and on at least one side in existing buildings. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.2.4.2)  | <b>C</b>   |
| 8. | Exits discharge to the outside at grade level or through an approved exit passageway that is continuous and terminates at a public way or at an exterior exit discharge. (For full text and any exceptions, refer to NFPA 101-2000: 7.7)   |  <b>A</b> |
| 9. | When stair doors are held open and the sprinkler or fire alarm system activates the release of one door in a stairway, all doors serving that stairway close. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.7)  | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

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| 10. | Doors to new boiler rooms, new heater rooms, and new mechanical equipment rooms located in a means of egress are not held open by an automatic release device. (For full text and any exceptions, refer to NFPA 101-2000: 18.2.2.2.6)  | <b>C</b>   |
| 11. | In new buildings, exit corridors are at least 8 feet wide; in existing buildings, exit corridors are at least 4 feet wide. If modifying existing buildings with exit corridors that exceed 8 feet, the exit corridors cannot be reduced to less than 8 feet. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.3.3)   | <b>C</b>   |
| 12. | The corridor width is not obstructed by wall projections. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.3.3)<br>Note: When corridors are 6 feet wide or more, The Joint Commission permits certain objects to project into the corridor, such as hand rub dispensers or computer desks that are retractable. They must be no more than 36 inches wide and cannot project more than 6 inches into the corridor. These items must be installed at least 48 inches apart and above the handrail height. (For full text and any exceptions, refer to: NFPA 101-2000: 18/19.2.3.3) | <b>C</b>   |
| 13. | 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 and any exceptions, refer to NFPA 101-2000: 7.1.10.1)  | <b>C</b>   |
| 14. | 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 and any exceptions, refer to NFPA 101-2000: 7.5.2.2)  | <b>C</b>   |
| 15. | Floors or compartments in a building have two or more approved exits arranged and constructed to be located remotely from each other. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.4.1)  | <b>A</b>   |
| 16. | Patient sleeping rooms or suites of patient sleeping rooms larger than 1,000 square feet are provided with at least two exit access doors remotely located from each other. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.5.2)  | <b>C</b>   |
| 17. | Rooms or suites (not used as patient sleeping rooms) larger than 2,500 square feet have at least two exit access doors remotely located from each other. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.5.3)   | <b>C</b>   |
| 18. | Suites of patient sleeping rooms are limited to 5,000 square feet, and suites used for other purposes are limited to 10,000 square feet. The suites are arranged so that no intervening rooms are hazardous areas. (See also LS.02.01.30, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.5.5-7)  | <b>C</b>   |
| 19. | In suites of patient sleeping rooms, the travel distance to an exit access door from any point in the suite is 100 feet or less. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.5.8)   | <b>C</b>   |
| 20. | In suites not used as patient sleeping rooms that have up to one intervening room, the travel distance to an exit access door from any point in the suite is 100 feet or less, and in suites containing two intervening rooms is 50 feet or less. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.5.8)  | <b>C</b>   |
| 21. | Patient sleeping rooms open directly onto an exit access corridor. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.5.1)   | <b>C</b>   |
| 22. | Doors to patient sleeping rooms are not locked. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.2)  |  <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

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| 23. | The travel distance to a room door from any point in a patient sleeping room is 50 feet or less. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.6.2.3)  | <b>C</b> |
| 24. | In existing buildings, the travel distance between any room door and an exit is 100 feet or less (or 150 feet or less when equipped with an approved automatic sprinkler system). In new buildings, the travel distance between any room door and an exit is 150 feet or less. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.6.2.1)  | <b>C</b> |
| 25. | In existing buildings, the travel distance between any point in a room and an exit is 150 feet or less (or 200 feet or less when equipped with an approved automatic sprinkler system). In new buildings, the travel distance between any point in a room and an exit is 200 feet or less. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.6.2.2)                                | <b>C</b> |
| 26. | In new buildings, no dead-end corridor is longer than 30 feet. (For full text and any exceptions, refer to NFPA 101-2000: 18.2.5.10)  | <b>C</b> |
| 27. | Means of egress are adequately illuminated at all points, including angles and intersections of corridors and passageways, stairways, stairway landings, exit doors, and exit discharges. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.8)   | <b>C</b> |
| 28. | Illumination in the means of egress, including exit discharges, is arranged so that failure of any single light fixture or bulb will not leave the area in darkness. (For full text and any exceptions, refer to NFPA 101-2000: 7.8.1.4)  | <b>C</b> |
| 29. | Stairs serving five or more stories have signs on each floor landing in the stairwell that identify the story, the stairwell, the top and bottom, and the direction to and story of exit discharge. The signs are placed 5 feet above the floor landing in a position that is easily visible when the door is open or closed. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.2.5.4) | <b>C</b> |
| 30. | Signs reading "No Exit" are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit. (For full text and any exceptions, refer to NFPA 101-2000: 7.10.8.1)   | <b>A</b> |
| 31. | 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). (For full text and any exceptions, refer to NFPA 101-2000: 7.10.1.2, 7.10.5, 7.10.6.1, and 7.10.7.1)   | <b>C</b> |
| 32. | The hospital meets all other Life Safety Code means of egress requirements related to NFPA 101-2000: 18/19.2.   | <b>C</b> |

## Standard LS.02.01.30

The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

### Rationale for LS.02.01.30

Fire and smoke are special concerns in health care organizations because of the inability of some patients to evacuate without assistance from staff. If not properly protected, the building can put patients at risk because smoke and fire can travel through openings in a building. To facilitate safe evacuation, the effects of fire and smoke can be contained when sections of a building are separated into multiple compartments. In addition, interior finishes need to be controlled to minimize smoke and toxic gases. Openings are necessary and include such features as heating, ventilating, and air conditioning (HVAC) systems, elevator shafts, and trash and laundry chutes. Hospitals should design and maintain these openings to contain fire to a compartment or floor.

### Elements of Performance for LS.02.01.30

1. Existing vertical openings (other than exit stairs) are enclosed with 1-hour fire-rated construction. In new construction, vertical openings (other than exit stairs) are enclosed by 1-hour fire-rated walls when connecting three or fewer floors and 2-hour fire-rated walls when connecting four or more floors. (See also LS.02.01.10, EP 4)  
Note: These vertical openings include, but are not limited to, communicating stairs, ramps, elevator shafts, ventilation shafts, light shafts, trash chutes, linen chutes, and utility chases. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.1.1)

**C**

2. All hazardous areas are protected by walls and doors in accordance with NFPA 101-2000: 18/19.3.2.1. (See also LS.02.01.10, EP 5; LS.02.01.20, EP 18) Hazardous areas include, but are not limited, to the following:
- Boiler/fuel-fired heater rooms
- Existing boiler/fuel-fired heater rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
  - New boiler/fuel-fired heater rooms have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- Central/bulk laundries larger than 100 square feet
- Existing central/bulk laundries larger than 100 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laundries have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
  - New central/bulk laundries larger than 100 square feet have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- Flammable liquid storage rooms (See NFPA 30-1996:4-4.2.1 and 4-4.4.2)
- Existing flammable liquid storage rooms have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
  - New flammable liquid storage rooms have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
- Laboratories (See NFPA 45-1996 to determine if a laboratory is a "severe hazard" area)
- Existing laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laboratories have walls fire rated for 1 hour with 3/4-hour fire-rated doors.
  - New laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
  - Existing laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. When there is a sprinkler system, the walls are fire rated for 1 hour with 3/4-hour fire-rated doors.
  - New laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
  - Existing flammable gas storage rooms in laboratories have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)
  - New flammable gas storage rooms in laboratories have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)
- Maintenance repair shops
- Existing maintenance repair shops have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with at least 3/4-hour fire-rated doors.
  - New maintenance repair shops have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- Piped oxygen tank supply rooms (See NFPA 99-1999: 4-3.1.1.2)
- Existing piped oxygen tank supply rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
  - New piped oxygen tank supply rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- Paint shops that are not severe hazard areas
- Existing paint shops that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
  - New paint shops that are not severe hazard areas have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- Soiled linen rooms

- Existing soiled linen rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

- New soiled linen rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

#### Storage rooms

- Existing storage rooms for combustible materials larger than 50 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

- New storage rooms for combustible materials 50 to 100 square feet are sprinklered, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.

- New storage rooms for combustible materials larger than 100 square feet are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

#### Trash collection rooms

- Existing trash collection rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

- New trash collection rooms are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

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| 3. | Gift shops storing or displaying combustibles in quantities considered hazardous are separated by 1-hour fire-rated walls and 3/4-hour fire-rated doors. In existing buildings, a combination of walls and doors to limit the passage of smoke and an approved automatic sprinkler system may be used for gift shops storing or displaying combustibles in quantities considered hazardous. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.2.5)   | <b>C</b> |
| 4. | Existing wall and ceiling interior finishes are rated Class A or B for limiting smoke development and the spread of flames. Newly installed wall and ceiling interior finishes are rated Class A. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.3.2)   | <b>C</b> |
| 5. | Newly installed interior floor finishes in corridors of smoke compartments without sprinkler systems have a Class I radiant flux rating. (For full text and any exceptions, refer to NFPA 101-2000: 19.3.3.3)   | <b>C</b> |
| 6. | Existing corridor partitions are fire rated for 1/2 hour, are continuous from the floor slab to the floor or roof slab above, extend through any concealed spaces (such as those above suspended ceilings and interstitial spaces), are properly sealed, and are constructed to limit the transfer of smoke.<br>Note 1: Unsealed spaces 1/8-inch wide or less around pipes, conduits, ducts, and wires above the ceiling are permitted.<br>Note 2: In smoke compartments protected throughout with an approved supervised sprinkler system, corridor partitions are allowed to terminate at the ceiling if the ceiling is constructed to limit the passage of smoke. The passage of smoke can be limited by an exposed, suspended-grid acoustical tile ceiling. The following ceiling features also limit the passage of smoke: sprinkler piping and sprinklers that penetrate the ceiling; ducted heating, ventilating, and air-conditioning (HVAC) supply and return-air diffusers; speakers; and recessed lighting fixtures. (For full text and any exceptions, refer to NFPA 101-2000: 19.3.6.2.1 and 19.3.6.2.2) | <b>C</b> |
| 7. | In new buildings, corridor walls are constructed to limit the transfer of smoke. (For full text and any exceptions, refer to NFPA 101-2000: 18.3.6.2)   | <b>C</b> |



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| 8.  | <p>In smoke compartments without sprinkler systems, fixed fire windows in corridor walls are 25% or less of the size of the corridor walls in which they are installed.</p> <p>Note: Existing window installations that conform to previously accepted Life Safety Code criteria (such as 1,296 square inches or less, fixed wired glass, or fire-rated glazing, and set in approved metal frames) are permitted. (For full text and any exceptions, refer to NFPA 101-2000: 19.3.6.3.8 and 8.2.3.2.2(2))</p>  | C |
| 9.  | <p>In existing buildings, all corridor doors are constructed of 1 3/4-inch or thicker solid bonded wood core or equivalent material and do not have ventilating louvers or transfer grills (with the exception of bathrooms, toilets, and sink closets that do not contain flammable or combustible materials). (For full text and any exceptions, refer to NFPA 101-2000: 19.3.6.3.1 and 19.3.6.4)</p>  | C |
| 10. | <p>Corridor doors do not have nonrated protective plates that are placed higher than 48 inches above the bottom of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.5)</p>   | C |
| 11. | <p>Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable.</p> <p>Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)</p>  | C |
| 12. | <p>Openings in vision panels or doors in corridor walls (other than in smoke compartments containing patient sleeping rooms) are installed at or below one half the distance from the floor to the ceiling. These openings may not be larger than 80 square inches in new buildings or larger than 20 square inches in existing buildings.</p> <p>Note: Openings may include, but are not limited to, mail slots and pass-through windows in areas such as laboratories, pharmacies, and cashier stations. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.5)</p>   | C |
| 13. | <p>Corridors serving adjoining areas are not used for a portion of an air supply, air return, or exhaust air plenum.</p> <p>Note: The Joint Commission interprets the NFPA code to allow incidental air movement between rooms and corridors (such as isolation rooms) because of the need for pressure differentials in health care hospitals. In such cases, the direction of airflow is not the focus for this element of performance. For the purpose of fire protection, air transfer should be limited to the amount necessary to maintain positive or negative pressure differentials. (For full text and any exceptions, refer to NFPA 90A-1999: 2-3.11.1)</p> | C |
| 14. | <p>In existing buildings at least two smoke compartments are provided for every story that has more than 30 patients in sleeping rooms. (For full text and any exceptions, refer to NFPA 101-2000: 19.3.7.1)</p>   | A |
| 15. | <p>In new buildings at least two smoke compartments are provided for every story with patient sleeping or treatment rooms, for non-sleeping stories that have an occupant capacity of 50 or more people, and on usable but unoccupied stories. (For full text and any exceptions, refer to NFPA 101-2000: 18.3.7.1 and 18.3.7.2)</p>   | A |
| 16. | <p>Smoke barriers limit the maximum size of each smoke compartment to 22,500 square feet. The travel distance from any point within the compartment to a smoke barrier door is no more than 200 feet. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.1)</p>  | C |
| 17. | <p>The size of smoke compartments meets the requirements of NFPA 101-2000: 18/19.3.7.4.</p>  | C |





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| 18. | Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.3)  | <b>C</b> |
| 19. | In existing buildings, smoke barriers are fire rated for 1/2 hour; in new buildings, smoke barriers are fire rated for 1 hour. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.3)  | <b>C</b> |
| 20. | In existing buildings, ducts that penetrate smoke barriers are protected by approved smoke dampers that close when a smoke detector is activated. The detector is located either within the duct system or in the area serving the smoke compartment.<br>Note: In existing buildings with two adjacent compartments with approved automatic sprinkler systems, dampers in common smoke barriers are not required. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.3 and 8.3.5.2)   | <b>C</b> |
| 21. | Approved smoke dampers protect air transfer openings extending through smoke barriers in ceiling spaces that are used as an unducted common plenum for either supply or return air. (For full text and any exceptions, refer to NFPA 101-2000: 8.3.5.1)   | <b>C</b> |
| 22. | 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.<br>Note: Existing window installations that have fixed wire 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 and any exceptions, refer to: NFPA 101-2000: 18.3.7.7, 19.3.7.5, and 8.2.3.2.2)                                    | <b>C</b> |
| 23. | Doors in smoke barriers are self-closing or automatic-closing, constructed of 1 3/4-inch or thicker solid bonded wood core or equivalent, and fitted to resist the passage of smoke. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 3/4 inch. Doors do not have nonrated protective plates more than 48 inches above the bottom of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.5, 18/19.3.7.6, and 8.3.4.1) | <b>C</b> |
| 24. | In buildings, exit stairs connecting three or fewer floors are fire rated for 1 hour; exit stairs connecting four or more floors are fire rated for 2 hours. (For full text and any exceptions, refer to: NFPA 101-2000:7.1.3.2.1)  | <b>C</b> |
| 25. | The hospital meets all other Life Safety Code fire and smoke protection requirements related to NFPA 101-2000: 18/19.3.<br>Note: For The Joint Commission's accepted amount of alcohol-based hand rub permitted within a single smoke compartment, see <a href="http://www.jointcommission.org/lsc">http://www.jointcommission.org/lsc</a> .  | <b>C</b> |

## Standard LS.02.01.34

The hospital provides and maintains fire alarm systems.

### Elements of Performance for LS.02.01.34





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| 1. | The fire alarm signal automatically transmits to one of the following (For full text and any exceptions, refer to NFPA 101-2000: 9.6.4):<br>- An auxiliary fire alarm system with direct connection to the servicing fire department as described in NFPA 72-1999: 6-16<br>- Central station service as described in NFPA 72-1999: 5-2<br>- A proprietary supervising station system as described in NFPA 72-1999: 5-3 or The Joint Commission's approved method for a manual transmission system at <a href="http://www.jointcommission.org/lsc">http://www.jointcommission.org/lsc</a><br>- A remote supervising station fire alarm system as described in NFPA 72-1999: 5-4 |  <b>A</b> |
| 2. | The master fire alarm control panel is located in a protected environment (an area enclosed with 1-hour fire-rated walls and 3/4-hour fire-rated doors) that is continuously occupied or in an area with a smoke detector. (See also LS.02.01.10, EP 5) (For full text and any exceptions, refer to NFPA 101-2000: 9.6.4 and NFPA 72-1999: 1-5.6 and 3-8.41)   |  <b>A</b> |
| 3. | The remote ancillary annunciator panel is in a location approved by the local fire department or its equivalent. (For full text and any exceptions, refer to NFPA 101-2000: 9.6.4)   | <b>A</b>   |
| 4. | The hospital meets all other Life Safety Code fire alarm requirements related to NFPA 101-2000: 18/19.3.4.   | <b>C</b>   |





**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

## Standard LS.02.01.35

The hospital provides and maintains systems for extinguishing fires.

### Elements of Performance for LS.02.01.35

1.	The fire alarm system monitors approved automatic sprinkler system components. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.5.2 and 9.7.2.2)		<b>A</b>
2.	The fire alarm system is connected to water flow alarms. (For full text and any exceptions, refer to NFPA 101-2000: 9.7.2.2)		<b>A</b>
3.	Piping supports for approved automatic sprinkler systems are not damaged or loose. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.3)		<b>C</b>
4.	Piping for approved automatic sprinkler systems is not used to support any other item. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.2)		<b>C</b>
5.	Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.1.1)		<b>C</b>
6.	There are 18 inches or more of open space maintained below the sprinkler deflector to the top of storage. Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text and any exceptions, refer to NFPA 13-1999: 5-8.5.2.1)		<b>C</b>
7.	Limited-area sprinkler systems protecting isolated, hazardous areas connected to the domestic water system have a shutoff valve and are limited to six or fewer sprinkler heads. Water flow detection is provided in new installations where two or more sprinkler heads serve one area. (For full text and any exceptions, refer to NFPA 101-2000: 9.7.1.2)		<b>A</b>
8.	The travel distance from any point to the nearest fire extinguisher is 75 feet or less. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.5.6 and NFPA 10-1998: 3-1.1)		<b>C</b>
9.	Class K-type portable fire extinguishers are located within 30 feet of grease-producing cooking devices such as deep fat fryers, ranges, griddles, or broilers. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.5.6 and NFPA 10-1998: 2-3.2)		<b>A</b>
10.	Grease-producing cooking devices such as deep fat fryers, ranges, griddles, or broilers have an exhaust hood, an exhaust duct system, and grease removal devices without mesh filters. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.2.6 and NFPA 96-1998: 1-3.1)		<b>C</b>
11.	The automatic fire extinguishing system for grease-producing cooking devices does the following: Activates the building fire alarm system. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.2.6; NFPA 96-1998: 7-1.1 and 7-6.2)		<b>A</b>
12.	The automatic fire extinguishing system for grease-producing cooking devices does the following: Deactivates the fuel source. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.2.6; NFPA 96-1998: 7-1.1 and 7-4.1)		<b>A</b>
13.	The automatic fire extinguishing system for grease-producing cooking devices does the following: Controls the exhaust fans as designed. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.2.6; NFPA 96-1998: 7-1.1 and 8-1.5)		<b>A</b>

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

14. The hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2000: 18/19.3.5.

**C**

### Standard LS.02.01.40

The hospital provides and maintains special features to protect individuals from the hazards of fire and smoke.

#### Elements of Performance for LS.02.01.40

1. Windowless buildings or portions of windowless buildings meet the requirements of NFPA 101-2000: 18/19.4.1. (For full text and any exceptions, refer to NFPA 101-2000: 11.7)
2. New high-rise buildings have an approved automatic sprinkler system that meets the requirements of NFPA 101-2000: 18.4.2. (For full text and any exceptions, refer to NFPA 101-2000: 11.8)

**C**








**A**

## Standard LS.02.01.50

The hospital provides and maintains building services to protect individuals from the hazards of fire and smoke.

### Elements of Performance for LS.02.01.50

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| 1.  | Fireplaces are not permitted in patient sleeping areas. Where allowed, fireplaces are separated from patient sleeping spaces by 1-hour or more fire-rated construction. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.5.2.2)  | <b>C</b>   |
| 2.  | Fireplaces are equipped with a fireplace enclosure guaranteed against breakage up to a temperature of 650°F (343.3°C) and constructed of heat-tempered glass or other approved material. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.5.2.2)   | <b>C</b>   |
| 3.  | The hearth of newly installed fireplaces is raised at least 4 inches above the floor. (For full text and any exceptions, refer to NFPA 101-2000: 18.5.2.2)   | <b>C</b>   |
| 4.  | <p>New elevators are equipped with the following:</p> <ul style="list-style-type: none"> <li>- Firefighters' service key recall</li> <li>- Smoke detector automatic recall</li> <li>- Firefighters' service emergency in-car key operation</li> <li>- Machine room smoke detectors</li> <li>- Elevator lobby smoke detectors</li> </ul> <p>Existing elevators that have a travel distance of 25 feet or more above or below the level that best serves the needs of firefighters also meet these requirements. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.5.3 and 9.4.3)</p> |  <b>A</b> |
| 5.  | Trash chutes discharge into collection rooms that are not used for any other purpose. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.5.4.3)  | <b>C</b>   |
| 6.  | In new buildings, linen and waste chutes have vent openings through the roof that open to the outside atmosphere. (For full text and any exceptions, refer to NFPA 101-2000: 18.5.4.1 and NFPA 82-1999: 3-2.2.4)   | <b>C</b>   |
| 7.  | In buildings more than two stories high, an approved automatic sprinkler system is located above the top of the linen and waste chute service openings on the lowest service levels and above the service door opening on alternate floor levels. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.5.4.2 and NFPA 82-1999: 3-2.5.1)  | <b>C</b>   |
| 8.  | In existing buildings, linen and waste chute service inlet door assemblies are fire rated for 3/4 hour (or for 1 hour if it opens into a corridor). In new buildings, the inlet door assemblies are fire rated for 1 hour (or for 1 1/2 hours in chutes of four stories or more). (For full text and any exceptions, refer to NFPA 101-2000: 18/19.5.4.1)  | <b>C</b>   |
| 9.  | <p>All linen and waste chute inlet and discharge service doors have both self-closing and positive latching devices.</p> <p>Note: Discharge doors may be held open with fusible links or electrical hold-open devices. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.5.4.1 and 8.2.3.2.3.1; NFPA 82-1999: 3-2.2.9)</p>  | <b>C</b>   |
| 10. | Linen and trash chute discharge door assemblies are fire rated for 1 hour. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.5.4.1 and 8.2.3.2.3.1)   | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

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| 11. | Linen and waste chutes discharge into a collection room separated from the corridor by 1-hour fire-rated walls. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.5.4.1 and 18/19.3.2.1; NFPA 82-1999: 3-2.6.1) | <b>C</b> |
| 12. | The hospital meets all other Life Safety Code building service requirements related to NFPA 101-2000: 18/19.5.   | <b>C</b> |

### Standard LS.02.01.70

The hospital provides and maintains operating features that conform to fire and smoke prevention requirements.

#### Elements of Performance for LS.02.01.70

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| 1. | The hospital prohibits all combustible decorations that are not flame retardant. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.7.5.4)  | <b>C</b> |
| 2. | 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 and any exceptions, refer to NFPA 101-2000: 18/19.7.5.5) | <b>C</b> |
| 3. | The hospital prohibits portable space heaters within smoke compartments containing patient sleeping areas and treatment areas. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.7.8)                    | <b>C</b> |
| 4. | The hospital meets all other Life Safety Code operating feature requirements related to NFPA 101-2000: 18.7/19.7. (See also EC.02.03.03, EP 1)  | <b>C</b> |

**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 hospital.

Note 2: This standard applies to all hospitals 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.03.01.10**

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|----|---|--|
| 1. | Buildings meet requirements for height and construction type in accordance with NFPA 101-2000: 20/21.1.6.2 and 1.6.3. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.1.6)   | <b>A</b>   |
| 2. | Buildings contain approved automatic sprinkler systems required by the construction type. (See also LS.03.01.35, EP 1) (For full text and any exceptions, refer to NFPA 101-2000: 20/21.1.6.3)  |  <b>A</b> |
| 3. | Hospitals located in multi-occupancy buildings are separated from health care occupancies by 2-hour fire-rated construction and from business occupancies by 1-hour fire-rated walls. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.1.2 and 20/21.3.7.1)   |  <b>A</b> |
| 4. | Any 2-hour fire-rated walls (such as common walls between buildings and occupancy separation walls within buildings) extend from the floor slab to the floor or roof slab above, and from exterior wall to exterior wall. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.2.2)   | <b>A</b>   |
| 5. | Openings in 2-hour fire-rated walls are fire-rated for 1 1/2 hours. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1)   | <b>A</b>   |
| 6. | Doors required to be fire-rated for 3/4 hour, 1 hour, or 1 1/2 hours have functioning hardware, including positive latching and self-closing or automatic-closing devices. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 3/4 inch. (See also LS.03.01.30, EPs 3 and 6) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1 and 8.2.3.2.1; NFPA 80-1999: 2-4.4.3, 2-4.5, 2-3.1.7, 1-11.4) | <b>C</b>   |
| 7. | Doors required to be fire-rated for 3/4 hour or longer are free of coverings, decorations, or other objects applied to the door face, with the exception of informational signs. (For full text and any exceptions, refer to NFPA 80-1999: 1-3.5)   | <b>C</b>   |
| 8. | Ducts that penetrate a 2-hour fire-rated separation, are protected by dampers that are fire-rated for 1 1/2 hours. (For full text and any exceptions, refer to NFPA 90A-1999: 3-3.1)  | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

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| 9.  | The space around pipes, conduits, bus ducts, cables/wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are filled with an approved fire-rated material.<br>Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2) | <b>C</b> |
| 10. | The hospital meets all other Life Safety Code requirements related to NFPA 101-2000: 20/21.1.  | <b>C</b> |

**Standard LS.03.01.20**

The hospital 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 hospital.

Note 2: This standard applies to all hospitals 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 hospital should make sure that a sufficient number of exits exist and that they are configured to provide protection from fire. It is important that egress doors are not locked in a way that restricts passage to safety.

**Elements of Performance for LS.03.01.20**

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| 1. | When doors in exit passageways, stair enclosures, horizontal exits, hazardous areas, or smoke partitions are held open, they have an electrical device that closes the door in response to the manual fire alarm system, loss of power, and smoke detectors. Note: The smoke detectors may be either installed to protect the entire building or installed in such a way to detect smoke on either side of the door opening. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.2.2.3) | <b>C</b>   |
| 2. | Stairs and ramps serving as a required means of egress have handrails on at least one side in existing buildings and on both sides in new buildings. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.2.4.2)   | <b>C</b>   |
| 3. | Exits discharge to the outside at grade level or through an approved exit passageway that is continuous and terminates at a public way or at an exterior exit discharge. (For full text and any exceptions, refer to NFPA 101-2000: 7.7.1)   |  <b>A</b> |
| 4. | Outside stairs are separated from the interior of the building by walls with the same fire rating required for enclosed stairs. These stairs extend vertically from the ground to a point 10 feet above the top landing of the stairs or roofline (whichever is lower) and extend 10 feet horizontally. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.2.6.3)  | <b>C</b>   |
| 5. | When stairway doors are held open and the sprinkler or fire alarm system activates the release of one door in a stairway, all doors serving that stairway close. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.2.2.4)   | <b>C</b>   |

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| 6.  | Exit corridors or passageways serving as a means of egress are 44 or more inches wide.<br>Note: When corridors are 6 feet wide or more, The Joint Commission permits certain objects to project into the corridor, such as hand rub dispensers or computer desks that are retractable. They must be no more than 36 inches wide and cannot project more than 6 inches into the corridor. These items must be installed at least 48 inches apart and above the handrail height. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.2.3) | <b>C</b>   |
| 7.  | Doors opening in the means of egress from diagnostic or treatment areas are 32 or more inches wide. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.2.3.3)  | <b>C</b>   |
| 8.  | 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 and any exceptions, refer to NFPA 101-2000: 7.1.10.1)  | <b>C</b>   |
| 9.  | 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 and any exceptions, refer to NFPA 101-2000: 7.5.2.2)  | <b>C</b>   |
| 10. | Floors or compartments of a building have two or more approved exits arranged and constructed to be located remotely from each other. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.2.4.1)  | <b>A</b>   |
| 11. | In existing buildings, dead-end corridors are no longer than 50 feet. In new buildings, dead-end corridors are no longer than 20 feet (or no longer than 50 feet when there is an approved automatic sprinkler system). (For full text and any exceptions, refer to NFPA 101-2000: 20/21.2.5)  | <b>C</b>   |
| 12. | The exits are arranged so that common paths of travel are 75 feet or less (or 100 feet or less when there are approved automatic sprinkler systems). (For full text and any exceptions, refer to NFPA 101-2000: 20/21.2.5)   | <b>C</b>   |
| 13. | The travel distance between any room door and an exit is 100 feet or less (or 150 feet or less when equipped with an approved automatic sprinkler system). (For full text and any exceptions, refer to NFPA 101-2000: 20/21.2.6.2)   | <b>C</b>   |
| 14. | The travel distance from any point in a room to an exit is 150 feet or less (or 200 feet or less when equipped with an approved automatic sprinkler system). (For full text and any exceptions, refer to NFPA 101-2000: 20/21.2.6.2)   | <b>C</b>   |
| 15. | Nothing is stored in any exit enclosure. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.2.5.3)   |  <b>A</b> |
| 16. | Means of egress are adequately illuminated at all points, including angles and intersections of corridors and passageways, stairways, stairway landings, exit doors, and exit discharges. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.2.8)  | <b>C</b>   |
| 17. | Illumination in the means of egress, including exit discharge, is arranged so that failure of any single light fixture or bulb will not leave the area in darkness. (For full text and any exceptions, refer to NFPA 101-2000: 7.8.1.4)  | <b>C</b>   |
| 18. | 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 and any exceptions, refer to NFPA 101-2000: 7.10.8.1)  | <b>A</b>   |

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| 19. | 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). (For full text and any exceptions, refer to NFPA 101-2000: 7.10.1.2, 7.10.1.4, 7.10.5, 7.10.6.1, and 7.10.7.1) | <b>C</b> |
| 20. | The hospital meets all other Life Safety Code means of egress requirements related to NFPA 101-2000: 20/21.2.   | <b>C</b> |

**Standard LS.03.01.30**


The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.





Note 1: This standard applies to 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 hospital.


Note 2: This standard applies to all hospitals 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.03.01.30**

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| 1. | Existing vertical openings (other than exit stairs) are enclosed with 1-hour fire-rated walls. In new construction, vertical openings (other than exit stairs) are enclosed by 1-hour fire-rated walls when connecting three or fewer floors, and 2-hour fire-rated walls when connecting four or more floors. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.3.1)<br>Note: These vertical openings include, but are not limited to, communicating stairs, ramp, elevator shafts, ventilation shafts, light shafts, trash chutes, linen chutes, and utility chases. |  <b>A</b> |
| 2. | In buildings, exit stairs connecting three or fewer floors are fire-rated for 1 hour; exit stairs connecting four or more floors are fire-rated for 2 hours. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.3.2.1)  | <b>C</b>   |
| 3. | Door assemblies in exit stair doors are fire-rated for 1 hour (or rated for 1 1/2 hours in buildings with four or more stories). (See also LS.03.01.10, EP 6) (For full text and any exceptions, refer to NFPA 101-2000: 7.1.3.2.1; NFPA 80-1999: 2-4.4.3)  | <b>C</b>   |
| 4. | Fixed fire window assemblies in exit stair doors are fire-rated for 1 hour (or rated for 1 1/2 hours in buildings with four or more stories); are 25% or smaller than the size of the fire barrier in which they are placed; and are 100 square inches or smaller in size. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1 and 8.2.3.2.2; NFPA 80-1999: 1-7.4)   | <b>C</b>   |
| 5. | All hazardous areas have sprinkler systems, resist the passage of smoke and have doors with self-closing or automatic-closing devices, or are enclosed with 1-hour fire-rated walls. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.3.2 and 38/39.3.2.1)  | <b>C</b>   |
| 6. | Doors in partitions enclosing hazardous areas without sprinklers are 3/4-hour fire-rated. (See also LS.03.01.10, EP 6) (For full text and any exceptions, refer to NFPA 101-2000: 20/21.3.2 and 38/39.3.2; NFPA 80-1999: 2-4.4.3)   | <b>C</b>   |
| 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 and any exceptions, refer to NFPA 101-2000: 20/21.3.3, 38/39.3.3.2, and 10.2.3)   | <b>C</b>   |
| 8. | Newly installed interior floor finishes in exits and enclosed corridors have a Class I or II radiant flux rating. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.3.3 and 10.2.7)  | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

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| 9.  | <p>Openings in vision panels or doors are installed at or below one half the distance from the floor to the room ceiling. These openings may be 20 square inches or smaller.</p> <p>Note: Openings may include, but are not limited to, mail slots and pass-through windows in areas such as laboratory, pharmacy, and cashier stations. (For full text and any exceptions, refer to NFPA 101-2000: 20.3.6.2)</p>   | C  |
| 10. | <p>In new buildings, the corridors providing access to exits are separated from other areas by 1-hour fire-rated systems. (For full text and any exceptions, refer to NFPA 101-2000: 20.3.6.1 and 38.3.6.1)</p>   | C  |
| 11. | <p>In new buildings without sprinkler systems, corridor doors are positive latching; have self-closing or automatic-closing devices; are fire-rated for 20 minutes; and have undercuts no larger than 3/4 inch to resist the passage of smoke. In existing buildings, doors in a means of egress are 28 or more inches wide; in new buildings, doors are 32 inches wide. (For full text and any exceptions, refer to NFPA 101-2000: 20.3.6, 38.3.6.1, 8.2.3, 8.2.3.2.1, 8.2.3.2.3.1; NFPA 80-1999: 2-4.4.3)</p> | C  |
| 12. | <p>Doors in a means of egress are always unlocked in the direction of egress, and swing in the direction of egress when there are 50 or more occupants. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.1.5.1 and 7.2.1.4.2)</p>   | <div style="display: inline-block; text-align: center; vertical-align: middle;">  </div> <b>A</b> |
| 13. | <p>Smoke barriers divide patient treatment floors into two or more smoke compartments. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.3.7.2)</p>  | A  |
| 14. | <p>The size of new smoke compartments meets the requirements of NFPA 101-2000 20.3.7.5. (For full text and any exceptions, refer to NFPA 101-2000: 20.3.7.5)</p>  | C  |
| 15. | <p>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, and new smoke barriers are constructed of 1-hour fire-rated materials. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.3.7.3)</p>  | C  |
| 16. | <p>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. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.3.7.3 and 8.3.5.2)</p>  | C  |
| 17. | <p>Approved smoke dampers protect air transfer openings through smoke barriers in ceiling spaces that are used as an unducted common plenum either for supply or return air.</p> <p>Note: In existing buildings with two adjacent compartments with approved automatic sprinkler systems, dampers in common smoke barriers are not required. (For full text and any exceptions, refer to NFPA 101-2000: 8.3.5.3)</p>  | C  |
| 18. | <p>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.</p> <p>Note: Existing window installations that have fixed 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 and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1)</p>   | C  |
| 19. | <p>Doors in smoke barriers are self-closing or automatic-closing, constructed of 1 3/4-inch or wider solid bonded wood core or equivalent, and fitted to resist the passage of smoke. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 3/4 inch. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.3.7.1)</p>   | C  |

20. The hospital meets all other Life Safety Code fire and smoke detection requirements related to NFPA 101-2000: 20/21.3.  
Note: For The Joint Commission's accepted amount of alcohol-based hand rub permitted within a single smoke compartment, see <http://www.jointcommission.org/lsc>.

C

### Standard LS.03.01.34

The hospital 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 hospital.


Note 2: This standard applies to all hospitals 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. The fire alarm signal automatically transmits to one of the following (For full text and any exceptions, refer to NFPA 101-2000: 9.6.4):
  - An auxiliary fire alarm system with direct connection to the servicing fire department as described in NFPA 72-1999: 6-16
  - Central station service as described in NFPA 72-1999: 5-2
  - A proprietary supervising station system as described in NFPA 72-1999: 5-3 or The Joint Commission's approved method for a manual transmission system at <http://www.jointcommission.org/lsc>
  - A remote supervising station fire alarm system as described in NFPA 72-1999: 5-4
2. The master fire alarm control panel is located in a protected environment (an area enclosed with 1-hour fire-rated walls and 3/4-hour fire-rated doors) that is continuously occupied or in an area with a smoke detector. (For full text and any exceptions, refer to: NFPA 101-2000: 9.6.4; NFPA 72-1999: 1-5.6 and 3-8.4.1)
3. The remote ancillary annunciator panel is in a location approved by the local fire department or its equivalent. (For full text and any exceptions, refer to NFPA 101-2000: 9.6.6)
4. The fire alarm system contains an audible and visual evacuation signal throughout the building and provides occupant notification without delay. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.3.4.3, 9.6.3.2, 9.6.3.6, and 9.6.3.7)
5. The fire alarm system is initiated by the approved automatic sprinkler system, or the fire detection system, or by manual pull stations. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.3.4.2 and 9.6.2.1)
6. The hospital meets all other Life Safety Code fire alarm requirements related to NFPA 101-2000: 20.3.4/21.3.4.

 A





 A

A

 A

 A

C

KEY: A indicates scoring category A; C indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard LS.03.01.35**



The hospital 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 hospital.

Note 2: This standard applies to all hospitals 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**

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|----|---|--|
| 1. | The fire alarm system monitors the components of any required approved automatic sprinkler system. (See also LS.03.01.10, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 20/21.1.6.3 and 9.7.2.2)   |  <b>A</b> |
| 2. | The fire alarm system is connected to water flow alarms of any required automatic sprinkler system. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.1.6.3 and 9.7.2.2)   |  <b>A</b> |
| 3. | Piping supports for approved automatic sprinkler systems are not damaged or loose. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.3)   | <b>C</b>   |
| 4. | Approved automatic sprinkler systems piping is not used to support any other item. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.2)   | <b>C</b>   |
| 5. | Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.1.1)   | <b>C</b>   |
| 6. | There is 18 inches or more of open space maintained below a sprinkler deflector to the top of storage.<br>Note: Perimeter wall shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text and any exceptions, refer to NFPA 13-1999: 5-8.5.2.1) | <b>C</b>   |
| 7. | Limited area sprinkler systems protecting isolated, hazardous areas connected to the domestic water system have a shut-off valve and are limited to six or fewer sprinkler heads. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.3.5.1)                                   | <b>C</b>   |
| 8. | The travel distance from any point to the nearest fire extinguisher is 75 feet or less. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.3.5.2)   | <b>C</b>   |
| 9. | The hospital meets all other Life Safety Code extinguishing requirements related to NFPA 101-2000: 20/21.3.5.   | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard LS.03.01.40**


The hospital provides and maintains special features to protect individuals from the hazards of fire and smoke.

Note 1: This standard applies to 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 hospital.

Note 2: This standard applies to all hospitals 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 101-2000: 20/21.4.           | <b>C</b>   |
| 2. | High-rise buildings have approved automatic sprinkler systems that meet the requirements of NFPA 101-2000: 20/21.4. |  <b>A</b> |

**Standard LS.03.01.50**


The hospital provides and maintains building services to protect individuals from the hazards of fire and smoke.





Note 1: This standard applies to sites of care where 4 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 hospital.

Note 2: This standard applies to all hospitals 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. | New elevators are equipped with all of the following:<br>- Firefighters service key recall and smoke detector automatic recall<br>- Firefighters service emergency in-car key operation<br>- Machine room smoke detectors<br>- Elevator lobby smoke detectors<br>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 and any exceptions, refer to NFPA 101-2000: 20/21.5.3) |  <b>A</b> |
| 2. | The hospital meets all other Life Safety Code building service requirements related to NFPA 101-2000: 20/21.5.   | <b>C</b>  |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard LS.03.01.70**



The hospital provides and maintains operating features that conform to fire and smoke prevention requirements.





Note 1: This standard applies to 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 hospital.

Note 2: This standard applies to all hospitals 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. | The hospital prohibits all combustible decorations that are not flame retardant. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.7.5.4)   | <b>C</b>   |
| 2. | 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 and any exceptions, refer to NFPA 101-2000: 20/21.7.5.5)                          | <b>C</b>   |
| 3. | The hospital prohibits portable space heaters in smoke compartments containing patient treatment and sleeping areas. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.7.8)   | <b>C</b>   |
| 4. | The hospital does not allow unvented fuel-fired heaters. (For full text and any exceptions, refer to NFPA 101-2000: 20/21.5.2.2)   |  <b>A</b> |
| 5. | 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 and any exceptions, refer to NFPA 101-2000: 20/21.5.2.2) |  <b>A</b> |
| 6. | The hospital meets all other Life Safety Code operating feature requirements related to NFPA 101-2000: 20/21.7. (See also EC.02.03.03, EP 1)   | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required



## Medication Management

**Standard MM.01.01.01**

The hospital plans its medication management processes.

**Rationale for MM.01.01.01**

Medication management is often complicated, involving many people and processes. For this reason, the hospital plans each part of the process with care so that safety and quality are maintained. This planning may involve the coordinated efforts of multiple services and disciplines.

**Elements of Performance for MM.01.01.01**

1. **D** 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: **A**
  - Age
  - Sex
  - Diagnoses
  - Allergies
  - Sensitivities
  - Current medications
  - Height and weight (when necessary)
  - Pregnancy and lactation information (when necessary)
  - Laboratory results (when necessary)
  - Any additional information required by the organization(See also MM.04.01.01, EP 10; IM.02.01.01, EP 3; RC.01.01.01, EP 13)
2. The hospital implements its policy to make information about the patient accessible to licensed independent practitioners and staff who participate in the management of the patient's medications. **A**

Note: This element of performance does not apply in emergency situations.

**Standard MM.01.01.03**

The hospital safely manages high-alert and hazardous medications.




**Rationale for MM.01.01.03**





High-alert medications are those medications involved in a high percentage of errors and/or sentinel events, as well as medications that carry a higher risk for abuse or other adverse outcomes. Lists of high-alert medications are available from organizations such as the Institute for Safe Medication Practices (ISMP) (<http://www.ismp.org/Tools/highalertmedications.pdf>). Examples of high-alert medications include investigational medications, controlled medications, medications not on the approved U.S. Food and Drug Administration (FDA) list, medications with a narrow therapeutic range, psychotherapeutic medications, and look-alike/sound-alike medications.

Hazardous medications are those in which studies in animals or humans indicate that exposures to them have a potential for causing cancer, developmental or reproductive toxicity, or harm to organs. Lists of hazardous medications are available from organizations such as the National Institute for Occupational Safety and Health (NIOSH) (<http://www.cdc.gov/niosh/docs/2004-165/2004-165d.html#o>).

For safe management, the hospital needs to develop its own list(s) of high-alert medications and hazardous medications based on its unique utilization patterns of medications and its own internal data about medication errors and sentinel events. It is up to the hospital to determine whether medications that are new to the market or new to the hospital are high alert or hazardous.

**Elements of Performance for MM.01.01.03**



- |  |   |  |
|--|---|--|
| 1.    | The hospital identifies, in writing, its high-alert and hazardous medications. (See also EC.02.02.01, EP 8)<br>Footnote: For a list of high-alert medications, see <a href="http://www.ismp.org">http://www.ismp.org</a> . For a list of hazardous medications, see <a href="http://www.cdc.gov/niosh/docs/2004-165/2004-165d.html#o">http://www.cdc.gov/niosh/docs/2004-165/2004-165d.html#o</a> . | <b>A</b>   |
| 2.   | The hospital has a process for managing high-alert and hazardous medications. (See also EC.02.02.01, EP 8; MM.03.01.01, EP 9)   | <b>A</b>   |
|  3. | The hospital implements its process for managing high-alert and hazardous medications. (See also EC.02.02.01, EPs 1 and 8)  |  <b>C</b> |
| 5.   | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports abuses and losses of controlled substances, in accordance with law and regulation, to the individual responsible for the pharmacy department or service and, as appropriate, to the chief executive.   | <b>A</b>   |





**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard MM.01.02.01**

The hospital addresses the safe use of look-alike/sound-alike medications.

**Elements of Performance for MM.01.02.01**






- |   |  |
|---|--|
| 1.  The hospital develops a list of look-alike/sound-alike medications it stores, dispenses, or administers.<br>Note: One source of look-alike/sound-alike medications is The Institute for Safe Medication Practices ( <a href="http://www.ismp.org/Tools/confuseddrugnames.pdf">http://www.ismp.org/Tools/confuseddrugnames.pdf</a> ). | <b>A</b>   |
| 2. The hospital takes action to prevent errors involving the interchange of the medications on its list of look-alike/sound-alike medications.  | <b>A</b>   |
| 3. The hospital annually reviews and, as necessary, revises its list of look-alike/sound-alike medications.   |  <b>A</b> |





**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required




**Standard MM.02.01.01**

The hospital selects and procures medications.

**Elements of Performance for MM.02.01.01**

- |   |  |   |
|---|--|---|
| 1.  |  Members of the medical staff, licensed independent practitioners, pharmacists, and staff involved in ordering, dispensing, administering, and/or monitoring the effects of medications develop written criteria for determining which medications are available for dispensing or administering to patients. | <b>A</b>  |
| 2.  | The hospital develops and approves criteria for selecting medications, which, at a minimum, include the following:<br>- Indications for use (See also MM.05.01.01, EP 10)<br>- Effectiveness<br>- Drug interactions<br>- Potential for errors and abuse<br>- Adverse drug events<br>- Sentinel event advisories<br>- Other risks<br>- Costs  | <b>A</b>  |
| 3.  | Before using a medication new to the hospital, the hospital determines a method to monitor the response of the patient. (See also MM.07.01.01, EP 2)   | <b>A</b>  |
| 4.  |  The hospital maintains a formulary, including medication strength and dosage.<br>Note 1: Sample medications are not required to be on the formulary.<br>Note 2: In some settings, the term "list of medications available for use" is used instead of "formulary." The terms are synonymous.                 | <b>A</b>  |
| 5.  | The hospital makes its formulary readily available to those involved in medication management.   | <b>A</b>  |
| 6.  | The hospital standardizes and limits the number of drug concentrations available to meet patient care needs.   |  <b>A</b> |
| 7.  | The hospital has a process to select, approve, and procure medications that are not on its formulary.  | <b>A</b>  |
|  8.  | The hospital implements the process to select, approve, and procure medications that are not on its formulary.   | <b>C</b>  |
| 9.  | Medications designated as available for dispensing or administration are reviewed at least annually based on emerging safety and efficacy information.   | <b>A</b>  |
| 10.   | The hospital has a process to communicate medication shortages and outages to licensed independent practitioners and staff who participate in medication management.   | <b>A</b>  |
|  11. | The hospital implements its process to communicate medication shortages and outages to licensed independent practitioners and staff who participate in medication management.  | <b>C</b>  |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

- |   |  |          |
|---|--|----------|
| 12.   |  The hospital develops and approves written medication substitution protocols to be used in the event of a medication shortage or outage. | <b>A</b> |
|  13. | The hospital implements its approved medication substitution protocols.  | <b>C</b> |
| 14.   | The hospital has a process to communicate to licensed independent practitioners and staff who participate in medication management about the medication substitution protocols for shortages or outages.                   | <b>A</b> |
|  15. | The hospital implements its process to communicate to licensed independent practitioners and staff who participate in medication management about the medication substitution protocols for shortages and outages.         | <b>C</b> |

**Standard MM.03.01.01**

The hospital safely stores medications.

**Rationale for MM.03.01.01**

Medication storage is designed to assist in maintaining medication integrity, promote the availability of medications when needed, minimize the risk of medication diversion, and reduce potential dispensing errors. Law and regulation and manufacturers' guidelines further define the hospital's approach to medication storage.

**Elements of Performance for MM.03.01.01**

<b>M</b>	2.	The hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.	<b>C</b>
	3.	The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, in accordance with law and regulation. Note: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970.	<b>A</b>
	4.	<b>D</b> The hospital has a written policy addressing the control of medication between receipt by an individual health care provider and administration of the medication, including safe storage, handling, security, disposition, and return to storage.	<b>A</b>
<b>M</b>	5.	The hospital implements its policy addressing the control of medication between receipt by an individual health care provider and its administration.	<b>C</b>
	6.	The hospital prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation.	<b>A</b>
<b>M</b>	7.	All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.	<b>3</b> <b>C</b>
<b>M</b>	8.	The hospital removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration.	<b>C</b>
	9.	The hospital keeps concentrated electrolytes present in patient care areas only when patient safety necessitates their immediate use, and precautions are used to prevent inadvertent administration. (See also MM.01.01.03, EP 2)	<b>3</b> <b>A</b>
<b>M</b>	10.	Medications in patient care areas are available in the most ready-to-administer forms commercially available or, if feasible, in unit-doses that have been repackaged by the pharmacy or a licensed repackager.	<b>3</b> <b>C</b>
<b>M</b>	18.	The hospital periodically inspects all medication storage areas.	<b>C</b>
	19.	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a pharmacy directed by a registered pharmacist or a supervised drug storage area, in accordance with law and regulation.	<b>A</b>

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required




**Standard MM.03.01.03**

The hospital safely manages emergency medications.

**Rationale for MM.03.01.03**

Patient emergencies occur frequently in health care settings. The hospital, therefore, needs to plan how it will address patient emergencies and what medications and supplies it will need. Although the processes may be different, the hospital treats emergency medications with the same care for safety as it does medications in nonemergency settings.

**Elements of Performance for MM.03.01.03**

	1. Hospital leaders, in conjunction with members of the medical staff and licensed independent practitioners, decide which emergency medications and their associated supplies will be readily accessible in patient care areas based on the population served.		<b>A</b>
	2. Emergency medications and their associated supplies are readily accessible in patient care areas. (See also PC.03.01.01, EP 8)		<b>A</b>
	3. Whenever possible, emergency medications are available in unit-dose, age-specific, and ready-to-administer forms.		<b>C</b>
	6. When emergency medications or supplies are used, the hospital replaces them as soon as possible to maintain a full stock.		<b>A</b>




**Standard MM.03.01.05**





The hospital safely controls medications brought into the hospital by patients, their families, or licensed independent practitioners.

**Rationale for MM.03.01.05**

A number of valid reasons exist for allowing the patient to use his or her own medications in an organization. The hospital needs to control the use of these medications in order to protect the safety of the patient and the quality of care provided. Therefore, the hospital needs to define its responsibilities for the safe use of these medications.

**Elements of Performance for MM.03.01.05**









	1. The hospital defines when medications brought into the hospital by patients, their families, or licensed independent practitioners can be administered.		<b>A</b>
	2. Before use or administration of a medication brought into the hospital by a patient, his or her family, or a licensed independent practitioner, the hospital identifies the medication and visually evaluates the medication's integrity. (See also MM.05.01.07, EP 3; MM.06.01.01, EP 4)		<b>C</b>
	3. The hospital informs the prescriber and patient if the medications brought into the hospital by patients, their families, or licensed independent practitioners are not permitted.		<b>C</b>





**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard MM.04.01.01**

Medication orders are clear and accurate.

**Elements of Performance for MM.04.01.01**

- |   |  |   |
|---|--|---|
| 1.     | The hospital has a written policy that identifies the specific types of medication orders that it deems acceptable for use.<br>Note: There are several different types of medication orders. Medication orders commonly used include the following:<br>- As needed (PRN) orders: orders acted on based on the occurrence of a specific indication or symptom<br>- Standing orders: A pre-written medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances<br>- Automatic stop orders: Orders that include a date or time to discontinue a medication<br>- Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status<br>- Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval<br>- Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status<br>- Orders for compounded drugs or drug mixtures not commercially available<br>- Orders for medication-related devices (for example, nebulizers, catheters)<br>- Orders for investigational medications<br>- Orders for herbal products<br>- Orders for medications at discharge or transfer | A   |
| 2.     | The hospital has a written policy that defines the following: The required elements of a complete medication order.  | A   |
| 3.     | The hospital has a written policy that defines the following: When indication for use is required on a medication order.   | A   |
| 4.     | The hospital has a written policy that defines the following: The precautions for ordering medications with look-alike or sound-alike names.   | A   |
| 5.    | The hospital has a written policy that defines the following: Actions to take when medication orders are incomplete, illegible, or unclear.  | A   |
| 6.  | The hospital minimizes the use of verbal and telephone medication orders.  | A   |
| 7.  | The hospital reviews and updates preprinted order sheets, within time frames it identifies or sooner if necessary, based on current evidence and practice.   | A   |
| 8.  | The hospital prohibits summary (blanket) orders to resume previous medications.  |  A |
|  9.  | A diagnosis, condition, or indication for use exists for each medication ordered.<br>Note: This information can be anywhere in the medical record and need not be on the order itself. For example, it might be part of the medical history.   | C   |
| 10.  | The hospital defines, in writing, the circumstances for which weight-based dosing is required for pediatric populations. (See also MM.01.01.01, EP 1)  | A   |

**KEY:** A indicates scoring category A; C indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

- |          |     |   |          |
|----------|-----|---|----------|
| <b>M</b> | 13. | The hospital implements its policies for medication orders.   | <b>C</b> |
|          | 14. | The hospital requires an order from a doctor of medicine or osteopathy, or, as permitted by law and regulation, a hospital-specific protocol(s) approved by a doctor of medicine or osteopathy, to administer influenza and pneumococcal polysaccharide vaccines. | <b>A</b> |

**Standard MM.05.01.01**

A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

**Elements of Performance for MM.05.01.01**







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|----------|-----|--|----------|
|          | 1.  | Before dispensing or removing medications from floor stock or from an automated storage and distribution device, a pharmacist reviews all medication orders or prescriptions unless a licensed independent practitioner controls the ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation (including sudden changes in a patient's clinical status), in accordance with law and regulation. | <b>A</b> |
| <b>M</b> | 2.  | When an on-site pharmacy is not open 24 hours a day, 7 days a week, a health care professional determined to be qualified by the hospital reviews the medication order in the pharmacist's absence.  | <b>C</b> |
| <b>M</b> | 3.  | When an on-site pharmacy is not open 24 hours a day, 7 days a week, a pharmacist conducts a retrospective review of all medication orders during this period as soon as a pharmacist is available or the pharmacy opens.   | <b>C</b> |
| <b>M</b> | 4.  | All medication orders are reviewed for the following: Patient allergies or potential sensitivities.  | <b>C</b> |
| <b>M</b> | 5.  | All medication orders are reviewed for the following: Existing or potential interactions between the medication ordered and food and medications the patient is currently taking.  | <b>C</b> |
| <b>M</b> | 6.  | All medication orders are reviewed for the following: The appropriateness of the medication, dose, frequency, and route of administration.   | <b>C</b> |
| <b>M</b> | 7.  | All medication orders are reviewed for the following: Current or potential impact as indicated by laboratory values.   | <b>C</b> |
| <b>M</b> | 8.  | All medication orders are reviewed for the following: Therapeutic duplication.   | <b>C</b> |
| <b>M</b> | 9.  | All medication orders are reviewed for the following: Other contraindications.   | <b>C</b> |
| <b>M</b> | 10. | All medication orders are reviewed for the following: Variation from the hospital's indications for use. (See also MM.02.01.01, EP 2)  | <b>C</b> |
| <b>M</b> | 11. | After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing.   | <b>C</b> |



**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; indicates situational decision rules apply; indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard MM.05.01.07**

The hospital safely prepares medications.

**Elements of Performance for MM.05.01.07**

- |          |    |   |  |
|----------|----|---|--|
|          | 1. | A pharmacist, or pharmacy staff under the supervision of a pharmacist, compounds or admixes all compounded sterile preparations except in urgent situations in which a delay could harm the patient or when the product's stability is short.   |  <b>A</b> |
| <b>M</b> | 2. | Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.   |  <b>C</b> |
|          | 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)  |  <b>A</b> |
|          | 4. | The hospital uses a laminar airflow hood or other ISO Class 5 environment in the pharmacy for preparing intravenous (IV) admixture or any sterile product that will not be used within 24 hours.  |  <b>A</b> |
|          | 5. | For hospitals that use Joint Commission accreditation for deemed status purposes: Medications are prepared and administered in accordance with the orders of a licensed independent practitioner responsible for the patient's care, and in accordance with law and regulation.<br>Footnote: For law and regulation guidance pertaining to those responsible for the care of patients, refer to 42 CFR 482.12(c). |  <b>A</b> |
|          | 6. | For hospitals that use Joint Commission accreditation for deemed status purposes: In-house preparation of radiopharmaceuticals is done by, or under the supervision of, an appropriately trained registered pharmacist or doctor of medicine or osteopathy.   |  <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard MM.05.01.09**

Medications are labeled.

**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.<br>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.   | 3 A |
| 2.  | Information on medication labels is displayed in a standardized format, in accordance with law and regulation and standards of practice.   | A   |
| 3.  | All medications prepared in the hospital are correctly labeled with the following: Medication name, strength, and amount (if not apparent from the container).   | 3 A |
| 4.  | All medications prepared in the hospital are correctly labeled with the following: Expiration date when not used within 24 hours.  | 3 A |
| 5.  | All medications prepared in the hospital are correctly labeled with the following: Expiration time when expiration occurs in less than 24 hours.   | 3 A |
| 6.  | All medications prepared in the hospital are correctly labeled with the following: The date prepared and the diluent for all compounded intravenous admixtures and parenteral nutrition formulas.  | 3 A |
| 7.  | When preparing individualized medications for multiple patients, the label also includes the following: The patient's name.  | 3 A |
| 8.  | When preparing individualized medications for multiple patients, the label also includes the following: The location where the medication is to be delivered. (See also NPSG.01.01.01, EP 1)<br>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.   | A   |
| 9.  | When preparing individualized medications for multiple patients, the label also includes the following: Directions for use and applicable accessory and cautionary instructions.   | 3 A |
| 10. | When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the following: The patient's name.  | 3 A |
| 11. | When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the following: The location where the medication is to be delivered. (See also NPSG.01.01.01, EP 1)<br>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. | A   |

**KEY:** A indicates scoring category A; C indicates scoring category C; 2 indicates situational decision rules apply; 3 indicates direct impact requirements apply; M indicates Measure of Success if needed; D indicates that documentation is required






12. When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the following: Directions for use and applicable accessory and cautionary instructions.





 **A**

### Standard MM.05.01.11

The hospital safely dispenses medications.

#### Elements of Performance for MM.05.01.11

- |   |   |  |
|---|---|--|
|  | 1. The hospital dispenses quantities of medications that are consistent with patient needs.   | <b>C</b>   |
|  | 2. The hospital dispenses medications and maintains records in accordance with law and regulation, licensure, and professional standards of practice.<br>Note: Dispensing practices and recordkeeping include antidiversion strategies. | <b>C</b>   |
|  | 3. The hospital dispenses medications within time frames it defines to meet patient needs.  |  <b>C</b> |
|  | 4. Medications are dispensed in the most ready-to-administer forms commercially available and, if feasible, in unit doses that have been repackaged by the pharmacy or licensed repackager.   | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required


**Standard MM.05.01.13**



The hospital safely obtains medications when the pharmacy is closed.

**Rationale for MM.05.01.13**

In today's health care settings, many organizations that provide 24-hour care do not provide 24-hour pharmacy services. However, patients in these settings may require medications during the times the pharmacy is not in operation. For safe, quality care, the hospital provides for the patient's urgent or emergent medication needs when the pharmacy is closed.

**Elements of Performance for MM.05.01.13**





- |          |    |  |   |
|----------|----|--|---|
|          | 1. | The hospital has a process for providing medications to meet patient needs when the pharmacy is closed.  | <b>A</b>  |
| <b>M</b> | 2. | When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: Medications available are limited to those approved by the hospital.  | <b>C</b>  |
| <b>M</b> | 3. | When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: The hospital stores and secures the medications approved for use outside of the pharmacy.   | <b>C</b>  |
| <b>M</b> | 4. | When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: Only trained, designated prescribers and nurses are permitted access to approved medications.   | <b>C</b>  |
| <b>M</b> | 5. | When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: Quality control procedures (such as an independent second check by another individual or a secondary verification built into the system such as bar coding) are in place to prevent medication retrieval errors.  | <b>C</b>  |
| <b>M</b> | 6. | When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: The hospital arranges for a qualified pharmacist to be available either on-call or at another location (for example, at another organization that has 24-hour pharmacy service) to answer questions or provide medications beyond those accessible to non-pharmacy staff. | <b>C</b>  |
| <b>M</b> | 7. | The hospital implements its process for providing medications to meet patient needs when the pharmacy is closed.   |  <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard MM.05.01.17**

The hospital follows a process to retrieve recalled or discontinued medications.

**Elements of Performance for MM.05.01.17**

- |  |   |          |
|--|---|----------|
| 1.   |  The hospital has a written policy describing how it will retrieve and handle medications within the hospital that are recalled or discontinued for safety reasons by the manufacturer or the U.S. Food and Drug Administration. (See also EC.02.01.01, EP 11) | <b>A</b> |
|  2. | The hospital implements its policy on retrieving and handling medications when they are recalled or discontinued for safety reasons. (See also EC.02.01.01, EP 11)  | <b>C</b> |
|  3. | When a medication is recalled or discontinued for safety reasons by the manufacturer or the U.S. Food and Drug Administration, the hospital notifies the prescribers and those who dispense or administer the medication. (See also EC.02.01.01, EP 11)   | <b>C</b> |
|  4. | When required by law and regulation or hospital policy, the hospital informs patients that their medication has been recalled or discontinued for safety reasons by the manufacturer or the U.S. Food and Drug Administration. (See also EC.02.01.01, EP 11)  | <b>C</b> |


**Standard MM.05.01.19**

The hospital safely manages returned medications.

**Rationale for MM.05.01.19**

Medications may be returned to the hospital when allowed by law or regulation and organization policy. Previously dispensed but unused, expired, or returned medications in the hospital must be accounted for, controlled, and disposed of in order to keep patients safe and prevent diversion.

**Elements of Performance for MM.05.01.19**

- |  |   |          |
|--|---|----------|
| 1.   | The hospital determines under what circumstances unused, expired, or returned medications will be managed by the pharmacy or the hospital.  | <b>A</b> |
| 2.   | When the hospital accepts unused, expired, or returned medications, it has a process for returning medications to the pharmacy's control that includes procedures for preventing diversion. | <b>A</b> |
| 3.   | The hospital determines if and when outside sources are used for destruction of medications.  | <b>A</b> |
|  4. | The hospital implements its process for managing unused, expired, or returned medications.  | <b>C</b> |

**Standard MM.06.01.01**

The hospital safely administers medications.

**Elements of Performance for MM.06.01.01**

- |      |   |   |          |
|------|---|---|----------|
| 1.   | ⓓ The hospital defines, in writing, licensed independent practitioners and the clinical staff disciplines that are authorized to administer medication, with or without supervision, in accordance with law and regulation. (See also MM.06.01.03, EP 1)  |   | <b>A</b> |
| 2.   | Only authorized licensed independent practitioners and clinical staff administer medications.<br>Note: This does not prohibit self-administration of medications by patients, when indicated. (See also MM.06.01.03, EP 1)  | 3 | <b>A</b> |
| Ⓜ 3. | Before administration, the individual administering the medication does the following: Verifies that the medication selected matches the medication order and product label.  | 3 | <b>C</b> |
| Ⓜ 4. | Before administration, the individual administering the medication does the following: 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)  | 3 | <b>C</b> |
| Ⓜ 5. | Before administration, the individual administering the medication does the following: Verifies that the medication has not expired.  | 3 | <b>C</b> |
| Ⓜ 6. | Before administration, the individual administering the medication does the following: Verifies that no contraindications exist.  | 3 | <b>C</b> |
| Ⓜ 7. | Before administration, the individual administering the medication does the following: Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route.   | 3 | <b>C</b> |
| Ⓜ 8. | Before administration, the individual administering the medication does the following: Discusses any unresolved concerns about the medication with the patient's licensed independent practitioner, prescriber (if different from the licensed independent practitioner), and/or staff involved with the patient's care, treatment, and services. | 3 | <b>C</b> |
| Ⓜ 9. | Before administering a new medication, the patient or family is informed about any potential clinically significant adverse drug reactions or other concerns regarding administration of a new medication. (See also MM.06.01.03, EPs 3-6; PC.02.03.01, EP 10)  | 3 | <b>C</b> |









**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **Ⓜ** indicates Measure of Success if needed; **ⓓ** indicates that documentation is required





**Standard MM.06.01.03**

Self-administered medications are administered safely and accurately.

Note: The term self-administered medication(s) may refer to medications administered by a family member.

**Elements of Performance for MM.06.01.03**

- |  |   |  |
|--|---|--|
| 1.   |  If self-administration of medications is allowed, written processes that address training, supervision, and documentation guide the safe and accurate self-administration of medications or the administration of medications by a family member. (See also MM.06.01.01, EPs 1 and 2) | <b>A</b>   |
|  2. | The hospital implements its written processes for medication self-administration or medication administration.  | <b>C</b>   |
|  3. | The hospital educates patients and families involved in self-administration about the following: Medication name, type, and reason for use. (See also MM.06.01.01, EP 9; PC.02.03.01, EP 10)  | <b>C</b>   |
|  4. | The hospital educates patients and families involved in self-administration about the following: How to administer medication, including process, time, frequency, route, and dose. (See also MM.06.01.01, EP 9; PC.02.03.01, EP 10)  | <b>C</b>   |
|  5. | The hospital educates patients and families involved in self-administration about the following: Anticipated actions and potential side effects of the medication administered. (See also MM.06.01.01, EP 9; PC.02.03.01, EP 10)  | <b>C</b>   |
|  6. | The hospital educates patients and families involved in self-administration about the following: Monitoring the effects of the medication. (See also MM.06.01.01, EP 9; PC.02.03.01, EP 10)   | <b>C</b>   |
|  7. | The hospital determines that the patient or the family member who administers the medication is competent at medication administration before allowing him or her to administer medications.  |  <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard MM.06.01.05**




The hospital safely manages investigational medications.

**Rationale for MM.06.01.05**

Investigational medications can be of great help to the patient. In some cases, investigational medications may represent one of a few options in the patient's care plan. The hospital contributes to the safety of patients participating in investigational or clinical medication studies by controlling and monitoring the use of these medications.

Note: For a discussion of patient rights regarding the use of investigational medications, see Standard RI.01.03.05.



**Elements of Performance for MM.06.01.05**

- |  |   |  |
|--|---|--|
| 1.  | The hospital has a written process addressing the use of investigational medications that includes review, approval, supervision, and monitoring.   | <b>A</b>   |
| 2.   | The hospital's written process for the use of investigational medications specifies that the pharmacy controls the storage, dispensing, labeling, and distribution of investigational medications.  | <b>A</b>   |
| 3.   | The written process for the use of investigational medications specifies that when a patient is involved in an investigational protocol that is independent of the hospital, the hospital evaluates and, if no contraindication exists, accommodates the patient's continued participation in the protocol. | <b>A</b>   |
|  4. | The hospital implements its processes for the use of investigational medications.   |  <b>C</b> |

**Standard MM.07.01.01**

The hospital monitors patients to determine the effects of their medication(s).

**Elements of Performance for MM.07.01.01**

- |   |  |          |
|---|--|----------|
|  1.  | The hospital monitors the patient's perception of side effects and the effectiveness of his or her medication(s).  | <b>C</b> |
|  2. | The hospital monitors the patient's response to medication(s) by taking into account clinical information from the medical record, relevant lab values, clinical response, and medication profile. (See also MM.02.01.01, EP 3)<br>Note: 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. | <b>C</b> |







**Standard MM.07.01.03**





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

**Rationale for MM.07.01.03**

Adverse drug reactions and medication errors place patients at considerable risk. For safe, quality care, hospitals must have systems in place to respond to and monitor a patient in the event of an adverse drug reaction or medication error.

**Elements of Performance for MM.07.01.03**

- |   |   |  |
|---|---|--|
|   | 1.  The hospital has a written process to respond to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.   | <b>A</b>   |
|   | 2.  The hospital has a written process addressing prescriber notification in the event of an adverse drug event, significant adverse drug reaction, or medication error.   | <b>A</b>   |
|  | 3. The hospital complies with internal and external reporting requirements for actual or potential adverse drug events, significant adverse drug reactions, and medication errors.  | <b>C</b>   |
|  | 5. The hospital implements its process for responding to adverse drug events, significant adverse drug reactions, and medication errors.  |  <b>C</b> |
|   | 6. For hospitals that use Joint Commission accreditation for deemed status purposes: Medication administration errors, adverse drug reactions, and medication incompatibilities as defined by the hospital are reported to the attending physician or clinical psychologist, immediately when possible, and as appropriate to the organization-wide performance improvement program.<br>Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). |  <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard MM.08.01.01**

The hospital evaluates the effectiveness of its medication management system.

**Elements of Performance for MM.08.01.01**

- | Elements of Performance for MM.08.01.01 |  |   |
|---|--|---|
| 1.                                      | The hospital collects data on the performance of its medication management system. (See also PI.01.01.01, EPs 14 and 15)   | A |
| 2.                                      | The hospital analyzes data on its medication management system.  | A |
| 3.                                      | The hospital compares data over time to identify risk points, levels of performance, patterns, trends, and variations of its medication management system.   | A |
| 4.                                      | The hospital reviews the literature and other external sources for new technologies and best practices.  | A |
| 5.                                      | Based on analysis of its data, as well as review of the literature for new technologies and best practices, the hospital identifies opportunities for improvement in its medication management system. | A |
| 6.                                      | The hospital takes action on improvement opportunities identified as priorities for its medication management system.  | A |
| 7.                                      | The hospital evaluates its actions to confirm that they resulted in improvements for its medication management system.   | A |
| 8.                                      | The hospital takes additional action when planned improvements for its medication management processes are either not achieved or not sustained.   | A |



## Medical Staff


**Standard MS.01.01.01**

Medical staff bylaws address self-governance and accountability to the governing body.

**Rationale for MS.01.01.01**

The organized medical staff and governing body must work collaboratively, reflecting clearly recognized roles, responsibilities, and accountabilities, to enhance the quality and safety of care, treatment, and services provided to patients. The organized medical staff creates a written set of documents that describes the organizational structure of the medical staff and the rules for self governance. These documents are called medical staff bylaws. The medical staff bylaws create a system of rights and responsibilities between the organized medical staff and the governing body, and between the organized medical staff and its members. As required by and pursuant to the medical staff bylaws, the organized medical staff may create additional governance documents such as policies, procedures, protocols, rules, and regulations, but the requirements listed below must be retained in the medical staff bylaws.

**Elements of Performance for MS.01.01.01**

- |   |          |
|---|----------|
| 1.  The organized medical staff develops medical staff bylaws.                         | <b>A</b> |
| 2. The medical staff bylaws are adopted and amended by the medical staff.   | <b>A</b> |
| 3. The governing body approves and complies with the medical staff bylaws.  | <b>A</b> |
| 4. The organized medical staff enforces and complies with the medical staff bylaws.   | <b>A</b> |
| 5. The medical staff bylaws, rules and regulations, and policies and the governing body bylaws do not conflict.   | <b>A</b> |
| 6. The medical staff bylaws include the following: The definition of the medical staff structure.   | <b>A</b> |
| 7. The medical staff bylaws include the following: The definition of the criteria and qualifications for appointment to the medical staff. (See also MS.02.01.01, EP 6) | <b>A</b> |

8. The medical staff bylaws include the following: When departments of the organized medical staff exist, the definition of the qualifications and roles and responsibilities of the department chair, including the following: **A**
- Qualifications
- Certification by an appropriate specialty board or affirmatively established comparable competence through the credentialing process
- Roles and responsibilities
- Clinically related activities of the department
  - Administratively related activities of the department, unless otherwise provided by the hospital
  - Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges
  - Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department
  - Recommending clinical privileges for each member of the department
  - Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the hospital
  - The integration of the department or service into the primary functions of the hospital
  - The coordination and integration of interdepartmental and intradepartmental services
  - The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services
  - The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services
  - The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services
  - The continuous assessment and improvement of the quality of care, treatment, and services
  - The maintenance of quality control programs, as appropriate
  - The orientation and continuing education of all persons in the department or service
  - Recommending space and other resources needed by the department or service
- Note: For hospitals that use Joint Commission accreditation for deemed status purposes: When departments of the medical staff do not exist, the medical staff is responsible for the development of policies and procedures that minimize medication errors. The medical staff may delegate this responsibility to the organized pharmaceutical service.
9. The medical staff bylaws must also include the following: A description of the medical staff executive committee's function, size, and composition, and of the methods for selecting and removing its members and the organized medical staff officers. (See also MS.02.01.01, EPs 1 and 9-12) **A**
10. The medical staff bylaws must also include the following: That the medical staff executive committee includes physicians and may include other licensed independent practitioners. (See also MS.02.01.01, EP 1) **A**
11. The medical staff bylaws must also include the following: That the medical staff executive committee is empowered to act for the organized medical staff between meetings of the organized medical staff. (See also MS.02.01.01, EP 1) **A**

- |     |   |   |
|-----|---|---|
| 12. | The medical staff bylaws must also include the following: A description of indications for automatic suspension or summary suspension of a practitioner's medical staff membership or clinical privileges.  | A |
| 13. | The medical staff bylaws must also include the following: A description of when automatic suspension or summary suspension procedures are implemented.  | A |
| 14. | The medical staff bylaws must also include the following: A description of the mechanism to recommend medical staff membership and/or terminations, suspensions, or reduction in privileges.  | A |
| 15. | The medical staff bylaws must also include the following: A description of the mechanism for a fair hearing and appeal process. (See also MS.10.01.01, EPs 1-5)   | A |
| 16. | The medical staff bylaws must also include the following: A description of the credentialing process. (See also MS.06.01.03, EP 4)  | A |
| 17. | The medical staff bylaws must also include the following: A description of the privileging process (including temporary and disaster privileging) and criteria for determining the privileges to be granted to individual practitioners. (See also MS.06.01.07, EP 7)   | A |
| 18. | The medical staff bylaws must also include the following: A description of the process of appointment to membership of the medical staff.   | A |
| 19. | <p><b>D</b> When administrative procedures, associated with processes described in the medical staff bylaws for corrective actions, fair hearing and appeal, credentialing, privileging, and appointment (MS.01.01.01, EPs 12-18), are described in medical staff governance documents that supplement the bylaws (i.e., rules and regulations, and policies):</p> <ul style="list-style-type: none"> <li>- The mechanism for the approval of the administrative procedures, which may be different from that for adoption and amendment of the medical staff bylaws, is described in the medical staff bylaws,</li> <li>- Criteria to identify those administrative procedures that can be in the supplementary documents are described in the bylaws, and</li> <li>- The administrative procedures are approved by both the medical staff and the governing body through the bylaws-described mechanism.</li> </ul> <p>Note: This element of performance is not in effect at this time.</p> | A |
| 20. | <p>For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy.</p> <p>Note: The definition of "physician" is the same as that used by the Centers for Medicare &amp; Medicaid Services (CMS) (refer to the Glossary).</p>  | A |
| 21. | For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following: A statement of the duties and privileges related to each category of the medical staff (for example, active, courtesy).   | A |

### Standard MS.01.01.03

Neither the organized medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules and regulations.

#### Rationale for MS.01.01.03

A hospital with an organized medical staff and governing body that cannot agree on amendments to critical documents has evidenced a breakdown in the required collaborative relationship.

#### Elements of Performance for MS.01.01.03

1. The medical staff bylaws, rules, and regulations are not unilaterally amended.

**A**

**Standard MS.02.01.01**

There is a medical staff executive committee.

**Rationale for MS.02.01.01**

The organized medical staff delegates authority in accordance with law and regulation to the medical staff executive committee to carry out medical staff responsibilities. The medical staff executive committee carries out its work within the context of the organization functions of governance, leadership, and performance improvement. The medical staff executive committee has the primary authority for activities related to self governance of the medical staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners privileged through the medical staff process.

Note: The medical staff as a whole may serve as the executive committee. In smaller, less complex hospitals where the entire medical staff functions as the executive committee, it is often designated as a committee of the whole.

**Elements of Performance for MS.02.01.01**

- |             |   |          |
|-------------|---|----------|
| 1.          | The structure and function of the medical staff executive committee conforms to the medical staff bylaws. (See also MS.01.01.01, EPs 9-11)  | <b>A</b> |
| 2.          | The chief executive officer (CEO) of the hospital or his or her designee attends each medical staff executive committee meeting on an ex-officio basis, with or without a vote.   | <b>A</b> |
| 3.          | All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the medical staff executive committee.   | <b>A</b> |
| 4.          | The majority of voting medical staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the hospital.  | <b>A</b> |
| <b>M</b> 5. | The medical staff executive committee acts on behalf of the organized medical staff between medical staff meetings.   | <b>C</b> |
| 6.          | The medical staff executive committee has a mechanism to recommend medical staff membership termination. (See also MS.01.01.01, EP 7)   | <b>A</b> |
| 7.          | The medical staff executive committee requests evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested.  | <b>A</b> |
| 8.          | The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: Medical staff membership.   | <b>A</b> |
| 9.          | The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: The organized medical staff's structure. (See also MS.01.01.01, EP 9)                         | <b>A</b> |
| 10.         | The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: The process used to review credentials and delineate privileges. (See also MS.01.01.01, EP 9) | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

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|-----|---|----------|
| 11. | The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: The delineation of privileges for each practitioner privileged through the medical staff process. (See also MS.01.01.01, EP 9)  | <b>A</b> |
| 12. | The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: The executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups. (See also MS.01.01.01, EP 9) | <b>A</b> |





**Standard MS.03.01.01**





The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.



**Rationale for MS.03.01.01**

The organized medical staff is responsible for establishing and maintaining patient care standards and oversight of the quality of care, treatment, and services rendered by practitioners privileged through the medical staff process. The organized medical staff designates member licensed independent practitioners to provide oversight of care, treatment, and services rendered by practitioners privileged through the medical staff process. The organized medical staff recommends practitioners for privileges to perform medical histories and physical examinations; the governing body approves such privileges. Licensed independent practitioners (that is, physicians, oral and maxillofacial surgeons, dentists, podiatrists, and some APRNs), physician assistants, and some APRNs may perform medical histories and physical examinations if permitted by law, the medical staff bylaws, and the organization to do so.

**Elements of Performance for MS.03.01.01**

- |     |  |   |          |
|-----|--|---|----------|
| 1.  | Licensed independent practitioner members of the organized medical staff are designated to perform the oversight activities of the organized medical staff.  |   | <b>A</b> |
| 2.  | Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.  |  | <b>A</b> |
| 3.  | Licensed independent practitioners are responsible for the oversight activities of the organized medical staff.  |   | <b>A</b> |
| 4.  | The organized medical staff through its designated mechanisms provides leadership in activities related to patient safety.   |   | <b>A</b> |
| 5.  | The organized medical staff provides oversight in the process of analyzing and improving patient satisfaction.   |   | <b>A</b> |
| 6.  |  The organized medical staff specifies the minimal content of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services. (See also PC.01.02.03, EP 4)  |   | <b>A</b> |
| 7.  | The organized medical staff monitors the quality of medical histories and physical examinations.   |   | <b>A</b> |
| 8.  | The medical staff requires that a practitioner who has been granted privileges by the hospital to do so performs a patient's medical history and physical examination and required updates. (See also PC.01.02.03, EP 5)   |   | <b>A</b> |
| 9.  | As permitted by state law and policy, the organized medical staff may choose to allow individuals who are not licensed independent practitioners to perform part or all of a patient's medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified doctor of medicine or osteopathy who is accountable for the patient's medical history and physical examination. |   | <b>A</b> |
| 10. |  The organized medical staff defines when a medical history and physical examination must be validated and countersigned by a licensed independent practitioner with appropriate privileges.  |   | <b>A</b> |
| 11. |  The organized medical staff defines the scope of the medical history and physical examination when required for non-inpatient services.  |   | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

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| 13. |  For hospitals that use Joint Commission accreditation for deemed status purposes: When emergency services are provided at the hospital but not at one or more off-campus locations, the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the off-campus locations. | <b>A</b> |
| 14. |  For hospitals that use Joint Commission accreditation for deemed status purposes: When emergency services are not provided at the hospital, the medical staff has written policies and procedures for appraisal of emergencies, initial treatment of patients, and referral of patients when needed.   | <b>A</b> |
| 16. | For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures.  | <b>A</b> |
| 17. | For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff approves the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.   | <b>A</b> |



**Standard MS.03.01.03**





The management and coordination of each patient's care, treatment, and services is the responsibility of a practitioner with appropriate privileges.

**Rationale for MS.03.01.03**

Quality of care, treatment, and services is dependent on coordination and communication of the plan of care which is given to all relevant health care providers to optimize resources and provide for patient safety. Practitioners have privileges that correspond to the care, treatment, and services needed by individual patients. Such privileges are specific to each patient's needs and therefore are "appropriate" for that particular patient. Communication and coordination are key to the safe management of patient care, treatment, and services. Communication among all practitioners and staff involved in a patient's care, treatment, and services is vital to ensuring coordinated, high-quality care.

**Elements of Performance for MS.03.01.03**

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| 1.  | Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services.<br>Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).  | <b>A</b>   |
| 2.  | The hospital educates all licensed independent practitioners on assessing and managing pain. (See also RI.01.01.01, EP 8)  | <b>A</b>   |
| 3.  | A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist. |  <b>A</b>   |
| 4.  | The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a doctor of medicine or osteopathy, or other licensed independent practitioner, is required.   | <b>A</b>   |
| 5.  | Consultation is obtained for the circumstances defined by the organized medical staff.   | <b>A</b>   |
| 6.  | There is coordination of the care, treatment, and services among the practitioners involved in a patient's care, treatment, and services.  | <b>A</b>   |
| 12. | For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy is on duty or on call at all times.   |  <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

## Standard MS.04.01.01

In hospitals participating in a professional graduate education program(s), the organized medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each member in the program in carrying out his or her patient care responsibilities.

### Rationale for MS.04.01.01

This standard applies to participants registered in a professional graduate education program when the graduate practitioner will be a licensed independent practitioner. The management of each patient's care, treatment, and services (including patients under the care of participants in professional graduate education programs) is the responsibility of a licensed independent practitioner with appropriate clinical privileges.

#### Elements of Performance for MS.04.01.01

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| 1. <b>D</b> | The organized medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each participant in the program in carrying out patient care responsibilities.   | <b>A</b> |
| 2. <b>D</b> | Written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs are provided to the organized medical staff and hospital staff.   | <b>A</b> |
| 3.          | The descriptions include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities.  | <b>A</b> |
| 4. <b>D</b> | Organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so (without prohibiting licensed independent practitioners from writing orders), and what entries, if any, must be countersigned by a supervising licensed independent practitioner.  | <b>A</b> |
| 5.          | There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the organized medical staff and the governing body.   | <b>A</b> |
| 6.          | There is responsibility for effective communication (whether training occurs at the organization that is responsible for the professional graduate education program or in a participating local or community organization or hospital).<br>- The professional graduate medical education committee(s) (GMEC) must communicate with the medical staff and governing body about the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs.<br>- If the graduate medical education program uses a community or local participating hospital or organization, the person(s) responsible for overseeing the participants from the program communicates to the organized medical staff and its governing body about the patient care, treatment, and services provided by, and the related educational and supervisory needs of, its participants in the professional graduate education programs.<br>Note: The GMEC can represent one or multiple graduate education programs depending on the number of specialty graduate programs within the organization. | <b>A</b> |
| 7.          | There is a mechanism for an appropriate person from the community or local hospital or organization to communicate information to the GMEC about the quality of care, treatment, and services and educational needs of the participants.  | <b>A</b> |

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| 8.          | Information about the quality of care, treatment, and services and educational needs is included in the communication that the GMEC has with the governing board of the sponsoring hospital.  | <b>A</b> |
| <b>M</b> 9. | <p>The medical staff demonstrates compliance with residency review committee citations.</p> <p>Note: Graduate medical education programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the American Dental Association's Commission on Dental Accreditation are expected to be in compliance with the above requirements; the hospital should be able to demonstrate compliance with any residency review committee citations related to this standard.</p> | <b>C</b> |

**Standard MS.05.01.01**

The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.

**Rationale for MS.05.01.01**

Relevant information developed from the following processes is integrated into performance improvement initiatives and consistent with hospital preservation of confidentiality and privilege of information.

**Elements of Performance for MS.05.01.01**

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| 1.  | The organized medical staff provides leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more licensed independent practitioners, and other practitioners credentialed and privileged through the medical staff process. (See also PI.03.01.01, EPs 1-4) | <b>A</b> |
| 2.  | The medical staff is actively involved in the measurement, assessment, and improvement of the following: Medical assessment and treatment of patients. (See also PI.03.01.01, EPs 1-4)  | <b>A</b> |
| 3.  | The medical staff is actively involved in the measurement, assessment, and improvement of the following: Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process. (See also PI.03.01.01, EPs 1-4)  | <b>A</b> |
| 4.  | The medical staff is actively involved in the measurement, assessment, and improvement of the following: Use of medications. (See also PI.03.01.01, EPs 1-4)  | <b>A</b> |
| 5.  | The medical staff is actively involved in the measurement, assessment, and improvement of the following: Use of blood and blood components. (See also PI.03.01.01, EPs 1-4)   | <b>A</b> |
| 6.  | The medical staff is actively involved in the measurement, assessment, and improvement of the following: Operative and other procedure(s) (See also PI.01.01.01, EP 4; PI.03.01.01, EPs 1-4)  | <b>A</b> |
| 7.  | The medical staff is actively involved in the measurement, assessment, and improvement of the following: Appropriateness of clinical practice patterns. (See also PI.03.01.01, EPs 1-4)   | <b>A</b> |
| 8.  | The medical staff is actively involved in the measurement, assessment, and improvement of the following: Significant departures from established patterns of clinical practice. (See also PI.03.01.01, EPs 1-4)   | <b>A</b> |
| 9.  | The medical staff is actively involved in the measurement, assessment, and improvement of the following: The use of developed criteria for autopsies. (See also PI.03.01.01, EPs 1-4)   | <b>A</b> |
| 10. | Information used as part of the performance improvement mechanisms, measurement, or assessment includes the following: Sentinel event data. (See also PI.03.01.01, EPs 1-4)   | <b>A</b> |
| 11. | Information used as part of the performance improvement mechanisms, measurement, or assessment includes the following: Patient safety data. (See also PI.03.01.01, EPs 1-4)   | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

17. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital attempts to secure autopsies in all cases of unusual deaths and cases of medical, legal, and educational interest, and informs the medical staff (specifically the attending physician or clinical psychologist) of autopsies that the hospital intends to perform.  
Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

**A****Standard MS.05.01.03**

The organized medical staff participates in organization-wide performance improvement activities.

**Elements of Performance for MS.05.01.03**

1. The organized medical staff participates in the following activities: Education of patients and families. **A**
2. The organized medical staff participates in the following activities: Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient. **A**
3. The organized medical staff participates in the following activities: Accurate, timely, and legible completion of patient’s medical records. (See also RC.01.04.01, EPs 1, 3, and 4) **A**
4. The organized medical staff participates in the following activities: Review of findings of the assessment process that are relevant to an individual’s performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner’s competence. **A**
5. The organized medical staff participates in the following activities: Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body. **A**

**Standard MS.06.01.01**

Prior to granting a privilege, the resources necessary to support the requested privilege are determined to be currently available, or available within a specified time frame.

**Rationale for MS.06.01.01**

Essential information, such as resources, equipment, and types of personnel necessary to support the requested privilege, is gathered in the process of granting, renewing, or revising clinical privileges.

**Elements of Performance for MS.06.01.01**

1. There is a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested privilege. **A**
2. The hospital consistently determines the resources needed for each requested privilege. **A**

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required


### Standard MS.06.01.03

The hospital collects information regarding each practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.

#### Rationale for MS.06.01.03

There must be a reliable and consistent process in place to process applications and verify credentials. The organized medical staff then reviews and evaluates the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.


#### Elements of Performance for MS.06.01.03

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|----|---|---|
| 1. | The hospital credentials applicants using a clearly defined process.  | A   |
| 2. | The credentialing process is based on recommendations by the organized medical staff.   | A   |
| 3. | The credentialing process is approved by the governing body.  | A   |
| 4. | ⓓ The credentialing process is outlined in the medical staff bylaws. (See also MS.01.01.01, EP 16)  | A   |
| 5. | <p>The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following:</p> <ul style="list-style-type: none"> <li>- A current picture hospital ID card</li> <li>- A valid picture ID issued by a state or federal agency (e.g., driver's license or passport)</li> </ul>  | A   |
| 6. | <p>ⓓ The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information:</p> <ul style="list-style-type: none"> <li>- The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration</li> <li>- The applicant's relevant training</li> <li>- The applicant's current competence</li> </ul> <p>(See also PC.03.01.01, EP 1)</p> | A   |
| 9. | For hospitals that use Joint Commission accreditation for deemed status purposes: A full-time, part-time, or consulting radiologist who is a doctor of medicine or osteopathy qualified by education and experience in radiology supervises ionizing radiology services.  |  A |

**Standard MS.06.01.05**

The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidenced-based process.

**Elements of Performance for MS.06.01.05**

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| 1. | All licensed independent practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation.   |  <b>A</b> |
| 2. | <b>D</b> The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria: <ul style="list-style-type: none"> <li>- Current licensure and/or certification, as appropriate, verified with the primary source</li> <li>- The applicant's specific relevant training, verified with the primary source</li> <li>- Evidence of physical ability to perform the requested privilege</li> <li>- Data from professional practice review by an organization(s) that currently privileges the applicant (if available)</li> <li>- Peer and/or faculty recommendation</li> <li>- When renewing privileges, review of the practitioner's performance within the hospital</li> </ul>  | <b>A</b>   |
| 3. | All of the criteria used are consistently evaluated for all practitioners holding that privilege.   | <b>A</b>   |
| 4. | <b>D</b> The hospital has a clearly defined procedure for processing applications for the granting, renewal, or revision of clinical privileges.  | <b>A</b>   |
| 5. | The procedure for processing applications for the granting, renewal, or revision of clinical privileges is approved by the organized medical staff.   | <b>A</b>   |
| 6. | <b>D</b> An applicant submits a statement that no health problems exist that could affect his or her ability to perform the privileges requested.<br>Note: The applicant's ability to perform privileges requested must be evaluated. This evaluation is documented in the individual's credentials file. Such documentation may include the applicant's statement that no health problems exist that could affect his or her practice. Documentation regarding an applicant's health status and his or her ability to practice should be confirmed. Initial applicants may have their health status confirmed by the director of a training program, the chief of services, or the chief of staff at another hospital at which the applicant holds privileges, or a by currently licensed doctor of medicine or osteopathy approved by the organized medical staff.<br>In instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff. | <b>A</b>   |
| 7. | The hospital queries the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.   | <b>A</b>   |

8. **D** Peer recommendation includes written information regarding the practitioner's current: **A**
- Medical/clinical knowledge
  - Technical and clinical skills
  - Clinical judgment
  - Interpersonal skills
  - Communication skills
  - Professionalism
- Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of practitioner-specific data collected from various sources for the purpose of validating current competence.
9. Before recommending privileges, the organized medical staff also evaluates the following: **A**
- Challenges to any licensure or registration
  - Voluntary and involuntary relinquishment of any license or registration
  - Voluntary and involuntary termination of medical staff membership
  - Voluntary and involuntary limitation, reduction, or loss of clinical privileges
  - Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
  - Documentation as to the applicant's health status
  - Relevant practitioner-specific data as compared to aggregate data, when available
  - Morbidity and mortality data, when available
10. The hospital has a process to determine whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege. **A**
- M** 11. Completed applications for privileges are acted on within the time period specified in the medical staff bylaws. **C**
12. Information regarding each practitioner's scope of privileges is updated as changes in clinical privileges for each practitioner are made. **A**

### Standard MS.06.01.07

The organized medical staff reviews and analyzes all relevant information regarding each requesting practitioner's current licensure status, training, experience, current competence, and ability to perform the requested privilege.

#### Elements of Performance for MS.06.01.07

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| 1.          | The information review and analysis process is clearly defined.  | <b>A</b> |
| 2. <b>D</b> | The hospital, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a requested privilege.<br>Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society. | <b>A</b> |
| <b>M</b> 3. | The hospital completes the credentialing and privileging decision process in a timely manner.  | <b>C</b> |
| 4.          | The hospital's privilege granting/denial criteria are consistently applied for each requesting practitioner.   | <b>A</b> |
| 5.          | Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services.  | <b>A</b> |
| 6.          | If privileging criteria are used that are unrelated to quality of care, treatment, and services or professional competence, evidence exists that the impact of resulting decisions on the quality of care, treatment, and services is evaluated.   | <b>A</b> |
| 7.          | The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges. (See also MS.01.01.01, EP 17)  | <b>A</b> |
| 8.          | Privileges are granted for a period not to exceed two years.   | <b>A</b> |

### Standard MS.06.01.09

The decision to grant, limit, or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within the time frame specified in the medical staff bylaws.

#### Elements of Performance for MS.06.01.09

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| 1.          | Requesting practitioners are notified regarding the granting decision.   | <b>A</b> |
| 2.          | In the case of privilege denial, the applicant is informed of the reason for denial.   | <b>A</b> |
| 3.          | The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to all appropriate internal and external persons or entities, as defined by the hospital and applicable law.            | <b>A</b> |
| 4. <b>D</b> | The process to disseminate all granting, modification, or restriction decisions is approved by the organized medical staff.  | <b>A</b> |
| 5.          | The hospital makes the practitioner aware of available due process or, when applicable, the option to implement the Fair Hearing and Appeal Process for Adverse Privileging Decisions. (See also MS.10.01.01, EPs 1-5) | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard MS.06.01.11**

An expedited governing body approval process may be used for initial appointment and reappointment to the medical staff and for granting privileges when criteria for that process are met.

**Elements of Performance for MS.06.01.11**

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|-------------|---|----------|
| 1. <b>D</b> | The organized medical staff develops criteria for an expedited process for granting privileges.<br>Note: To expedite initial appointments to membership and granting of privileges, reappointment to membership, or renewal or modification of privileges, the governing body may delegate the authority to render those decisions to a committee of at least two voting members of the governing body. | <b>A</b> |
| 2.          | The criteria provide that an applicant for privileges is ineligible for the expedited process if any of the following has occurred:<br>- The applicant submits an incomplete application.<br>- The medical staff executive committee makes a final recommendation that is adverse or has limitations  | <b>A</b> |
| 3.          | The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: There is a current challenge or a previously successful challenge to licensure or registration.   | <b>A</b> |
| 4.          | The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: The applicant has received an involuntary termination of medical staff membership at another hospital.  | <b>A</b> |
| 5.          | The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.   | <b>A</b> |
| 6.          | The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.  | <b>A</b> |
| 7.          | The organized medical staff uses the criteria developed for the expedited process when recommending privileges.   | <b>A</b> |

**Standard MS.06.01.13**

Under certain circumstances, temporary clinical privileges may be granted for a limited period of time.

**Rationale for MS.06.01.13**





There are two circumstances in which temporary privileges may be granted. Each circumstance has different criteria for granting privileges. The circumstances for which the granting of temporary privileges is acceptable include the following:

- To fulfill an important patient care, treatment, and service need
- When a new applicant with a complete application that raises no concerns is awaiting review and approval of the medical staff executive committee and the governing body

Medical staff bylaws or other documents may stipulate that in an emergency, any medical staff member with clinical privileges is permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm—regardless of his or her medical staff status or clinical privileges—provided that the care, treatment, and services provided are within the scope of the individual's license.

**Elements of Performance for MS.06.01.13**


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|----|---|----------|
| 1. | Temporary privileges are granted to meet an important patient care need for the time period defined in the medical staff bylaws.  | <b>A</b> |
| 2. | When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence.  | <b>A</b> |
| 3. | Temporary privileges for new applicants may be granted while awaiting review and approval by the organized medical staff upon verification of the following: <ul style="list-style-type: none"> <li>- Current licensure</li> <li>- Relevant training or experience</li> <li>- Current competence</li> <li>- Ability to perform the privileges requested</li> <li>- Other criteria required by the organized medical staff bylaws</li> <li>- A query and evaluation of the National Practitioner Data Bank (NPDB) information</li> <li>- A complete application</li> <li>- No current or previously successful challenge to licensure or registration</li> <li>- No subjection to involuntary termination of medical staff membership at another organization</li> <li>- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges</li> </ul> | <b>A</b> |
| 4. | All temporary privileges are granted by the chief executive officer or authorized designee.   | <b>A</b> |
| 5. | All temporary privileges are granted on the recommendation of the medical staff president or authorized designee.   | <b>A</b> |
| 6. | Temporary privileges for new applicants are granted for no more than 120 days.  | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

## Standard MS.07.01.01

The organized medical staff provides oversight for the quality of care, treatment, and services by recommending members for appointment to the medical staff.

### Elements of Performance for MS.07.01.01

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|---|---|
| 1.  The organized medical staff develops criteria for medical staff membership.<br>Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society. | A |
| 2. The professional criteria are designed to assure the medical staff and governing body that patients will receive quality care, treatment, and services.  | A |
| 3. The organized medical staff uses the criteria in appointing members to the medical staff and appointment does not exceed a period of two years.  | A |
| 4. Membership is recommended by the medical staff and granted by the governing body.  | A |

### Standard MS.07.01.03

Deliberations by the medical staff in developing recommendations for appointment to or termination from the medical staff and for the initial granting, revision, or revocation of clinical privileges include information provided by peer(s) of the applicant.

#### Rationale for MS.07.01.03

In circumstances where there are insufficient peer review data available when evaluating an applicant for privileges, the organized medical staff uses peer recommendations. A recommendation(s) from peers (appropriate practitioners in the same professional discipline as the applicant who have personal knowledge of the applicant) reflects a basis for recommending the granting of privileges.

Sources for peer recommendations may include the following:

- An organization performance improvement committee, the majority of whose members are the applicant's peers
- A reference letter(s), written documentation, or documented telephone conversation(s) about the applicant from a peer(s) who is knowledgeable about the applicant's professional performance and competence
- A department or major clinical service chairperson who is a peer
- The medical staff executive committee

#### Elements of Performance for MS.07.01.03

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|----|---|----------|
| 1. | Recommendations from peers are obtained and evaluated for all new applicants for privileges.  | <b>A</b> |
| 2. | Upon renewal of privileges, when insufficient practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations.   | <b>A</b> |
| 3. | Peer recommendations include the following information: <ul style="list-style-type: none"> <li>- Medical/clinical knowledge</li> <li>- Technical and clinical skills</li> <li>- Clinical judgment</li> <li>- Interpersonal skills</li> <li>- Communication skills</li> <li>- Professionalism</li> </ul> | <b>A</b> |
| 4. | Peer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice.  | <b>A</b> |

**Standard MS.08.01.01**

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

**Rationale for MS.08.01.01**

The focused evaluation process is defined by the organized medical staff. The time period of the evaluation can be extended, and/or a different type of evaluation process assigned. Information for focused professional practice evaluation may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel).

Relevant information resulting from the focused evaluation process is integrated into performance improvement activities, consistent with the organization's policies and procedures that are intended to preserve confidentiality and privilege of information.


**Elements of Performance for MS.08.01.01**

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|----|--|----------|
| 1. | A period of focused professional practice evaluation is implemented for all initially requested privileges.  | <b>A</b> |
| 2. | <b>D</b> The organized medical staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified.   | <b>A</b> |
| 3. | The performance monitoring process is clearly defined and includes each of the following elements:<br>- Criteria for conducting performance monitoring<br>- Method for establishing a monitoring plan specific to the requested privilege<br>- Method for determining the duration of performance monitoring<br>- Circumstances under which monitoring by an external source is required | <b>A</b> |
| 4. | Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.  | <b>A</b> |
| 5. | The triggers that indicate the need for performance monitoring are clearly defined.<br>Note: Triggers can be single incidents or evidence of a clinical practice trend.  | <b>A</b> |
| 6. | The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a practitioner's current clinical competence, practice behavior, and ability to perform the requested privilege.<br>Note: Other existing privileges in good standing should not be affected by this decision.   | <b>A</b> |
| 7. | <b>D</b> Criteria are developed that determine the type of monitoring to be conducted.   | <b>A</b> |
| 8. | <b>D</b> The measures employed to resolve performance issues are clearly defined.  | <b>A</b> |
| 9. | The measures employed to resolve performance issues are consistently implemented.  | <b>A</b> |

**Standard MS.08.01.03**

Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

**Elements of Performance for MS.08.01.03**

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|---|----------|
| 1.  The process for the ongoing professional practice evaluation includes the following: There is a clearly defined process in place that facilitates the evaluation of each practitioner's professional practice. | <b>A</b> |
| 2. The process for the ongoing professional practice evaluation includes the following: The type of data to be collected is determined by individual departments and approved by the organized medical staff.   | <b>A</b> |
| 3. The process for the ongoing professional practice evaluation includes the following: Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).   | <b>A</b> |


**Standard MS.09.01.01**

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

**Rationale for MS.09.01.01**

A well-structured internal reporting process supports the ongoing professional practice evaluation and enhances the quality of care and patient safety.

**Elements of Performance for MS.09.01.01**

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| 1.  The hospital, based on recommendations by the organized medical staff and approval by the governing body, has a clearly defined process for collecting, investigating, and addressing clinical practice concerns. (See also RI.01.07.01, EPs 1, 2, 4, 6, 7, and 10) | <b>A</b> |
| 2. Reported concerns regarding a privileged practitioner's professional practice are uniformly investigated and addressed, as defined by the hospital and applicable law.  | <b>A</b> |






**Standard MS.10.01.01**

There are mechanisms including a fair hearing and appeal process for addressing adverse decisions regarding reappointment, denial, reduction, suspension, or revocation of privileges that may relate to quality of care, treatment, and services issues.

**Rationale for MS.10.01.01**

Mechanisms for fair hearing and appeal processes are designed to allow the affected individual a fair opportunity to defend herself or himself regarding the adverse decision to an unbiased hearing body of the medical staff, and an opportunity to appeal the decision of the hearing body to the governing body. The purpose of a fair hearing and appeal is to assure full consideration and reconsideration of quality and safety issues and, under the current structure of reporting to the National Practitioner Data Bank (NPDB), allow practitioners an opportunity to defend themselves.

**Elements of Performance for MS.10.01.01**

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| 1.  The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: Is designed to provide a fair process that may differ for members and nonmembers of the medical staff. (See also MS.01.01.01, EP 15; MS.06.01.09, EP 5)              | <b>A</b> |
| 2.  The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: Has a mechanism to schedule a hearing of such requests. (See also MS.01.01.01, EP 15; MS.06.01.09, EP 5)   | <b>A</b> |
| 3.  The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: Has identified the procedures for the hearing to follow. (See also MS.01.01.01, EP 15; MS.06.01.09, EP 5)  | <b>A</b> |
| 4.  The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: Identifies the composition of the hearing committee as a committee that includes impartial peers. (See also MS.01.01.01, EP 15; MS.06.01.09, EP 5)                   | <b>A</b> |
| 5.  The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: With the governing body, provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws. (See also MS.01.01.01, EP 15; MS.06.01.09, EP 5) | <b>A</b> |

**Standard MS.11.01.01**

The medical staff implements a process to identify and manage matters of individual health for licensed independent practitioners which is separate from actions taken for disciplinary purposes.

**Rationale for MS.11.01.01**

The organized medical staff and organization leaders have an obligation to protect patients, its members, and other persons present in the hospital from harm. Therefore, the organized medical staff designs a process that provides education about licensed independent practitioner health; addresses prevention of physical, psychiatric, or emotional illness; and facilitates confidential diagnosis, treatment, and rehabilitation of licensed independent practitioners who suffer from a potentially impairing condition.

The purpose of the process is to facilitate the rehabilitation, rather than discipline, by assisting a practitioner to retain and to regain optimal professional functioning that is consistent with protection of patients. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a practitioner is unable to safely perform the privileges he or she has been granted, the matter is forwarded for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

Note: Organizations should consider the applicability of the Americans with Disabilities Act (ADA) to their credentialing and privileging activities, and, if applicable, review their medical staff bylaws, policies, and procedures. Federal entities are required to comply with the Rehabilitation Act of 1974.

**Elements of Performance for MS.11.01.01**

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| 1. | Process design addresses the following issues: Education of licensed independent practitioners and other organization staff about illness and impairment recognition issues specific to licensed independent practitioners (at-risk criteria).   | <b>A</b> |
| 2. | Process design addresses the following issues: Self referral by a licensed independent practitioner.   | <b>A</b> |
| 3. | Process design addresses the following issues: Referral by others and maintaining informant confidentiality.   | <b>A</b> |
| 4. | Process design addresses the following issues: Referral of the licensed independent practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.  | <b>A</b> |
| 5. | Process design addresses the following issues: Maintenance of confidentiality of the licensed independent practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened. | <b>A</b> |
| 6. | Process design addresses the following issues: Evaluation of the credibility of a complaint, allegation, or concern.   | <b>A</b> |
| 7. | Process design addresses the following issues: Monitoring the licensed independent practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required.  | <b>A</b> |
| 8. | Process design addresses the following issues: Reporting to the organized medical staff leadership instances in which a licensed independent practitioner is providing unsafe treatment.   | <b>A</b> |

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| 9.  | Process design addresses the following issues: Initiating appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program. | <b>A</b> |
| 10. | The medical staff implements its process to identify and manage matters of individual health for licensed independent practitioners.  | <b>A</b> |

### Standard MS.12.01.01

All licensed independent practitioners and other practitioners privileged through the medical staff process participate in continuing education.

### Rationale for MS.12.01.01

Continuing education is an adjunct to maintaining clinical skills and current competence.

#### Elements of Performance for MS.12.01.01

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| 1. | Hospital-sponsored educational activities are prioritized by the organized medical staff.   | <b>A</b> |
| 2. | These activities relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital.   | <b>A</b> |
| 3. | Education is based on the findings of performance improvement activities.   | <b>A</b> |
| 4. | ④ Each individual's participation in continuing education is documented.  | <b>A</b> |
| 5. | Participation in continuing education is considered in decisions about reappointment to membership on the medical staff or renewal or revision of individual clinical privileges. | <b>A</b> |

**Standard MS.13.01.01**

For originating sites only: Licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.

**Rationale for MS.13.01.01**

The originating site retains responsibility for overseeing the safety and quality of services offered to its patients.

**Elements of Performance for MS.13.01.01**

1. All licensed independent practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms:
  - The originating site fully privileges and credentials the practitioner according to Standards MS.06.01.03 through MS.06.01.13.
  - The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited organization.

Or

  - The originating site uses the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:
    1. The distant site is a Joint Commission–accredited hospital or ambulatory care organization.
    2. The practitioner is privileged at the distant site for those services to be provided at the originating site.
    3. The originating site has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site. (See also LD.04.03.09, EP 9)

Note 1: This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.

Note 2: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care.

Note 3: A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. See the "Sentinel Events" (SE) chapter for additional information.

**A**


### Standard MS.13.01.03

For originating and distant sites: The medical staffs at both the originating and distant sites recommend the clinical services to be provided by licensed independent practitioners through a telemedical link at their respective sites.

#### Rationale for MS.13.01.03

Telemedicine will continue to evolve making novel services and approaches through technology more readily available. Medical staff at the originating site evaluates the organization's ability to safely provide services on an ongoing basis. Medical staff at the distant site evaluates performance of those services as part of privileging and as part of the reappraisal conducted at the time of reappointment, renewal, or revision of clinical privileges.

#### Elements of Performance for MS.13.01.03

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|----|---|---|
| 1. |  The medical staff recommends which clinical services are appropriately delivered by licensed independent practitioners through this medium. | A |
| 2. | The clinical services offered are consistent with commonly accepted quality standards.  | A |



# National Patient Safety Goals



**NPSG.01.01.01**

Use at least two patient identifiers when providing care, treatment, and services.

**Rationale for NPSG.01.01.01**

Wrong-patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual. Acceptable identifiers may be the individual's name, an assigned identification number, telephone number, or other person-specific identifier.




**Elements of Performance for NPSG.01.01.01**

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| <b>M</b> 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) |  <b>C</b> |
| 2. Label containers used for blood and other specimens in the presence of the patient. (See also NPSG.01.03.01, EP 1)  |  <b>A</b> |

**NPSG.01.03.01**

Eliminate transfusion errors related to patient misidentification.

**Elements of Performance for NPSG.01.03.01**

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| 1. Before initiating a blood or blood component transfusion:<br>- Match the blood or blood component to the order.<br>- Match the patient to the blood or blood component.<br>- Use a two-person verification process.<br>(See also NPSG.01.01.01, EPs 1 and 2)<br>Note: If two individuals are not available, an automated identification technology (for example, bar coding) may be used in place of one of the individuals. |  <b>A</b>   |
| 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.   |  <b>A</b> |
| 3. When using a two-person verification process, the second individual conducting the identification verification is qualified to participate in the process, as determined by the hospital.  |  <b>A</b> |


**NPSG.02.03.01**

Report critical results of tests and diagnostic procedures on a timely basis.

**Rationale for NPSG.02.03.01**

Critical results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life-threatening situation. The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated.

**Elements of Performance for NPSG.02.03.01**

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| 1.  Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following: | <b>A</b> |
| - The definition of critical results of tests and diagnostic procedures  |          |
| - By whom and to whom critical results of tests and diagnostic procedures are reported   |          |
| - The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures  |          |
| 2. Implement the procedures for managing the critical results of tests and diagnostic procedures.  | <b>A</b> |
| 3. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.   | <b>A</b> |

**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**

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| 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.<br>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. |  <b>A</b>   |
| 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.   |  <b>A</b>   |
| 3.   | In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:<br>- Medication name<br>- Strength<br>- Quantity<br>- Diluent and volume (if not apparent from the container)<br>- Preparation date<br>- Expiration date when not used within 24 hours<br>- Expiration time when expiration occurs in less than 24 hours<br>Note: The date and time are not necessary for short procedures, as defined by the hospital.         |  <b>A</b>   |
|  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.  |  <b>C</b> |
| 5.   | Label each medication or solution as soon as it is prepared, unless it is immediately administered.<br>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.   |  <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

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| 6.   | Immediately discard any medication or solution found unlabeled.   |  <b>A</b> |
| 7.   | Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.<br>Note: This does not apply to multiuse vials that are handled according to infection control practices. |  <b>A</b> |
|  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.  |  <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**NPSG.03.05.01**

Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

Note: This requirement applies only to hospitals that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values.

**Rationale for NPSG.03.05.01**

Anticoagulation therapy can be used as therapeutic treatment for a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant. However, it is important to note that anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance. This National Patient Safety Goal has great potential to positively impact the safety of patients on this class of medications and result in better outcomes.

To achieve better patient outcomes, patient education is a vital component of an anticoagulation therapy program. Effective anticoagulation patient education includes face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy, the precautions they need to take, and the need for regular International Normalized Ratio (INR) monitoring. The use of standardized practices for anticoagulation therapy that include patient involvement can reduce the risk of adverse drug events associated with heparin (unfractionated), low molecular weight heparin, and warfarin.

**Elements of Performance for NPSG.03.05.01**

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| 1.   | Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.<br>Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.   | 3 A |
| M 2. | Use approved protocols for the initiation and maintenance of anticoagulant therapy.  | 3 C |
| 3.   | Before starting a patient on warfarin, assess the patient's baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the medical record. | 3 A |
| 4.   | Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin.  | 3 A |
| 5.   | When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing.  | 3 A |
| 6. D | A written policy addresses baseline and ongoing laboratory tests that are required for heparin and low molecular weight heparin therapies.   | 3 A |

**KEY:** A indicates scoring category A; C indicates scoring category C; 2 indicates situational decision rules apply; 3 indicates direct impact requirements apply; M indicates Measure of Success if needed; D indicates that documentation is required

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| <b>M</b> | 7. Provide education regarding anticoagulant therapy to staff, patients, and families. Patient/family education includes the following: <ul style="list-style-type: none"> <li>- The importance of follow-up monitoring</li> <li>- Compliance</li> <li>- Drug-food interactions</li> <li>- The potential for adverse drug reactions and interactions</li> </ul> | <b>C</b> |
|          | 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.  | <b>A</b> |

### NPSG.07.01.01

Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

#### Rationale for NPSG.07.01.01

According to the Centers for Disease Control and Prevention, each year, millions of people acquire an infection while receiving care, treatment, and services in a health care organization. Consequently, health care-associated infections (HAIs) are a patient safety issue affecting all types of health care organizations. One of the most important ways to address HAIs is by improving the hand hygiene of health care staff. Compliance with the World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines will reduce the transmission of infectious agents by staff to patients, thereby decreasing the incidence of HAIs. To ensure compliance with this National Patient Safety Goal, an organization should assess its compliance with the CDC and/or WHO guidelines through a comprehensive program that provides a hand hygiene policy, fosters a culture of hand hygiene, and monitors compliance and provides feedback.

#### Elements of Performance for NPSG.07.01.01

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| 1. | Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines. (See also IC.01.04.01, EP 5) | <b>A</b> |
| 2. | Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP 3)  | <b>A</b> |
| 3. | Improve compliance with hand hygiene guidelines based on established goals.  | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; indicates situational decision rules apply; indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**NPSG.07.03.01**

Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.



Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria.





**Rationale for NPSG.07.03.01**




Patients continue to acquire health care–associated infections at an alarming rate. Risks and patient populations, however, differ between hospitals. Therefore, prevention and control strategies must be tailored to the specific needs of each hospital based on its risk assessment. The elements of performance for this requirement are designed to help reduce or prevent health care–associated infections from epidemiologically important multidrug-resistant organisms (MDROs).

Note: Hand hygiene, contact precautions, as well as cleaning and disinfecting patient care equipment and the patient's environment are essential strategies for preventing the spread of health care–associated infections. Hand hygiene is addressed in NPSG.07.01.01. Contact precautions for patients with epidemiologically significant multidrug-resistant organisms (MDROs) are covered in IC.02.01.01, EP 3. Cleaning and disinfecting patient care equipment are addressed in IC.02.02.01.

**Elements of Performance for NPSG.07.03.01**

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| 1.  | Conduct periodic risk assessments (in time frames defined by the hospital) for multidrug-resistant organism acquisition and transmission. (See also IC.01.03.01, EPs 1-5)   | <b>A</b> |
|  2.  | Based on the results of the risk assessment, educate staff and licensed independent practitioners about health care–associated infections, multidrug-resistant organisms, and prevention strategies at hire and annually thereafter.<br>Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the hospital.                       | <b>C</b> |
|  3. | Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care–associated infection strategies.  | <b>C</b> |
| 4.  | Implement a surveillance program for multidrug-resistant organisms based on the risk assessment.<br>Note: Surveillance may be targeted rather than hospital-wide.   | <b>A</b> |
| 5.  | Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following:<br>- Multidrug-resistant organism infection rates using evidence-based metrics<br>- Compliance with evidence-based guidelines or best practices<br>- Evaluation of the education program provided to staff and licensed independent practitioners<br>Note: Surveillance may be targeted rather than hospital-wide. | <b>A</b> |
| 6.  | Provide multidrug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.  | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

7. Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).  **C**
8. When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms.  
Note: The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods.  **A**
9. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms.  
Note 1: The alert system information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both.  
Note 2: Each hospital may define its own parameters in terms of time and clinical manifestation to determine which re-admitted patients require isolation.  **A**

**NPSG.07.04.01**

Implement evidence-based practices to prevent central line–associated bloodstream infections.

Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

**Elements of Performance for NPSG.07.04.01**

<b>M</b>	1. Educate staff and licensed independent practitioners who are involved in managing central lines about central line–associated bloodstream infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in these procedures is added to an individual's job responsibilities.	<b>C</b>
<b>M</b>	2. Prior to insertion of a central venous catheter, educate patients and, as needed, their families about central line–associated bloodstream infection prevention.	<b>C</b>
<b>M</b>	3. Implement policies and practices aimed at reducing the risk of central line–associated bloodstream infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).	<b>3 C</b>
	4. Conduct periodic risk assessments for central line–associated bloodstream infections, monitor compliance with evidence-based practices, and evaluate the effectiveness of prevention efforts. The risk assessments are conducted in time frames defined by the hospital, and this infection surveillance activity is hospital-wide, not targeted.	<b>A</b>
	5. Provide central line–associated bloodstream infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.	<b>A</b>
<b>M</b>	6. <b>D</b> Use a catheter checklist and a standardized protocol for central venous catheter insertion.	<b>3 C</b>
<b>M</b>	7. Perform hand hygiene prior to catheter insertion or manipulation.	<b>3 C</b>
<b>M</b>	8. For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable.	<b>3 C</b>
<b>M</b>	9. Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters.	<b>3 C</b>
<b>M</b>	10. Use a standardized protocol for sterile barrier precautions during central venous catheter insertion.	<b>3 C</b>
<b>M</b>	11. Use a chlorhexidine-based antiseptic for skin preparation during central venous catheter insertion in patients over 2 months of age, unless contraindicated.	<b>3 C</b>
<b>M</b>	12. <b>D</b> Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.	<b>3 C</b>
<b>M</b>	13. Evaluate all central venous catheters routinely and remove nonessential catheters.	<b>3 C</b>

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**NPSG.07.05.01**

Implement evidence-based practices for preventing surgical site infections.

**Elements of Performance for NPSG.07.05.01**

- |  |  |
|--|--|
| <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center; margin-right: 5px;">M</div> <div> <p>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.</p> </div> </div>                              | C  |
| <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center; margin-right: 5px;">M</div> <div> <p>2. Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.</p> </div> </div>   | C  |
| <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center; margin-right: 5px;">M</div> <div> <p>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).</p> </div> </div>                | <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center; margin-right: 5px;">3</div> <div>C</div> </div> |
| <p>4. As part of the effort to reduce surgical site infections:</p> <ul style="list-style-type: none"> <li>- Conduct periodic risk assessments for surgical site infections in a time frame determined by the hospital.</li> <li>- Select surgical site infection measures using best practices or evidence-based guidelines.</li> <li>- Monitor compliance with best practices or evidence-based guidelines.</li> <li>- Evaluate the effectiveness of prevention efforts.</li> </ul> <p>Note: Surveillance may be targeted to certain procedures based on the hospital's risk assessment.</p> | A  |
| <p>5. Measure surgical site infection rates for the first 30 days following procedures that do not involve inserting implantable devices and for the first year following procedures involving implantable devices. The hospital's measurement strategies follow evidence-based guidelines.</p> <p>Note: Surveillance may be targeted to certain procedures based on the hospital's risk assessment.</p>   | A  |
| <p>6. Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.</p>   | A  |
| <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center; margin-right: 5px;">M</div> <div> <p>7. Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to evidence-based best practices.</p> </div> </div>   | <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center; margin-right: 5px;">3</div> <div>C</div> </div> |
| <p>8. When hair removal is necessary, use clippers or depilatories.</p> <p>Note: Shaving is an inappropriate hair removal method.</p>  | <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center; margin-right: 5px;">3</div> <div>A</div> </div> |

**NPSG.08.01.01**





A process exists for comparing the patient's current medications with those ordered for the patient while under the care of the hospital.



Note: This standard is not in effect at this time.

**Rationale for NPSG.08.01.01**

Patients are at high risk for harm from adverse drug events when communication about medications is not clear. The chance for communication errors increases whenever individuals involved in a patient's care change. Communicating about the medication list, making sure it is accurate, and reconciling any discrepancies whenever new medications are ordered or current medications are adjusted are essential to reducing the risk of transition-related adverse drug events.

**Elements of Performance for NPSG.08.01.01**

- |  |   |
|--|---|
| <p><b>M</b> 1. <b>D</b> At the time the patient enters the hospital or is admitted, a complete list of the medications the patient is taking at home (including dose, route, and frequency) is created and documented. The patient and, as needed, the family are involved in creating this list.</p> <p>Note: This element of performance is not in effect at this time.</p>  | <p> <b>C</b></p> |
| <p><b>M</b> 2. The medications ordered for the patient while under the care of the hospital are compared to those on the list created at the time of entry to the hospital or admission.</p> <p>Note: This element of performance is not in effect at this time.</p>   | <p> <b>C</b></p> |
| <p><b>M</b> 3. Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the patient is under the care of the hospital.</p> <p>Note: This element of performance is not in effect at this time.</p>  | <p> <b>C</b></p> |
| <p><b>M</b> 4. When the patient's care is transferred within the hospital (for example, from the ICU to a floor), the current provider(s) informs the receiving provider(s) about the up-to-date reconciled medication list and documents the communication.</p> <p>Note 1: Updating the status of a patient's medications is also an important component of all patient care hand-offs.</p> <p>Note 2: This element of performance is not in effect at this time.</p> | <p> <b>C</b></p> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**NPSG.08.02.01**

When a patient is referred to or transferred from one hospital to another, the complete and reconciled list of medications is communicated to the next provider of service, and the communication is documented. Alternatively, when a patient leaves the hospital's care to go directly to his or her home, the complete and reconciled list of medications is provided to the patient's known primary care provider, the original referring provider, or a known next provider of service.


Note 1: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the patient and, as needed, the family the list of reconciled medications is sufficient.

Note 2: This standard is not in effect at this time.

**Rationale for NPSG.08.02.01**

The accurate communication of a patient's reconciled medication list to the next provider of service reduces the risk of transition-related adverse drug events. The communication enables the next provider of service to receive thorough knowledge of the patient's medications and to safely order/prescribe other medications that may be needed. This communication is especially important at transitions in care when a patient is referred or transferred from one organization to another.

**Elements of Performance for NPSG.08.02.01**

- |                    |   |   |
|--------------------|---|---|
| <p><b>M</b> 1.</p> | <p>The patient's most current reconciled medication list is communicated to the next provider of service, either within or outside the hospital. The communication between providers is documented.</p> <p>Note: This element of performance is not in effect at this time.</p> | <p> <b>C</b></p> |
| <p><b>M</b> 2.</p> | <p>At the time of transfer, the transferring hospital informs the next provider of service how to obtain clarification on the list of reconciled medications.</p> <p>Note: This element of performance is not in effect at this time.</p>                                       | <p><b>C</b></p>   |

**NPSG.08.03.01**

When a patient leaves the hospital's care, a complete and reconciled list of the patient's medications is provided directly to the patient and, as needed, the family, and the list is explained to the patient and/or family.

Note: This standard is not in effect at this time.

**Rationale for NPSG.08.03.01**

The accurate communication of the patient's medication list to the patient and, as needed, the family, reduces the risk of transition-related adverse drug events. A thorough knowledge of the patient's medications is essential for the patient's primary care provider or next provider of service to manage the subsequent stages of care for the patient.

**Elements of Performance for NPSG.08.03.01**

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|-----------------------------|--|-----------------|
| <p><b>M</b> 1. <b>D</b></p> | <p>When the patient leaves the hospital's care, the current list of reconciled medications is provided and explained to the patient and, as needed, the family. This interaction is documented.</p> <p>Note 1: Patients and families are reminded to discard old lists and to update any records with all medication providers or retail pharmacies.</p> <p>Note 2: This element of performance is not in effect at this time.</p> | <p><b>C</b></p> |
|-----------------------------|--|-----------------|

**NPSG.08.04.01**

In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed.






Note 1: This requirement does not apply to hospitals that do not administer medications. It may be important for health care organizations to know which types of medications their patients are taking because these medications could affect the care, treatment, and services provided.

Note 2: This standard is not in effect at this time.

**Rationale for NPSG.08.04.01**

A number of patient care settings exist in which medications are not used, are used minimally, or are prescribed for only a short duration. This includes areas such as the emergency department, urgent and emergent care, convenient care, office-based surgery, outpatient radiology, ambulatory care, and behavioral health care. In these settings, obtaining a list of the patient's original, known, and current medications that he or she is taking at home is still important; however, obtaining information on the dose, route, and frequency of use is not required.

**Elements of Performance for NPSG.08.04.01**

- |                             |  |   |
|-----------------------------|--|---|
| <p><b>M</b> 1.</p>          | <p>The hospital obtains and documents an accurate list of the patient's current medications and known allergies in order to safely prescribe any setting-specific medications (for example, intravenous contrast media, local anesthesia, antibiotics) and to assess for potential allergic or adverse drug reactions.</p> <p>Note: This element of performance is not in effect at this time.</p>   | <p> <b>C</b></p>   |
| <p><b>M</b> 2. <b>D</b></p> | <p>When only short-term medications (for example, a preprocedure medication or a short-term course of an antibiotic) will be prescribed and no changes are made to the patient's current medication list, the patient and, as needed, the family are provided with a list containing the short-term medication additions that the patient will continue after leaving the hospital.</p> <p>Note 1: This list of new short-term medications is not considered to be part of the original, known, and current medication list. When patients leave these settings, a list of the original, known, and current medications does not need to be provided, unless the patient is assessed to be confused or unable to comprehend adequately. In this case, the patient's family is provided both medication lists and the circumstances are documented.</p> <p>Note 2: This element of performance is not in effect at this time.</p> | <p> <b>C</b></p>   |
| <p><b>M</b> 3.</p>          | <p>In these settings, a complete, documented medication reconciliation process is used when: Any new long-term (chronic) medications are prescribed.</p> <p>Note: This element of performance is not in effect at this time.</p>   | <p> <b>C</b></p> |
| <p><b>M</b> 4.</p>          | <p>In these settings, a complete, documented medication reconciliation process is used when: There is a prescription change for any of the patient's current, known long-term medications.</p> <p>Note: This element of performance is not in effect at this time.</p>   | <p> <b>C</b></p> |
| <p><b>M</b> 5.</p>          | <p>In these settings, a complete, documented medication reconciliation process is used when: The patient is required to be subsequently admitted to an organization from these settings for ongoing care.</p> <p>Note: This element of performance is not in effect at this time.</p>  | <p> <b>C</b></p> |

- M** 6. When a complete, documented, medication reconciliation is required in any of these settings, the complete list of reconciled medications is provided to the patient, and their family as needed, and to the patient's known primary care provider or original referring provider or a known next provider of service.  
Note: This element of performance is not in effect at this time.

**3** **C**

### NPSG.15.01.01

Identify patients at risk for suicide.

Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

#### Rationale for NPSG.15.01.01

Suicide of a patient while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

#### Elements of Performance for NPSG.15.01.01

- M** 1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
- M** 2. Address the patient's immediate safety needs and most appropriate setting for treatment.
- M** 3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

**3** **C**

**3** **C**

**3** **C**

**UP.01.01.01**

Conduct a preprocedure verification process.

**Rationale for UP.01.01.01**

Hospitals should always make sure that any procedure is what the patient needs and is performed on the right person. The frequency and scope of the verification process will depend on the type and complexity of the procedure.

The preprocedure verification is an ongoing process of information gathering and confirmation. The purpose of the preprocedure verification process is to make sure that all relevant documents and related information or equipment are:




- Available prior to the start of the procedure
- Correctly identified, labeled, and matched to the patient's identifiers
- Reviewed and are consistent with the patient's expectations and with the team's understanding of the intended patient, procedure, and site

Preprocedure verification may occur at more than one time and place before the procedure. It is up to the hospital to decide when this information is collected and by which team member, but it is best to do it when the patient can be involved. Possibilities include the following:





- When the procedure is scheduled
- At the time of preadmission testing and assessment
- At the time of admission or entry into the facility for a procedure
- Before the patient leaves the preprocedure area or enters the procedure room

Missing information or discrepancies are addressed before starting the procedure.

**Elements of Performance for UP.01.01.01**

1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site.  
Note: The patient is involved in the verification process when possible.  **A**
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:  **A**
  - 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. **A**



**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**UP.01.02.01**

Mark the procedure site.

**Elements of Performance for UP.01.02.01**

- |   |   |   |
|---|---|---|
| <p><b>M</b> 1.</p> <p><b>M</b> 2.</p> <p><b>M</b> 3.</p> <p>4.</p> <p>5. <b>D</b></p> | <p>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.<br/>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.</p> <p>Mark the procedure site before the procedure is performed and, if possible, with the patient involved.</p> <p>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:<br/>- An individual in a medical residency 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<br/>- 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 (A.P.R.N.) or physician assistant (P.A.)); who is familiar with the patient; and who will be present when the procedure is performed.</p> <p>The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital.<br/>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.</p> <p>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).<br/>Note: Examples of other situations that involve alternative processes include:<br/>- Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice<br/>- Interventional procedure cases for which the catheter/instrument insertion site is not predetermined (for example, cardiac catheterization, pacemaker insertion)<br/>- Teeth<br/>- Premature infants, for whom the mark may cause a permanent tattoo</p> | <p> <b>C</b></p> <p> <b>C</b></p> <p> <b>C</b></p> <p> <b>A</b></p> <p> <b>A</b></p> |
|---|---|---|

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**UP.01.03.01**






A time-out is performed before the procedure.





**Rationale for UP.01.03.01**

The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. A hospital may conduct the time-out before anesthesia or may add another time-out at that time. During a time-out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure.

A designated member of the team initiates the time-out and it includes active communication among all relevant members of the procedure team. The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the hospital.

**Elements of Performance for UP.01.03.01**

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|--|---|--|
| 1.   | Conduct a time-out immediately before starting the invasive procedure or making the incision.   |  <b>A</b>   |
| 2.   | The time-out has the following characteristics:<br>- It is standardized, as defined by the hospital.<br>- It is initiated by a designated member of the team.<br>- 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. | <b>A</b>   |
| 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.  |  <b>A</b>   |
| 4.   | During the time-out, the team members agree, at a minimum, on the following:<br>- Correct patient identity<br>- The correct site<br>- The procedure to be done  |  <b>A</b>  |
|  5. | Document the completion of the time-out.<br>Note: The hospital determines the amount and type of documentation.   |  <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required



# Nursing


## Standard NR.01.01.01

The nurse executive directs the delivery of nursing care, treatment, and services.

### Rationale for NR.01.01.01

Nurses make up the front line of patient care; they are directly and intimately involved in the care, treatment, and services patients receive and are likely to be the most visible face of health care for patients who enter the hospital. As a leader in the health care delivery system, the nurse executive is vital to the establishment of a cohesive and collaborative nursing-care team, and ultimately, to the hospital that wishes to maintain safe, quality patient care. The nurse executive is also vital to the continuity of care each patient receives. In order to improve organization-wide quality in nursing care, treatment, and services, the nurse executive must assume an active leadership role in the hospital.


### Elements of Performance for NR.01.01.01

- |    |   |          |
|----|---|----------|
| 1. | The nurse executive functions at the senior leadership level to provide effective leadership and to coordinate leaders to deliver nursing care, treatment, and services. (See also LD.04.01.05, EP 5)   | <b>A</b> |
| 2. | The nurse executive has the authority to speak on behalf of nursing to the same extent that other hospital leaders speak for their respective disciplines, departments, or service lines. (See also LD.01.02.01, EP 1 and LD.02.01.01, EP 1)  | <b>A</b> |
| 3. | An identified nurse leader, at the executive level, assumes an active leadership role with the hospital's governing body, senior leadership, medical staff, management, and other clinical leaders in the hospital's decision-making structure and process. (See also LD.01.01.01, EP 3; LD.01.02.01, EP 1; LD.01.03.01, EP 5; LD.01.04.01, EP 5; LD.02.03.01, EP 1; LD.04.01.03, EP 1) | <b>A</b> |
| 4. | The nurse executive participates in defined and established meetings of the hospital's corporate leaders (when such leaders exist) and with other senior clinical and managerial leaders. (See also LD.01.04.01, EP 5)  | <b>A</b> |
| 5. |  The hospital defines the nurse executive's authority and responsibility in a written contract, written agreement, letter, memorandum, job or position description, or other document. (See also LD.04.01.05, EP 3)  | <b>A</b> |

## Standard NR.01.02.01

The nurse executive is a licensed professional registered nurse qualified by advanced education and management experience.

### Elements of Performance for NR.01.02.01

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|--|---|----------|
| 1.   | The hospital has an established process for selecting, electing, or appointing a qualified nurse as its nurse executive.<br>Note: Hospitals with decentralized services and/or geographically distinct sites employ one nurse executive to oversee nursing care.  | <b>A</b> |
| 2.   | The nurse executive is currently licensed as a registered professional nurse in the state in which he or she practices, in accordance with law and regulation.  | <b>A</b> |
| 3.  | The nurse executive possesses a postgraduate degree in nursing or a related field; or the knowledge and skills associated with an advanced degree; or a written plan to obtain these qualifications.<br>Note: A related field may include health care administration or business administration.                            | <b>A</b> |
| 4.   | When appointing the nurse executive, the hospital considers: The education and experience required for peer leadership positions.<br>Note: For example, when leadership peers are expected to have a master's degree, doctoral degree, or professional certification, the nurse executive possesses similar qualifications. | <b>A</b> |
| 5.   | When appointing the nurse executive, the hospital considers: The hospital's scope of services and complexity and the position's authority and responsibility.   | <b>A</b> |
| 6.   | When appointing the nurse executive, the hospital considers: The scope and complexity of the nursing care needs of the major patient population(s) served by the hospital.  | <b>A</b> |
| 7.   | When appointing the nurse executive, the hospital considers: The availability of nursing and administrative staff and services needed to assist the nurse executive in the execution of responsibilities.   | <b>A</b> |

## Standard NR.02.01.01

The nurse executive directs the hospital's nursing services.






### Elements of Performance for NR.02.01.01

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| 1. | The nurse executive coordinates: The development of hospital-wide plans to provide nursing care, treatment, and services.  | <b>A</b> |
| 2. | The nurse executive coordinates: The development of hospital-wide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated.<br>Note: Examples of patient populations include pediatric, diabetic, and geriatric patients.                             | <b>A</b> |
| 3. | The nurse executive coordinates: The development of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. (See also LD.03.02.01, EP 5)  | <b>A</b> |
| 4. | The nurse executive directs: The implementation of hospital-wide plans to provide nursing care, treatment, and services.   | <b>A</b> |
| 5. | The nurse executive directs: The implementation of hospital-wide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. (See also LD.04.04.07, EP 1)<br>Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. | <b>A</b> |
| 6. | The nurse executive directs: The implementation of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. (See also LD.03.02.01, EP 5)   | <b>A</b> |

## Standard NR.02.02.01

The nurse executive establishes guidelines for the delivery of nursing care, treatment, and services.



### Elements of Performance for NR.02.02.01





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| 1. |  The nurse executive, registered nurses, and other designated nursing staff write: Standards of nursing practice for the hospital.               | <b>A</b> |
| 2. |  The nurse executive, registered nurses, and other designated nursing staff write: Nursing standards of patient care, treatment, and services.  | <b>A</b> |
| 3. |  The nurse executive, registered nurses, and other designated nursing staff write: Nursing policies and procedures.                            | <b>A</b> |
| 4. |  The nurse executive, registered nurses, and other designated nursing staff write: Nurse staffing plan(s). (See also LD.04.03.11, EP 6)        | <b>A</b> |
| 5. |  The nurse executive, registered nurses, and other designated nursing staff write: Standards to measure, assess, and improve patient outcomes. | <b>A</b> |

## Standard NR.02.03.01

The nurse executive directs the implementation of nursing policies and procedures, nursing standards, and a nurse staffing plan(s).

### Elements of Performance for NR.02.03.01

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| 1. | The nurse executive or designee approves nursing policies; nursing standards of patient care, treatment, and services; and standards of nursing practice for the hospital before implementation. (See also LD.04.01.07, EP 1) | A   |
| 2. | The nurse executive implements nursing policies, procedures, and standards that describe and guide how the staff provide nursing care, treatment, and services. (See also LD.04.01.07, EP 2)                                  | A   |
| 3. | The nurse executive provides access to all nursing policies, procedures, and standards to the nursing staff.  | A   |
| 4. | The nurse executive is responsible for the provision of nursing services 24 hours a day, 7 days a week. (See also NR.01.02.01, EP2)   |  A |
| 6. | The nurse executive or designee exercises final authority over staff who provide nursing care, treatment, and services.   | A   |
| 7. | A registered nurse provides or supervises the nursing services 24 hours a day, 7 days a week.   |  A |

**KEY:** A indicates scoring category A; C indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required












# Provision of Care, Treatment, and Services

**Standard PC.01.01.01**

The hospital accepts the patient for care, treatment, and services based on its ability to meet the patient's needs.

**Elements of Performance for PC.01.01.01**


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| 2.   |  The hospital has a written process for accepting a patient that includes the following: Criteria to determine the patient's eligibility for care, treatment, and services.   | <b>A</b>   |
| 3.   |  The hospital has a written process for accepting a patient that includes the following: Procedures for accepting referrals.  | <b>A</b>   |
| 4.   |  Hospitals that do not primarily provide psychiatric or substance abuse services have a written plan that defines the care, treatment, and services or the referral process for patients who are emotionally ill or who suffer the effects of alcoholism or substance abuse.  | <b>A</b>   |
| 5.   | The hospital provides or refers patients who are emotionally ill or who suffer from alcoholism or substance abuse for care, treatment, and services, consistent with its written plan.   | <b>A</b>   |
| 6.   | Administrative and clinical decisions are coordinated for patients under legal or correctional restrictions on the following: <ul style="list-style-type: none"> <li>- The use of seclusion and restraint for nonclinical purposes</li> <li>- The imposition of disciplinary restrictions</li> <li>- The restriction of rights</li> <li>- The plan for discharge and continuing care, treatment, and services</li> <li>- The length of stay</li> </ul> | <b>A</b>   |
|  7. | The hospital follows its written process for accepting a patient for care, treatment, and services. (See also LD.01.03.01, EP 3)   |  <b>C</b> |



**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard PC.01.02.01**

The hospital assesses and reassesses its patients.

**Elements of Performance for PC.01.02.01**












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| 1.           | <b>D</b> The hospital defines, in writing, the scope and content of screening, assessment, and reassessment information it collects. (See also RC.02.01.01, EP 2)<br>Note: In defining the scope and content of the information it collects, the organization may want to consider information that it can obtain, with the patient's consent, from the patient's family and the patient's other care providers, as well as information conveyed on any medical jewelry. | <b>A</b>   |
| 2.           | <b>D</b> The hospital defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed. (See also PC.01.02.07, EP 1; PC.01.02.03 EPs 7 and 8)<br>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.   | <b>A</b>   |
| 3.           | The hospital has defined criteria that identify when nutritional plans are developed. (See also PC.01.02.03, EP 7)   | <b>A</b>   |
| 4.           | Based on the patient's condition, information gathered in the initial assessment includes the following:<br>- Physical, psychological, and social assessment<br>- Nutrition and hydration status<br>- Functional status<br>- For patients who are receiving end-of-life care, the social, spiritual, and cultural variables that influence the patient's and family members' perception of grief<br>(See also RC.02.01.01, EP 2)   | <b>A</b>   |
| <b>M</b> 23. | During patient assessments and reassessments, the hospital gathers the data and information it requires.   |  <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard PC.01.02.03**

The hospital assesses and reassesses the patient and his or her condition according to defined time frames.

**Elements of Performance for PC.01.02.03**





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| 1.  |  The hospital defines, in writing, the time frame(s) within which it conducts the patient's initial assessment, in accordance with law and regulation. (See also RC.01.03.01, EP 1)  |   | <b>A</b> |
|  | 2. The hospital performs initial patient assessments within its defined time frame. (See also RC.01.03.01, EP 3)  |  | <b>C</b> |
|  | 3. Each patient is reassessed as necessary based on his or her plan for care or changes in his or her condition.<br>Note: Reassessments may also be based on the patient's diagnosis; desire for care, treatment, and services; response to previous care, treatment, and services; and/or his or her setting requirements.   |  | <b>C</b> |
|  | 4. The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 6; RC.02.01.03, EP 3)   |   | <b>C</b> |
|  | 5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3) |   | <b>C</b> |
|  | 6. A registered nurse completes a nursing assessment within 24 hours after the patient's inpatient admission. (See also RC.02.01.01, EP 2)  |  | <b>C</b> |
|  | 7. The hospital completes a nutritional screening (when warranted by the patient's needs or condition) within 24 hours after inpatient admission. (See also PC.01.02.01, EPs 2 and 3; RC.02.01.01, EP 2)  |   | <b>C</b> |
|  | 8. The hospital completes a functional screening (when warranted by the patient's needs or condition) within 24 hours after inpatient admission. (See also PC.01.02.01, EP 2; RC.02.01.01, EP 2)  |   | <b>C</b> |

**Standard PC.01.02.05**

Qualified staff or licensed independent practitioners assess and reassess the patient.

**Elements of Performance for PC.01.02.05**

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|----|--|--|----------|
| 1. | Based on the initial assessment, a registered nurse determines the patient's need for nursing care, as required by hospital policy and law and regulation. |  | <b>A</b> |
|----|--|--|----------|

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required








**Standard PC.01.02.07**

The hospital assesses and manages the patient's pain.

**Rationale for PC.01.02.07**

The identification and treatment of pain is an important component of the plan of care. Patients can expect that their health care providers will ask them about whether they have pain. When pain is identified the individual is assessed based on his or her clinical presentation and in accordance with the care, treatment, and services provided by the organization.




**Elements of Performance for PC.01.02.07**

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|  | 1. The hospital conducts a comprehensive pain assessment that is consistent with its scope of care, treatment, and services and the patient's condition. (See also PC.01.02.01, EP 2; RI.01.01.01, EP 8) |  <b>C</b> |
|  | 2. The hospital uses methods to assess pain that are consistent with the patient's age, condition, and ability to understand.  | <b>C</b>   |
|  | 3. The hospital reassesses and responds to the patient's pain, based on its reassessment criteria.   |  <b>C</b> |
|  | 4. The hospital either treats the patient's pain or refers the patient for treatment.  |  <b>C</b> |

**Standard PC.01.02.08**

The hospital assesses and manages the patient's risks for falls.

**Elements of Performance for PC.01.02.08**

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|  | 1. The hospital assesses the patient's risk for falls based on the patient population and setting. |  <b>C</b> |
|   | 2. The hospital implements interventions to reduce falls based on the patient's assessed risk.     |  <b>A</b> |

**Standard PC.01.02.09**

The hospital assesses the patient who may be a victim of possible abuse and neglect.

**Rationale for PC.01.02.09**






Family violence and child and elder abuse are frequently reported. A study published by the Centers for Disease Control and Prevention (CDC) estimates that “intimate partner abuse” results each year in 2 million injuries to women and 600,000 injuries among men. The National Center on Elder Abuse references a study that estimates that between 1 and 2 million Americans age 65 or older have been injured, exploited, or otherwise mistreated by someone on whom they depended for care or protection.





National Consensus Guidelines produced by The Family Violence Prevention Fund points out that “most Americans are seen at some point by a health care provider, and the health care setting offers a critical opportunity for early identification and even the primary prevention of abuse.” People who are victims of abuse or neglect may come to an organization for a variety of reasons. Sometimes the reason a patient seeks health care is not connected to his or her experience with abuse or neglect. By assessing patients who may be possible victims of abuse or neglect, health care organizations fulfill an important role in helping to protect patients.

Footnote 1: The Centers for Disease Control and Prevention: Adverse health conditions and health risk behaviors associated with intimate partner violence. Morbidity and Mortality Weekly Report, Feb. 8, 2008.

Footnote 2: National Research Council Panel to Review Risk and Prevalence of Elder Abuse and Neglect: Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America. Washington, DC: NRC, 2003.

**Elements of Performance for PC.01.02.09**

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| 1.  |  The hospital has written criteria to identify those patients who may be victims of physical assault, sexual assault, sexual molestation, domestic abuse, or elder or child abuse and neglect. (See also RI.01.06.03, EP 2)<br>Note: Criteria can be based on age, sex, and circumstance. | <b>A</b>   |
| 2.  |  To assist with referrals of possible victims of abuse and neglect, the hospital maintains a list of private and public community agencies that can provide or arrange for assessment and care.   | <b>A</b>   |
|  3. | The hospital educates staff about how to recognize signs of possible abuse and neglect and about their roles in follow-up. (See also HR.01.05.03, EP 5)  | <b>C</b>   |
| 4.  | The hospital uses its criteria to identify possible victims of abuse and neglect upon entry into the hospital and on an ongoing basis.   |  <b>A</b> |
| 5.  | The hospital either assesses the patient who meets criteria for possible abuse and neglect or refers the patient to a public or private community agency for assessment.   |  <b>A</b> |
| 6.  | The hospital internally reports cases of possible abuse and neglect. (See also RI.01.06.03, EP 3)  | <b>A</b>   |
| 7.  | The hospital reports cases of possible abuse and neglect to external agencies, in accordance with law and regulation. (See also RI.01.06.03, EP 3)   | <b>A</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required



**Standard PC.01.02.11**

The hospital assesses the needs of patients who receive psychosocial services to treat alcoholism or other substance use disorders.

**Elements of Performance for PC.01.02.11**

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|-------------|---|----------|
| 1.          | Patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders receive an assessment that includes: The patient's history of each substance use, including age of onset, duration, intensity, patterns of use, consequences of use, types of previous treatments, and responses to such treatment.   | <b>A</b> |
| 2.          | Patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders receive an assessment that includes: A history of the patient's mental, emotional, and behavioral problems; their co-occurrence with substance use disorders; and their treatment.  | <b>A</b> |
| 3.          | Patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders receive an assessment that includes: A history of the patient's biomedical complications associated with his or her substance use disorders and the patient's level of awareness of the relationships between his or her behavioral conditions and his or her pattern of substance use.   | <b>A</b> |
| 4.          | Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes: The patient's acceptance of treatment or motivation for change, as well as recovery environment features that serve as resources or obstacles to recovery, including family members' use of alcohol or other substances.   | <b>A</b> |
| <b>M</b> 5. | Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following: <ul style="list-style-type: none"> <li>- The patient's religion and spiritual beliefs, values, and preferences</li> <li>- Living situation</li> <li>- Leisure and recreation activities</li> <li>- Military service history</li> <li>- Peer-group</li> <li>- Social factors</li> <li>- Ethnic and cultural factors</li> <li>- Financial status</li> <li>- Vocational or educational background</li> <li>- Legal history</li> <li>- Communication skills</li> </ul> | <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

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|  | 6. Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following: <ul style="list-style-type: none"><li>- The patient's history of any physical or sexual abuse, as either the abuser or the abused</li><li>- The patient's sexual history and identification</li><li>- Childhood history</li><li>- Emotional and health issues</li><li>- Visual-motor functioning</li><li>- Self care</li></ul> | <b>C</b> |
| <br>  |  |          |
|  | 7. Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes: The patient's family circumstances, including the composition of the family group and the need for their participation in the patient's care.  | <b>C</b> |

**Standard PC.01.02.13**

The hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.

**Elements of Performance for PC.01.02.13**

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|-------------|---|----------|
| 1.          | Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes a history of mental, emotional, behavioral, and substance use problems, their co-occurrence, and their treatment.   | <b>A</b> |
| 2.          | Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following: <ul style="list-style-type: none"> <li>- Current mental, emotional, and behavioral functioning</li> <li>- Maladaptive or problematic behaviors</li> <li>- Mental status examination</li> </ul>   | <b>A</b> |
| <b>M</b> 3. | Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following: <ul style="list-style-type: none"> <li>- The patient's religion and spiritual beliefs, values, and preferences</li> <li>- Living situation</li> <li>- Leisure and recreation activities</li> <li>- Military service history</li> <li>- Peer-group</li> <li>- Social factors</li> <li>- Ethnic and cultural factors</li> <li>- Financial status</li> <li>- Vocational or educational background</li> <li>- Legal history</li> <li>- Communication skills</li> </ul> | <b>C</b> |
| <b>M</b> 4. | Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following: <ul style="list-style-type: none"> <li>- Any history of physical or sexual abuse as either the abuser or abused</li> <li>- The patient's sexual history</li> <li>- Childhood history</li> <li>- Emotional and health care issues</li> <li>- Visual-motor functioning</li> <li>- Self care</li> </ul>   | <b>C</b> |
| <b>M</b> 5. | Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following: <ul style="list-style-type: none"> <li>- The patient's family circumstances, including the composition of the family group</li> <li>- The community resources currently used by the patient</li> <li>- The need for the family members' participation in the patient's care</li> </ul>   | <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

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| <b>M</b> | 6. Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:<br>- A psychiatric evaluation<br>- Psychological assessments, including intellectual, projective, neuropsychological, and personality testing | <b>C</b> |
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**Standard PC.01.02.15**

The hospital provides for diagnostic testing.

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**Elements of Performance for PC.01.02.15**


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| <b>M</b> | 1. Diagnostic testing and procedures are performed as ordered.  | <b>C</b> |
| <b>M</b> | 2. Diagnostic testing and procedures are performed within time frames defined by the hospital.  | <b>C</b> |
| <b>M</b> | 3. When a test report requires clinical interpretation, information necessary to interpret the results is provided with the request for the test. | <b>C</b> |
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**Standard PC.01.03.01**

The hospital plans the patient's care.

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**Elements of Performance for PC.01.03.01**






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| <b>M</b> | 1. The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also RC.02.01.01, EP 2) | <b>C</b> |
|          | 5. The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.  | <b>A</b> |
| <b>M</b> | 22. Based on the goals established in the patient's plan of care, staff evaluate the patient's progress.   | <b>C</b> |
| <b>M</b> | 23. The hospital revises plans and goals for care, treatment, and services based on the patient's needs. (See also RC.02.01.01, EP 2)  | <b>C</b> |

**Standard PC.01.03.03**

The hospital defines its patient behavior management policies.

**Elements of Performance for PC.01.03.03**

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| 1.  The hospital's written behavior management policies describe the conditions under which specific behavior management procedures can and cannot be used.  | <b>A</b>   |
| 2.  The hospital's written behavior management policies disallow the use of any procedure that could physically harm the patient or place him or her at psychological risk.  | <b>A</b>   |
| 3.  The hospital's written behavior management policies include the following:<br>- Limit patient time-outs to no more than 30 minutes in an unlocked room.<br>- Prohibit the use of intimidation, force, or threat.<br>- Require that the patient receive education about the conditions under which time-outs are used.  | <b>A</b>   |
| 4. The hospital prohibits the following:<br>- The denial of the patient's basic needs, such as the denial of a nutritious diet and water<br>- The denial of shelter<br>- The denial of essential, safe clothing<br>- The use of corporal punishment<br>- The use of fear-eliciting techniques<br>- The use of mechanical restraint and seclusion<br>- Any procedures that allow another patient to implement behavior management and treatment techniques on other patients<br>Note: The use of mechanical restraint and seclusion as treatment interventions is prohibited except for patients who exhibit intractable behavior that is severely self-injurious or injurious to others, who have not responded to traditional interventions, and who are unable to contract with staff for safety (that is, understand the concept of, and act on, criteria for the discontinuation of restraint or seclusion). When restraint or seclusion is used in an emergency situation, its use needs to be in compliance with standards PC.03.03.01 - PC.03.03.31 and RC.02.01.05. |  <b>A</b> |
| 5. The hospital's written behavior management policies on the use of aversive procedures are reviewed and approved by clinical leaders and a person(s) external to the hospital, such as an expert in the use of aversive procedures, a patient advocate, or a human rights committee. (See also PC.01.03.05, EP 6)   | <b>A</b>   |

**Standard PC.01.03.05**

The hospital's use of behavior management procedures adhere to the patient's plan for care, treatment, and services and organization policy.

**Elements of Performance for PC.01.03.05**

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| <b>M</b> | 1. Behavior management procedures, when used, are part of the patient's plan of care.  | <b>C</b>   |
| <b>M</b> | 2. The hospital includes in the patient plan of care for behavior management the following:<br>- Target behavior(s)<br>- Adaptive or replacement behavior(s)<br>- Interventions<br>- Criteria for discontinuation of behavior management procedures<br>- Behavior management techniques used | <b>C</b>   |
| <b>M</b> | 3. The patient and, based on his or her plan of care, the family participate in selecting behavior management and treatment interventions.   | <b>C</b>   |
| <b>M</b> | 4. Qualified staff review, evaluate, and approve the use of all behavior management procedures.  | <b>C</b>   |
| <b>M</b> | 5. Group contingencies are based on collective group outcomes and not on a single patient's behavior.  | <b>C</b>   |
|          | 6. Time-outs and procedures using restraining devices or aversive techniques are used only in a manner consistent with the patient's plan of care, policies and procedures, and state and federal laws. (See also PC.01.03.03, EP 5)   | <b>3 A</b> |
| <b>M</b> | 7. When behavior management techniques are used, the hospital uses education and positive reinforcement techniques whenever possible.  | <b>C</b>   |
| <b>M</b> | 8. When restrictive behavior management techniques are necessary, the hospital chooses the least restrictive technique from among those that are approved for use before progressing to more restrictive behavior management techniques.   | <b>C</b>   |
|          | 9. When behavior management techniques are used, the hospital protects the patient's physical safety.  | <b>3 A</b> |

**Standard PC.02.01.01**

The hospital provides care, treatment, and services for each patient.

**Elements of Performance for PC.02.01.01**






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| <b>M</b> | 1. The hospital provides the patient with care, treatment, and services according to his or her individualized plan of care.   | <b>3 C</b> |
|          | 15. For hospitals that use Joint Commission accreditation for deemed status purposes: Blood transfusions and intravenous medications are administered in accordance with state law and approved medical staff policies and procedures. | <b>3 A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard PC.02.01.03**

The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.


**Elements of Performance for PC.02.01.03**

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| 1.  | For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner in accordance with professional standards of practice and law and regulation.<br>Footnote: For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c). |  <b>A</b> |
| 7.  | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s).   |  <b>A</b> |
| 14.   | For hospitals that use Joint Commission accreditation for deemed status purposes: Respiratory services are provided only on, and in accordance with, the orders of a doctor of medicine or osteopathy.  |  <b>A</b> |
|  20. | Before taking action on a verbal order or verbal report of a test result, staff uses a record and "read back" process to verify the information.  |  <b>C</b> |

**Standard PC.02.01.05**

The hospital provides interdisciplinary, collaborative care, treatment, and services.




**Elements of Performance for PC.02.01.05**





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|  1. | Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner. | <b>C</b> |
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**Standard PC.02.01.11**

Resuscitation services are available throughout the hospital.

**Elements of Performance for PC.02.01.11**

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| 1. | Resuscitation services are provided to the patient according to the hospital's policies, procedures, or protocols.   |  <b>A</b> |
| 2. | Resuscitation equipment is available for use based on the needs of the population served.<br>Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EPs 2 and 3) |  <b>A</b> |
| 3. | Resuscitation equipment is located strategically throughout the hospital.  |  <b>A</b> |
| 4. | An evidenced-based training program(s) is used to train staff to recognize the need for and use of resuscitation equipment and techniques.   | <b>A</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard PC.02.01.19**






The hospital recognizes and responds to changes in a patient's condition.

Note: Hospitals are not required to create "rapid response teams" or "medical emergency teams" in order to meet this standard. The existence of these types of teams does not mean that all of the elements of performance are automatically achieved.

**Rationale for PC.02.01.19**

A significant number of critical inpatient events are preceded by warning signs prior to the event. A majority of patients who have cardiopulmonary or respiratory arrest demonstrate clinical deterioration in advance. Early response to changes in a patient's condition by a specially trained individual(s) may reduce cardiopulmonary arrests and patient mortality.






**Elements of Performance for PC.02.01.19**





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| 1.   | The hospital has a process for recognizing and responding as soon as a patient's condition appears to be worsening.  | <b>A</b>   |
| 2.   |  The hospital develops written criteria describing early warning signs of a change or deterioration in a patient's condition and when to seek further assistance. |  <b>A</b> |
|  3. | Based on the hospital's early warning criteria, staff seek additional assistance when they have concerns about a patient's condition.  |  <b>C</b> |
|  4. | The hospital informs the patient and family how to seek assistance when they have concerns about a patient's condition.  | <b>C</b>   |

**Standard PC.02.02.01**

The hospital coordinates the patient's care, treatment, and services based on the patient's needs.

**Elements of Performance for PC.02.02.01**

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|---|--|---|
| 1.  | The hospital has a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services. (See also PC.04.02.01, EP 1)   | <b>A</b>  |
|  2.   | The hospital's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information.<br>Note: Such information may include the patient's condition, care, treatment, medications, services, and any recent or anticipated changes to any of these. |  <b>C</b> |
|  3.  | The hospital coordinates the patient's care, treatment, and services.<br>Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services.  | <b>C</b>  |
|  10. | When the hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services.   | <b>C</b>  |
|  17. | The hospital coordinates care, treatment, and services within a time frame that meets the patient's needs.   | <b>C</b>  |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required


**Standard PC.02.02.03**

The hospital makes food and nutrition products available to its patients.

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**Elements of Performance for PC.02.02.03**


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| 1.           | The hospital assigns responsibility for the safe and accurate provision of food and nutrition products.   | <b>A</b>   |
| <b>M</b> 6.  | The hospital prepares food and nutrition products using proper sanitation, temperature, light, moisture, ventilation, and security.   | <b>C</b>   |
| <b>M</b> 7.  | Food and nutrition products are consistent with each patient's care, treatment, and services.   | <b>C</b>   |
| <b>M</b> 8.  | The hospital accommodates a patient's special diet and altered diet schedule, unless contraindicated.   | <b>C</b>   |
| <b>M</b> 9.  | When possible, the hospital accommodates the patient's cultural, religious, or ethnic food and nutrition preferences, unless contraindicated.   | <b>C</b>   |
| <b>M</b> 10. | When a patient refuses food, the hospital offers substitutes of equal nutritional value.  | <b>C</b>   |
| <b>M</b> 11. | The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.                                  |  <b>C</b> |
| 22. <b>D</b> | For hospitals that use Joint Commission accreditation for deemed status purposes: A current therapeutic diet manual approved by the dietitian and medical staff is available to all medical, nursing, and food service staff. | <b>A</b>   |
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**Standard PC.02.02.07**

The hospital arranges for academic education to children and youth, as needed.

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**Elements of Performance for PC.02.02.07**


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| <b>M</b> 1. | The hospital arranges for a child or youth to receive academic education based on his or her length of stay and condition in accordance with law and regulation. | <b>C</b> |
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**Standard PC.02.02.11**

The hospital provides access to the outdoors to patients with long lengths of stay.

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**Elements of Performance for PC.02.02.11**


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| <b>M</b> 1. | The hospital arranges for patients who experience long lengths of stay to spend time outdoors, according to their plan of care, treatment, and services.<br>Note: The hospital can use its own grounds for this purpose or it can use community resources, such as parks. | <b>C</b> |
|-------------|---|----------|

**Standard PC.02.02.13**

The patient's comfort and dignity receive priority during end-of-life care.

**Elements of Performance for PC.02.02.13**

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|----------|----|--|----------|
| <b>M</b> | 1. | To the extent possible, the hospital provides care and services that accommodate the patient's and his or her family's comfort, dignity, psychosocial, emotional, and spiritual end-of-life needs. | <b>C</b> |
| <b>M</b> | 2. | The hospital provides staff with education about the unique needs of dying patients and their families.  | <b>C</b> |

**Standard PC.02.03.01**

The hospital provides patient education and training based on each patient's needs and abilities.

**Elements of Performance for PC.02.03.01**








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| <b>M</b> | 1.  | The hospital performs a learning needs assessment for each patient, which includes the patient's cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.  | <b>C</b> |
| <b>M</b> | 4.  | The hospital provides education and training to the patient based on his or her assessed needs.   | <b>C</b> |
| <b>M</b> | 5.  | The hospital coordinates the patient education and training provided by all disciplines involved in the patient's care, treatment, and services.  | <b>C</b> |
| <b>M</b> | 10. | Based on the patient's condition and assessed needs, the education and training provided to the patient by the hospital include any of the following: <ul style="list-style-type: none"> <li>- An explanation of the plan for care, treatment, and services</li> <li>- Basic health practices and safety</li> <li>- Information on the safe and effective use of medications (See also MM.06.01.01, EP 9; MM.06.01.03, EPs 3-6)</li> <li>- Nutrition interventions (for example, supplements) and modified diets</li> <li>- Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management</li> <li>- Information on oral health</li> <li>- Information on the safe and effective use of medical equipment or supplies provided by the hospital</li> <li>- Habilitation or rehabilitation techniques to help the patient reach maximum independence</li> <li>- Fall reduction strategies</li> </ul> | <b>C</b> |
| <b>M</b> | 25. | The hospital evaluates the patient's understanding of the education and training it provided.   | <b>C</b> |
| <b>M</b> | 27. | The hospital provides the patient education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.   | <b>C</b> |

**Standard PC.02.03.03**

The patient's personal hygiene is maintained.

Note: This standard applies to hospitals with behavioral health units.

**Elements of Performance for PC.02.03.03**







	1. Personal hygiene, grooming articles, and products are available to the patient and are consistent with the patient's age and developmental level.	<b>C</b>
	2. The hospital helps the patient take responsibility for maintaining his or her living quarters and for contributing to the day-to-day housekeeping activities of the program.	<b>C</b>
	3. The hospital implements an oral care program.	<b>C</b>
	4. The hospital provides the patient with education about maintaining his or her personal hygiene and grooming.	<b>C</b>
	5. Depending on the setting and the patient's length of stay, the hospital provides the patient with barber or beautician services available either from the hospital or the community.	<b>C</b>
	6. The hospital helps the patient with his or her personal hygiene and grooming activities.	<b>C</b>
	7. Patients who are incontinent are cleaned or bathed immediately after voiding or soiling, in a manner that respects their privacy.	<b>C</b>





**Standard PC.03.01.01**

The hospital plans operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.

Note: Equipment identified in the elements of performance is available to the operating room suites.

**Elements of Performance for PC.03.01.01**

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|----|---|--|
| 1. | Individuals administering moderate or deep sedation and anesthesia are qualified and have credentials to manage and rescue patients at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally. (See also MS.06.01.03, EP 6)  |  <b>A</b> |
| 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.<br>Note: Hospitals that provide obstetric emergency operative services can provide anesthesia services as required by law or regulation. |  <b>A</b> |
| 5. | A registered nurse supervises perioperative nursing care.   |  <b>A</b> |
| 6. | For operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia: The hospital has equipment available to monitor the patient's physiological status.  |  <b>A</b> |
| 7. | For operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia: The hospital has equipment available to administer intravenous fluids and medications, and blood and blood components.   |  <b>A</b> |
| 8. | For operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia: The hospital has resuscitation equipment available. (See also MM.03.01.03, EP 2)   |  <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required



10. For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the hospital's policy and state scope-of-practice laws, anesthesia is administered only by the following individuals:

- An anesthesiologist
- A doctor of medicine or osteopathy other than an anesthesiologist
- A doctor of dental surgery or dental medicine
- A doctor of podiatric medicine
- A certified registered nurse anesthetist (CRNA) supervised by the operating practitioner except as provided in 42 CFR 482.52(c) regarding the state exemption for this supervision
- An anesthesiologist's assistant supervised by an anesthesiologist
- A supervised trainee in an approved educational program

Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law or, if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission.








Note 2: "Anesthesiologist assistant" is defined in 42 CFR 410.69(b).

Footnote: The CoP at 42 CFR 482.52(c) for state exemption states: A hospital may be exempt from the requirement for doctors of medicine or osteopathy to supervise CRNAs if the state in which the hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor attests that he or she has consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.

**Standard PC.03.01.03**

The hospital provides the patient with care before initiating operative or other high-risk procedures, including those that require the administration of deep sedation or anesthesia.


**Elements of Performance for PC.03.01.03**



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|----------|-----|---|---|----------|
|          | 1.  | Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital conducts a presedation or preanesthesia patient assessment. (See also RC.02.01.01, EP 2)                                      |  | <b>A</b> |
|          | 2.  | Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital assesses the patient's anticipated needs in order to plan for the postprocedure care.   |  | <b>A</b> |
|          | 3.  | Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital provides the patient with preprocedural treatment and services, according to his or her plan for care.                        |  | <b>A</b> |
| <b>M</b> | 4.  | Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital provides the patient with preprocedural education, according to his or her plan for care.                                     |  | <b>C</b> |
|          | 7.  | Before administering moderate or deep sedation or anesthesia, a licensed independent practitioner plans or concurs with the plan for sedation or anesthesia.  |  | <b>A</b> |
|          | 8.  | The hospital reevaluates the patient immediately before administering moderate or deep sedation or anesthesia. (See also RC.02.01.01, EP 2)   |  | <b>A</b> |
|          | 18. | For hospitals that use Joint Commission accreditation for deemed status purposes: A preanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services. |  | <b>A</b> |

**Standard PC.03.01.05**

The hospital monitors the patient during operative or other high-risk procedures and/or during the administration of moderate or deep sedation or anesthesia.

**Elements of Performance for PC.03.01.05**







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|--|----|--|---|----------|
|  | 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) |  | <b>A</b> |
|--|----|--|---|----------|

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard PC.03.01.07**

The hospital provides care to the patient after operative or other high-risk procedures and/or the administration of moderate or deep sedation or anesthesia.


**Elements of Performance for PC.03.01.07**



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|------------|----|---|---|----------|
|            | 1. | The hospital assesses the patient's physiological status immediately after the operative or other high risk procedure and/or as the patient recovers from moderate or deep sedation or anesthesia. (See also RC.02.01.03, EP 8)   |  | <b>A</b> |
| <b>(M)</b> | 2. | The hospital monitors the patient's physiological status, mental status, and pain level at a frequency and intensity consistent with the potential effect of the operative or other high risk procedure and/or the sedation or anesthesia administered.   |  | <b>C</b> |
|            | 4. | A qualified licensed independent practitioner discharges the patient from the recovery area or from the hospital. In the absence of a qualified licensed independent practitioner, patients are discharged according to criteria approved by clinical leaders. (See also RC.02.01.03, EPs 9 and 10) |  | <b>A</b> |
| <b>(M)</b> | 6. | Patients who have received sedation or anesthesia as outpatients are discharged in the company of an individual who accepts responsibility for the patient.   |  | <b>C</b> |
|            | 7. | For hospitals that use Joint Commission accreditation for deemed status purposes: A postanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services.                    |  | <b>A</b> |
|            | 8. | For hospitals that use Joint Commission accreditation for deemed status purposes: The postanesthesia evaluation for anesthesia recovery is completed in accordance with law and regulation and policies and procedures that have been approved by the medical staff.                                |  | <b>A</b> |

**Standard PC.03.01.08**

For hospitals that use Joint Commission accreditation for deemed status purposes: The laboratory has written policies and procedures for the handling of tissue specimens removed during a surgical procedure.

**Elements of Performance for PC.03.01.08**





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|------------|---------------|---|---|----------|
|            | 1. <b>(D)</b> | For hospitals that use Joint Commission accreditation for deemed status purposes: The laboratory has a written policy, approved by the medical staff and a pathologist, that establishes which tissue specimens require only a macroscopic examination, and which require both a macroscopic and microscopic examination. |   | <b>A</b> |
|            | 2. <b>(D)</b> | For hospitals that use Joint Commission accreditation for deemed status purposes: The laboratory has written policies and procedures for collecting, preserving, transporting, receiving, and reporting examination results for tissue specimens.   |   | <b>A</b> |
| <b>(M)</b> | 3.            | For hospitals that use Joint Commission accreditation for deemed status purposes: The laboratory follows its policies and procedures for the handling of tissue specimens removed during a surgical procedure.  |  | <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **(M)** indicates Measure of Success if needed; **(D)** indicates that documentation is required

**Standard PC.03.01.09**

The hospital provides electroconvulsive therapy safely.





**Elements of Performance for PC.03.01.09**

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| 1.   |  The hospital has a written policy that addresses the use of electroconvulsive therapy.   | <b>A</b>   |
| 2.   | The hospital obtains written consent for electroconvulsive therapy from the patient and documents it in the medical record.  |  <b>A</b> |
| 3.   | Before initiating electroconvulsive therapy for a child or youth, two qualified, experienced child psychiatrists who are not directly involved in treating the child or youth examine the child or youth; consult with the child's or youth's psychiatrist; and document in the medical record their concurrence with the decision to use electroconvulsive therapy. | <b>A</b>   |
| 4.   | The hospital justifies the use of electroconvulsive therapy in the patient's medical record.   | <b>A</b>   |
|  5. | The hospital implements its policy on the use of electroconvulsive therapy.  |  <b>C</b> |

**Standard PC.03.01.11**

The hospital uses surgical treatments for emotional, mental, or behavioral disorders safely.

**Elements of Performance for PC.03.01.11**

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|--|---|--|
| 1.   |  The hospital has a written policy that addresses the use of surgical treatments for emotional, mental, or behavioral disorders. | <b>A</b>   |
|  2. | Whenever surgical treatments for emotional, mental, or behavioral disorders are used, the hospital justifies their use in the patient's medical record.   | <b>C</b>   |
|  3. | The hospital implements its policy addressing surgical treatment for mental, emotional, or behavioral disorders.  |  <b>C</b> |

**Standard PC.03.02.01**

For hospitals that do not use accreditation for deemed status purposes: The hospital limits its use of restraint for non-behavioral health purposes.


**Elements of Performance for PC.03.02.01**

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|----|---|----------|
| 1. | For hospitals that do not use accreditation for deemed status purposes: Leadership determines the hospital's approach to limiting the use of restraint for non-behavioral health purposes.  | <b>A</b> |
| 2. | For hospitals that do not use accreditation for deemed status purposes: The hospital justifies its use of restraint in clinical settings for non-behavioral health purposes.<br>Note: The hospital uses criteria drawn from evidence-based national practice guidelines, pathways of care, or other nationally recognized standardized care processes. In the absence of such information, the hospital establishes its own criteria. | <b>A</b> |

**Standard PC.03.02.03**

For hospitals that do not use accreditation for deemed status purposes: Written policies and procedures guide the hospital's safe use of restraint for non-behavioral health purposes.

**Elements of Performance for PC.03.02.03**

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|---|----------|
| 1.  For hospitals that do not use accreditation for deemed status purposes: The hospital has written policies and procedures on the use of restraint for non-behavioral health purposes which include the following: <ul style="list-style-type: none"><li>- Protection of the patient's rights, dignity, and well-being</li><li>- The use of restraint based on the patient's assessed needs</li><li>- Use of the least restrictive method of restraint</li><li>- Safe application and removal of restraints</li><li>- Monitoring and reassessment of patients who are restrained</li><li>- Methods for meeting the physical needs of patients who are limited by restraint</li><li>- Risks posed by restraint to vulnerable patient populations, such as emergency and pediatric patients and patients who are cognitively or physically challenged</li><li>- Discussion of the use of restraint with patients and their families</li><li>- Limitation of written orders for restraint to licensed independent practitioners</li><li>- Renewal of orders in accordance with law and regulation</li><li>- Frequency and content of entries in the patient's medical record for each episode of restraint</li></ul> (See also RC.02.01.05, EP 1) | <b>A</b> |
| 2. For hospitals that do not use accreditation for deemed status purposes: Medical staff and nursing leadership approve the written policies and procedures on the use of restraint for non-behavioral health purposes.   | <b>A</b> |

**Standard PC.03.02.05**



For hospitals that do not use accreditation for deemed status purposes: Use of restraint for non-behavioral health purposes is initiated either by an individual order or by an approved written protocol, the use of which is authorized by an individual order.


**Rationale for PC.03.02.05**

Individual orders provide the framework for ensuring clinical justification of restraint use and for protecting patient rights, dignity, and well-being.

During the treatment of certain specific conditions (for example, post-traumatic brain injury) or certain specific clinical procedures (for example, intubation), restraint may be necessary to promote healing and prevent significant harm to the patient. For specified conditions or procedures, protocols for restraint use may be established based on the frequent presentation in those conditions or procedures of behavior by patients that seriously endangers the patient or seriously compromises the effectiveness of the procedure.

**Elements of Performance for PC.03.02.05**

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|--|---|----------|
| 1.   | For hospitals that do not use accreditation for deemed status purposes: A licensed independent practitioner issues the order for use of restraint for non-behavioral health purposes. If a licensed independent practitioner is not available to order the use of restraint for non-behavioral health purposes, a registered nurse can initiate use based on an assessment of the patient. (See also RC.02.01.05, EP 2) | <b>A</b> |
| 2.   | For hospitals that do not use accreditation for deemed status purposes: If a registered nurse initiates use of restraint for non-behavioral health purposes in response to an unanticipated change in the patient's condition, he or she immediately notifies a licensed independent practitioner.  | <b>A</b> |
| 3.   | For hospitals that do not use accreditation for deemed status purposes: If a registered nurse initiates use of restraint for non-behavioral health purposes, a licensed independent practitioner provides a verbal or written order within 12 hours of initiation.  | <b>A</b> |
| 4.   | For hospitals that do not use accreditation for deemed status purposes: A licensed independent practitioner examines the patient within 24 hours of initiation of restraint used for non-behavioral health purposes and enters a written order into the patient's medical record.   | <b>A</b> |
| 5.   | For hospitals that do not use accreditation for deemed status purposes: If restraint for non-behavioral health purposes is continued beyond 24 hours, its use is ordered once each calendar day by a licensed independent practitioner, based on his or her examination of the patient.   | <b>A</b> |
|  6. | For hospitals that do not use accreditation for deemed status purposes: Orders for use of restraint for non-behavioral health purposes are consistent with the hospital's policies and procedures.  | <b>C</b> |
|  7. | For hospitals that do not use accreditation for deemed status purposes: The reason for any variation from the hospital's policies and procedures for monitoring a patient in restraint for non-behavioral health purposes or for releasing a patient before his or her order expires is documented in the order.  | <b>C</b> |

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| 8.  For hospitals that do not use accreditation for deemed status purposes: Written protocols for the use of restraint for non-behavioral health purposes include the following: <ul style="list-style-type: none"><li>- Guidelines for assessing the patient</li><li>- Criteria for the use of restraint</li><li>- Criteria for monitoring the patient and reassessing his or her need for restraint</li><li>- Criteria for when restraint can be discontinued</li></ul> | <b>A</b> |
| 9. For hospitals that do not use accreditation for deemed status purposes: Written protocols that guide the use of restraint for non-behavioral health purposes reflect the hospital's policies and procedures.  | <b>A</b> |
| 10. For hospitals that do not use accreditation for deemed status purposes: Written protocols that guide the use of restraint for non-behavioral health purposes are approved by the medical staff and nursing leadership.   | <b>A</b> |
| 11. For hospitals that do not use accreditation for deemed status purposes: A licensed independent practitioner issues a patient-specific order authorizing the use of written protocols for the use of restraint for non-behavioral health purposes. (See also RC.02.01.05, EP 2)   | <b>A</b> |
| 12. For hospitals that do not use accreditation for deemed status purposes: Authorized staff maintain and discontinue restraint for non-behavioral health purposes according to the written protocol(s).   | <b>A</b> |

**Standard PC.03.02.07**



For hospitals that do not use accreditation for deemed status purposes: The hospital monitors patients who are restrained for non-behavioral health purposes.



**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**

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| <b>M</b> | 1. For hospitals that do not use accreditation for deemed status purposes: The frequency and extent of monitoring patients who are restrained for non-behavioral purposes are determined by the following: <ul style="list-style-type: none"> <li>- Hospital policies and procedures</li> <li>- Protocols</li> <li>- Individual orders</li> <li>- The care setting</li> <li>- Individual patient needs</li> <li>- Applicable law and regulation</li> </ul> (See also RC.02.01.05, EP 1) | <b>C</b>  |
| 2.       | For hospitals that do not use accreditation for deemed status purposes: A patient in restraint for non-behavioral health purposes is monitored either every two hours or more frequently if required by his or her needs and hospital policy. (See also RC.02.01.05, EP 1)  |  <b>A</b>  |
| 3.       | For hospitals that do not use accreditation for deemed status purposes: Qualified staff monitor a patient in restraint for non-behavioral health purposes.<br>Note: Monitoring may occur using observation, interaction with the patient, or direct examination.  |  <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard PC.03.02.11**

For hospitals that do not use accreditation for deemed status purposes: The hospital uses performance improvement processes to identify opportunities to reduce risks associated with the use of restraint for non-behavioral health purposes.

**Rationale for PC.03.02.11**

The measurement and assessment process related to restraint seeks to understand why restraint is used and incorporates this understanding into the hospital's plans and priorities to evaluate and, if appropriate, reduce its use. This understanding can be advanced by an initial baseline assessment of aggregate data on restraint episodes, followed by targeted monitoring.

**Elements of Performance for PC.03.02.11**

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| 1.  | For hospitals that do not use accreditation for deemed status purposes: The hospital identifies the frequency with which it collects data on its use of restraint for non-behavioral health purposes.   | <b>A</b> |
| 2.  | For hospitals that do not use accreditation for deemed status purposes: The hospital collects data on its use of restraint for non-behavioral health purposes.  | <b>A</b> |
| 3.  | For hospitals that do not use accreditation for deemed status purposes: The hospital compiles its data on the use of restraint for non-behavioral health purposes in usable formats.  | <b>A</b> |
| 4.  | For hospitals that do not use accreditation for deemed status purposes: The hospital identifies the frequency with which it analyzes its data on the use of restraint for non-behavioral health purposes.   | <b>A</b> |
| 5.  | For hospitals that do not use accreditation for deemed status purposes: The hospital uses statistical tools and techniques to analyze and display its data on the use of restraint for non-behavioral health purposes.  | <b>A</b> |
| 6.  | For hospitals that do not use accreditation for deemed status purposes: The hospital analyzes and compares its data on the use of restraint for non-behavioral health purposes over time to identify levels of performance, patterns, trends, and variations. | <b>A</b> |
| 7.  | For hospitals that do not use accreditation for deemed status purposes: The hospital uses the results of its data analysis on the use of restraint for non-behavioral health purposes to identify opportunities to improve.                                   | <b>A</b> |
| 8.  | For hospitals that do not use accreditation for deemed status purposes: The hospital prioritizes opportunities to improve its use of restraint for non-behavioral health purposes.  | <b>A</b> |
| 9.  | For hospitals that do not use accreditation for deemed status purposes: The hospital takes action on its improvement priorities for the use of restraint for non-behavioral health purposes.  | <b>A</b> |
| 10. | For hospitals that do not use accreditation for deemed status purposes: The hospital evaluates changes to confirm they resulted in improvements to the use of restraint for non-behavioral health purposes.   | <b>A</b> |
| 11. | For hospitals that do not use accreditation for deemed status purposes: The hospital takes action when planned improvements in its use of restraint for non-behavioral health purposes are either not achieved or not sustained.                              | <b>A</b> |

**Standard PC.03.03.01**

For hospitals that do not use accreditation for deemed status purposes: The hospital defines its approach to the use of restraint and seclusion for behavioral health purposes.

**Elements of Performance for PC.03.03.01**

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| 1. | For hospitals that do not use accreditation for deemed status purposes: The hospital's approach to the use of restraint and seclusion for behavioral health purposes includes the following: <ul style="list-style-type: none"><li>- Its commitment to prevent, reduce, and work to eliminate the use of restraint and seclusion</li><li>- The need to prevent emergencies that have the potential to lead to the use of restraint or seclusion</li><li>- The use of non-physical interventions as the preferred interventions</li><li>- Limitation of the use of restraint and seclusion to emergencies involving imminent risk of a patient causing self harm or harm to others, including staff</li><li>- The responsibility to discontinue restraint or seclusion as soon as possible</li><li>- The need to raise awareness among staff about what restraint or seclusion may feel like to the patient</li><li>- Preservation of the patient's safety and dignity when restraint or seclusion is used</li></ul> | <b>A</b> |
| 2. | For hospitals that do not use accreditation for deemed status purposes: The hospital communicates its approach to the use of restraint and seclusion for behavioral health purposes to those licensed independent practitioners and staff who are involved in their use.  | <b>A</b> |

**Standard PC.03.03.03**

For hospitals that do not use accreditation for deemed status purposes: Written policies and procedures guide restraint and seclusion use for behavioral health purposes.

**Elements of Performance for PC.03.03.03**

1. **D** For hospitals that do not use accreditation for deemed status purposes: The hospital has written policies and procedures that guide the use of restraint and seclusion for behavioral health purposes, which include the following:
- Staffing levels
  - Staff competence and training
  - The patient's initial assessment
  - The role of non-physical techniques in behavior management (for example, time outs)
  - Limiting restraint or seclusion to emergencies
  - Notifying the patient's family when restraint or seclusion is initiated
  - Ordering of restraint and seclusion by a licensed independent practitioner
  - In-person evaluation of a patient in restraint or seclusion
  - Initiation of restraint or seclusion by staff other than a licensed independent practitioner
  - Time-limited orders
  - The patient's reassessment
  - Monitoring a patient in restraint or seclusion
  - Discontinuing restraint or seclusion
  - Debriefing a patient after each use of restraint or seclusion
  - Reporting injuries and deaths to the hospital's leadership and appropriate external agencies, in accordance with law and regulation
  - Documentation
  - Performance improvement activities

**A**

**Standard PC.03.03.05**

For hospitals that do not use accreditation for deemed status purposes: Staffing levels and assignments are designed to minimize the use and maximize the safety of restraint or seclusion for behavioral health purposes.

**Elements of Performance for PC.03.03.05**


- M** 1. For hospitals that do not use accreditation for deemed status purposes: When the hospital uses restraint or seclusion for behavioral health purposes, the hospital bases its staffing levels and assignments on the following:
- Staff qualifications
  - The physical design of the environment
  - Patient diagnoses
  - Patients' co-occurring conditions
  - Patient acuity levels
  - Patients' ages and developmental functioning



**C**


**Standard PC.03.03.07**

For hospitals that do not use accreditation for deemed status purposes: Staff are competent in minimizing the use of restraint and seclusion for behavioral health purposes and maximizing patient safety when they are used.

**Elements of Performance for PC.03.03.07**

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| <b>M</b> | 1. For hospitals that do not use accreditation for deemed status purposes: The hospital educates staff about how to minimize the use of restraint and seclusion for behavioral health purposes.  | <b>C</b>   |
| <b>M</b> | 2. For hospitals that do not use accreditation for deemed status purposes: Before staff participate in the use of restraint or seclusion for behavioral health purposes, the hospital assesses their competence to safely use them.  | <b>C</b>   |
| <b>M</b> | 3. For hospitals that do not use accreditation for deemed status purposes: In order to help minimize the use of restraint and seclusion for behavioral health purposes, staff who participate in their use receive training and demonstrate an understanding of the following: <ul style="list-style-type: none"> <li>- The underlying causes of threatening behaviors exhibited by patients</li> <li>- The medical conditions that may cause a patient to exhibit aggressive behavior</li> <li>- The ways in which their behavior can affect patients' behaviors</li> <li>- De-escalation, mediation, self-protection, and time-out techniques</li> <li>- The ways to recognize signs of physical distress in patients who are being held, restrained, or secluded</li> </ul>   | <b>C</b>   |
|          | 4. For hospitals that do not use accreditation for deemed status purposes: Staff who participate in the use of restraint or seclusion for behavioral health purposes receive training and demonstrate competence in the safe use of physical holding techniques, take-down procedures, and the application and removal of mechanical restraints.   |  <b>A</b> |
| <b>M</b> | 5. For hospitals that do not use accreditation for deemed status purposes: Staff who are authorized to perform 15-minute assessments of patients who are in restraint or seclusion for behavioral health purposes receive ongoing training and can demonstrate competence in the following: <ul style="list-style-type: none"> <li>- Recognition of when to contact emergency medical assistance to evaluate and/or treat the patient's physical status</li> <li>- Recognition of signs of restraints applied incorrectly</li> <li>- Taking of vital signs and the interpretation of their relevance to the patient's physical safety</li> <li>- Recognition of the patient's nutrition and hydration needs</li> <li>- How to check the patient's circulation and range of motion in his or her extremities</li> <li>- How to address the patient's hygiene and elimination</li> <li>- How to address the patient's physical and psychological status and comfort</li> <li>- How to help the patient meet criteria for discontinuing restraint or seclusion</li> <li>- Recognition of the patient's readiness for discontinuing restraint or seclusion</li> </ul> (See also RC.02.01.05, EP 3) | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

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|-----------------|-----------|--|---|
| <p><b>M</b></p> | <p>6.</p> | <p>For hospitals that do not use accreditation for deemed status purposes: Staff who are authorized to initiate restraint or seclusion for behavioral health purposes in the absence of a licensed independent practitioner, to perform evaluations and reevaluations of patients in restraint or seclusion to assess their readiness for release, or to establish the need for a new order receive training and demonstrate competence in the following:</p> <ul style="list-style-type: none"> <li>- Recognition of when to contact emergency medical assistance to evaluate and/or treat the patient's physical status</li> <li>- Recognition of signs of incorrectly applied restraints</li> <li>- Taking vital signs and interpreting their relevance to the patient's physical safety</li> <li>- Recognition of the patient's nutritional and hydration needs</li> <li>- How to check the patient's circulation and range of motion in his or her extremities</li> <li>- How to address the patient's hygiene and elimination</li> <li>- How to address the patient's physical and psychological status and comfort</li> <li>- Recognition of how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which a patient reacts to physical contact</li> <li>- The use of criteria for discontinuing restraint or seclusion for behavioral health purposes</li> <li>- How to help the patient meet criteria for discontinuing restraint or seclusion</li> <li>- Recognition of the patient's readiness for discontinuing restraint or seclusion</li> </ul> | <p><b>C</b></p>   |
|                 | <p>7.</p> | <p>For hospitals that do not use accreditation for deemed status purposes: The hospital plans for providing emergency medical care to patients who are restrained or secluded for behavioral health purposes.</p>  | <p><b>A</b></p>   |
|                 | <p>8.</p> | <p>For hospitals that do not use accreditation for deemed status purposes: A licensed independent practitioner(s) or staff who are competent to initiate emergency medical care and cardiopulmonary resuscitation for patients who are restrained or secluded for behavioral health purposes are available at all times.</p>   | <p> <b>A</b></p> |
|                 | <p>9.</p> | <p>For hospitals that do not use accreditation for deemed status purposes: The viewpoints of patients who have been restrained or secluded for behavioral health purposes are incorporated into training and education.</p> <p>Note: Whenever possible, patients who have experienced restraint or seclusion for behavioral health purposes contribute to staff training and education curricula and participate in the training and education.</p>  | <p><b>A</b></p>   |

**Standard PC.03.03.09**

For hospitals that do not use accreditation for deemed status purposes: The hospital obtains information about the patient that could help minimize the need to use restraint or seclusion for behavioral health purposes with the patient.

**Elements of Performance for PC.03.03.09**




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| <p><b>M</b> 1.</p> <p><b>M</b> 2.</p> <p><b>M</b> 3.</p> <p><b>M</b> 4.</p> <p><b>M</b> 5.</p> | <p>For hospitals that do not use accreditation for deemed status purposes: During the initial assessment of a patient who is at risk of self harm or harm to others, information is obtained from the patient and/or the patient's family to identify the following:</p> <ul style="list-style-type: none"> <li>- Pre-existing medical conditions or any physical disabilities or limitations that would place the patient at increased risk if restraint or seclusion is used for behavioral health purposes</li> <li>- Any history of sexual or physical abuse that would place the patient at greater psychological risk if restraint or seclusion is used for behavioral health purposes</li> <li>- Techniques, methods, or tools that would help the patient to control his or her behavior</li> </ul> <p>(See also PC.03.03.11, EP 5)</p> <p>For hospitals that do not use accreditation for deemed status purposes: The hospital discusses with the patient the role the patient's family can play, if any, in minimizing the need to use restraint or seclusion for behavioral health purposes.</p> <p>Note: With the patient's permission, his or her family can participate in this discussion, unless the family's participation is contraindicated by the patient's condition.</p> <p>For hospitals that do not use accreditation for deemed status purposes: If the patient defines a role his or her family can play in minimizing the need to use restraint or seclusion for behavioral health purposes, the hospital determines whether the family agrees to fulfill that role.</p> <p>For hospitals that do not use accreditation for deemed status purposes: The patient and/or the patient's family are educated about the hospital's approach to the use of restraint and seclusion for behavioral health purposes.</p> <p>For hospitals that do not use accreditation for deemed status purposes: The hospital determines if the patient has a behavioral health advance directive and informs the licensed independent practitioner and staff who participate in the use of restraint and seclusion of the directive and its content.</p> | <p><b>C</b></p> <p><b>C</b></p> <p><b>C</b></p> <p><b>C</b></p> <p><b>C</b></p> |
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**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard PC.03.03.11**

For hospitals that do not use accreditation for deemed status purposes: The use of restraint or seclusion for behavioral health purposes is limited to emergencies.

**Elements of Performance for PC.03.03.11**

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| 1.   | For hospitals that do not use accreditation for deemed status purposes: Non-physical interventions for behavioral health purposes are used whenever possible.   | <b>A</b>   |
| 2.   | For hospitals that do not use accreditation for deemed status purposes: Restraint or seclusion for behavioral health purposes are used only when non-physical interventions are ineffective or not viable and when the patient is at imminent risk of self harm or harm to others.<br>Note: Because the use of restraint and seclusion is limited to emergencies in which a licensed independent practitioner may not be immediately available, the hospital may authorize qualified, trained staff members to initiate restraint or seclusion for behavioral health purposes before an order is obtained from the licensed independent practitioner. | <b>A</b>   |
| 3.   | For hospitals that do not use accreditation for deemed status purposes: The hospital does not permit restraint or seclusion for behavioral health purposes to be used for the purpose of coercion, discipline, convenience, or staff retaliation.   |  <b>A</b> |
| 4.   | For hospitals that do not use accreditation for deemed status purposes: The use of restraint or seclusion for behavioral health purposes is not based on the patient's history of use nor solely on the patient's history of dangerous behavior, if any.  | <b>A</b>   |
|  5. | For hospitals that do not use accreditation for deemed status purposes: The type of intervention used in lieu of restraint or seclusion for behavioral health purposes takes into consideration information learned from the patient's initial assessment. (See also PC.03.03.09, EP 1)   | <b>C</b>   |
|  6. | For hospitals that do not use accreditation for deemed status purposes: If the patient consents to have his or her family informed about his or her care, and the family has agreed to be notified, staff attempts to promptly contact the family to notify them when restraint or seclusion is used for behavioral health purposes.  | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard PC.03.03.13**

For hospitals that do not use accreditation for deemed status purposes: A licensed independent practitioner orders the use of restraint or seclusion for behavioral health purposes.


**Elements of Performance for PC.03.03.13**

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| 1. | For hospitals that do not use accreditation for deemed status purposes: The licensed independent practitioner who is primarily responsible for the ongoing care of the individual served orders the use of restraint or seclusion. (See also RC.02.01.05, EP 3)<br>Note 1: In the absence of the licensed independent practitioner who is primarily responsible for the patient's ongoing care, his or her designee or other licensed independent practitioner may order the use of restraint or seclusion.<br>Note 2: This element of performance is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to physician assistants and advanced practice nurses to the extent recognized under state law or a state's regulatory mechanism and as allowed by the hospital. | <b>A</b> |
| 2. | For hospitals that do not use accreditation for deemed status purposes: When restraint or seclusion is initiated without an order by a licensed independent practitioner, within one hour, qualified staff does the following:<br>- Notifies the licensed independent practitioner.<br>- Obtains an order (verbal or written) from a licensed independent practitioner.<br>- Consults with the licensed independent practitioner about the patient's physical and psychological condition.<br>(See also RC.02.01.05, EP 3)   | <b>A</b> |
| 3. | For hospitals that do not use accreditation for deemed status purposes: When restraint or seclusion is initiated for behavioral health purposes, the licensed independent practitioner does the following:<br>- Reviews with staff the patient's physical and psychological status<br>- Determines whether restraint or seclusion should be continued<br>- Guides staff in identifying ways to help the patient regain control so that restraint or seclusion can be discontinued<br>(See also RC.02.01.05, EP 3)  | <b>A</b> |

**Standard PC.03.03.15**

For hospitals that do not use accreditation for deemed status purposes: A licensed independent practitioner sees and evaluates in person the patient who is in restraint or seclusion for behavioral health purposes.

**Elements of Performance for PC.03.03.15**

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| 1. | For hospitals that do not use accreditation for deemed status purposes: The licensed independent practitioner who is primarily responsible for the patient's ongoing care conducts an in-person evaluation of the patient who is in restraint or seclusion for behavioral health purposes within one of the following time frames:<br>- Four hours of restraint or seclusion initiation for patients ages 18 and over<br>- Two hours of restraint or seclusion initiation for patients ages 9 to 17<br>- One hour of restraint or seclusion initiation for patients under age 9<br>Note: In the absence of the licensed independent practitioner who is primarily responsible for the patient's ongoing care, his or her designee or other licensed independent practitioner may conduct the in-person evaluation. |  <b>A</b> |
| 2. | For hospitals that do not use accreditation for deemed status purposes: At the time of the in-person evaluation of the patient who is in restraint or seclusion for behavioral health purposes, the licensed independent practitioner does the following:<br>- Works with the patient and staff to identify ways to help the patient regain control.<br>- Revises the patient's plan for care, treatment, and services as needed.<br>- Provides a new written order, if necessary.   | <b>A</b>   |
| 3. | For hospitals that do not use accreditation for deemed status purposes: If the patient is released from restraint or seclusion used for behavioral health purposes prior to the expiration of the original order, the licensed independent practitioner conducts an in-person evaluation of the patient within 24 hours of the initiation of restraint or seclusion.   | <b>A</b>   |

**Standard PC.03.03.17**

For hospitals that do not use accreditation for deemed status purposes: Orders for restraint or seclusion for behavioral health purposes are time limited.

**Rationale for PC.03.03.17**

Time-limited orders do not mean that restraint or seclusion must be applied for the entire length of time for which the order is written. The standard for periodic assessment, the standard for monitoring and assisting, and the standard for reevaluation are intended to encourage the discontinuation of restraint or seclusion as soon as the patient meets the behavior criteria for its discontinuation.

When restraint or seclusion is terminated before the time-limited order expires, the original order can be used to reapply the restraint or seclusion if the patient is at imminent risk of physically harming himself or herself or others, and nonphysical interventions are not effective. However, when the original order expires, a new order for restraint or seclusion is obtained from the licensed independent practitioner primarily responsible for the patient's ongoing care, treatment, and services, or his or her licensed independent practitioner designee, or another licensed independent practitioner.




**Elements of Performance for PC.03.03.17**





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| <p><b>M</b> 1.</p> | <p>For hospitals that do not use accreditation for deemed status purposes: Verbal and written orders for restraint or seclusion used for behavioral health purposes are time-limited, as follows:</p> <ul style="list-style-type: none"> <li>- Four hours for patients ages 18 and older</li> <li>- Two hours for patients ages 9 to 17</li> <li>- One hour for patients under age 9</li> </ul> <p>(See also RC.02.01.05, EP 3)</p> | <p><b>C</b></p> |
| <p>2.</p>          | <p>For hospitals that do not use accreditation for deemed status purposes: An order for restraint or seclusion for behavioral health purposes is not written as a standing order or as an as needed (PRN) order.</p>  | <p><b>A</b></p> |
| <p><b>M</b> 3.</p> | <p>For hospitals that do not use accreditation for deemed status purposes: If restraint or seclusion used for behavioral health purposes needs to continue beyond the expiration of the time-limited order, a new order is obtained.</p>  | <p><b>C</b></p> |

**Standard PC.03.03.19**

For hospitals that do not use accreditation for deemed status purposes: Patients who are in restraint or seclusion for behavioral health purposes are reevaluated.

**Elements of Performance for PC.03.03.19**

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| 1.   | For hospitals that do not use accreditation for deemed status purposes: The licensed independent practitioner who is primarily responsible for the patient's ongoing care conducts an in-person reevaluation of the patient for each episode of continued restraint or seclusion used for behavioral health purposes.<br>Note: This in-person evaluation may also be conducted by the licensed independent practitioner's designee, another licensed independent practitioner, or a qualified trained individual authorized by the hospital to perform this function. | <b>A</b>   |
| 2.   | For hospitals that do not use accreditation for deemed status purposes: The patient is reevaluated in person for continued need for restraint or seclusion for behavioral health purposes by a licensed independent practitioner or a qualified, trained individual authorized by the hospital to perform this function at least once within the following time frames:<br>- Every four hours for patients ages 18 and older<br>- Every two hours for patients ages 9 to 17<br>- Every hour for patients under age 9  |  <b>A</b> |
| 3.   | For hospitals that do not use accreditation for deemed status purposes: The patient is reevaluated in person for continued need for restraint or seclusion for behavioral health purposes by a licensed independent practitioner at least once within the following time frames:<br>- Every eight hours for patients ages 18 and older<br>- Every four hours for patients ages 17 and younger   |  <b>A</b> |
| 4.   | For hospitals that do not use accreditation for deemed status purposes: When the patient who is in restraint or seclusion for behavioral health purposes is reevaluated in person, the licensed independent practitioner or other qualified, authorized staff member reevaluates the effectiveness of the patient's treatment plan and works with the patient to identify ways to help him or her regain control.   | <b>A</b>   |
|  5. | For hospitals that do not use accreditation for deemed status purposes: When restraint or seclusion is continued for behavioral health purposes and the individual providing the order is someone other than the patient's licensed independent practitioner or his or her licensed independent practitioner designee, the patient's licensed independent practitioner is notified of the patient's status.   | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard PC.03.03.21**

For hospitals that do not use accreditation for deemed status purposes: Clinical leaders are informed of the extended use or multiple episodes of restraint or seclusion for behavioral health purposes.

**Rationale for PC.03.03.21**

Information is communicated to leadership in order to assess whether additional resources are needed to facilitate discontinuation of restraint or seclusion or minimize the recurrent instances of restraint or seclusion.

Clinical leaders need to be informed about extended use or multiple episodes of restraint or seclusion so that they can assess whether additional resources are necessary to facilitate their reduced use and to minimize instances of recurrent use.




**Elements of Performance for PC.03.03.21**

1. For hospitals that do not use accreditation for deemed status purposes: Clinical leaders are immediately notified of any instance in which a patient remains in restraint or seclusion for behavioral health purposes for more than 12 hours, or experiences two or more separate episodes of restraint or seclusion of any duration within 12 hours. Thereafter, the clinical leaders are notified every 24 hours if either of these conditions continues.





**A****Standard PC.03.03.23**

For hospitals that do not use accreditation for deemed status purposes: Patients in restraint or seclusion for behavioral health purposes are assessed and assisted in meeting criteria for the discontinuation of restraint or seclusion.

**Elements of Performance for PC.03.03.23**

-  1. For hospitals that do not use accreditation for deemed status purposes: A staff member who is trained and competent in the use of restraint and seclusion for behavioral health purposes assesses the patient when restraint or seclusion is initiated and every 15 minutes thereafter.
-  2. For hospitals that do not use accreditation for deemed status purposes: Depending upon the type of restraint or seclusion used for behavioral health purposes, the patient is assessed every 15 minutes for the following:
  - Signs of any injury associated with applying restraint or seclusion
  - Nutrition and hydration
  - Circulation and range of motion in the extremities
  - Vital signs
  - Hygiene and elimination
  - Physical and psychological status and comfort
  - Readiness for discontinuing restraint or seclusion
-  3. For hospitals that do not use accreditation for deemed status purposes: Staff assist the patient who is in restraint or seclusion for behavioral health purposes to meet criteria for discontinuation.



**C****C****C**

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard PC.03.03.25**

For hospitals that do not use accreditation for deemed status purposes: The hospital monitors patients who are restrained or secluded for behavioral health purposes.



**Elements of Performance for PC.03.03.25**





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| 1. | For hospitals that do not use accreditation for deemed status purposes: The patient in restraint or seclusion for behavioral health purposes is monitored by continuous in-person observation by an assigned staff member who is competent and trained in the use of restraint and seclusion. (See also RC.02.01.05, EP 3)<br>Note: After the first hour in seclusion (without restraint) for behavioral health purposes, the patient may be monitored continuously using simultaneous video and audio equipment, if this method of monitoring is consistent with the patient's condition and wishes. |  <b>A</b> |
| 2. | For hospitals that do not use accreditation for deemed status purposes: If the patient is in a physical hold for behavioral health purposes, another staff person who is trained and competent in the use of restraint and seclusion and who is not involved in the physical hold is assigned to observe the patient. (See also RC.02.01.05, EP 3)  |  <b>A</b> |

**Standard PC.03.03.27**

For hospitals that do not use accreditation for deemed status purposes: The hospital discontinues restraint or seclusion use for behavioral health purposes when the patient meets criteria for their discontinuation.

**Elements of Performance for PC.03.03.27**

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|  | 1. For hospitals that do not use accreditation for deemed status purposes: As early as possible after the initiation of restraint or seclusion for behavioral health purposes, the patient is informed of the reason why restraint or seclusion was initiated and what the criteria is for their discontinuation. | <b>C</b> |
|  | 2. For hospitals that do not use accreditation for deemed status purposes: Restraint or seclusion used for behavioral health purposes is discontinued as soon as the patient meets the criteria for their discontinuation.  | <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard PC.03.03.29**

For hospitals that do not use accreditation for deemed status purposes: Patients are debriefed after the use of restraint or seclusion for behavioral health purposes.

**Elements of Performance for PC.03.03.29**

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|---|----|--|----------|
| <div style="text-align: center;"><b>M</b></div> | 1. | For hospitals that do not use accreditation for deemed status purposes: After each episode of restraint or seclusion used for behavioral health purposes, staff members who participated in their use, if available, participate in a debriefing with the patient and, as determined by the patient's plan of care, the patient's family. (See also RC.02.01.05, EP 3)   | <b>C</b> |
| <div style="text-align: center;"><b>M</b></div> | 2. | For hospitals that do not use accreditation for deemed status purposes: Debriefings with the patient after the use of restraint or seclusion for behavioral health purposes occurs as soon as possible, but no longer than 24 hours, after each episode.   | <b>C</b> |
| <div style="text-align: center;"><b>M</b></div> | 3. | For hospitals that do not use accreditation for deemed status purposes: The content of the debriefing with the patient after each episode of restraint or seclusion use for behavioral health purposes includes the following: <ul style="list-style-type: none"> <li>- Identification of what led to the use of restraint or seclusion and what could have been done differently</li> <li>- Ascertainment that the patient's physical well-being, psychological comfort, and the right to privacy were maintained</li> <li>- Counseling of the patient for any physical or psychological trauma that may have resulted from the use of restraint or seclusion</li> <li>- Modification of the patient's plan for care, treatment, and services, if such modification is indicated</li> </ul> | <b>C</b> |
|   | 4. | For hospitals that do not use accreditation for deemed status purposes: Information obtained and documented from the debriefing with the patient after each episode of restraint or seclusion used for behavioral health purposes is used in performance improvement activities.   | <b>A</b> |

**Standard PC.03.03.31**

For hospitals that do not use accreditation for deemed status purposes: The hospital uses performance improvement processes to identify opportunities to reduce risks associated with the use of restraint and seclusion for behavioral health purposes.

**Rationale for PC.03.03.31**

The hospital collects restraint and seclusion data to monitor and improve its performance of processes that involve risks or may result in sentinel events. It uses the data to do the following:

- Ascertain that restraint or seclusion are used only as emergency intervention.
- Identify opportunities for incrementally reducing the rate and increasing the safety of restraint or seclusion use.
- Identify any need to redesign care processes.

**Elements of Performance for PC.03.03.31**






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|----|--|----------|
| 1. | For hospitals that do not use accreditation for deemed status purposes: The hospital uses patient identifiers to track patients for whom restraint or seclusion is used for behavioral health purposes in order to trend restraint and seclusion use.  | <b>A</b> |
| 2. | <b>D</b> For hospitals that do not use accreditation for deemed status purposes: For each episode of restraint or seclusion use for behavioral health purposes, the hospital collects the following data: <ul style="list-style-type: none"> <li>- The shift during which the episode occurs</li> <li>- The setting/unit/location where the episode occurs</li> <li>- The staff who initiated restraint or seclusion</li> <li>- The length of each episode</li> <li>- The date and time each episode is initiated</li> <li>- The day of the week each episode is initiated</li> <li>- The type of restraint used</li> <li>- Any injuries sustained by the patient or staff</li> <li>- A patient identifier</li> <li>- The patient's age</li> <li>- The patient's gender</li> <li>- The use of psychoactive medications as an alternative to restraint or seclusion or to enable their discontinuation</li> </ul> | <b>A</b> |
| 3. | For hospitals that do not use accreditation for deemed status purposes: Licensed independent practitioners participate in measuring and assessing the use of restraint and seclusion for behavioral health purposes for all patients in the hospital.  | <b>A</b> |
| 4. | For hospitals that do not use accreditation for deemed status purposes: The hospital leaders identify the frequency with which data on the use of restraint and seclusion for behavioral health purposes are analyzed.   | <b>A</b> |





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| 5.  | For hospitals that do not use accreditation for deemed status purposes: At a minimum, the hospital analyzes data on the use of restraint and seclusion for behavioral health purposes in order to identify the following:   | <b>A</b> |
|     | <ul style="list-style-type: none"> <li>- Multiple uses of restraint or seclusion for a patient within a 12-hour time frame</li> <li>- The number of episodes of restraint or seclusion per patient</li> <li>- The number of times restraint or seclusion extend beyond 12 consecutive hours</li> <li>- The number of times when psychoactive medications are used as an alternative to or to enable discontinuation of restraint and seclusion</li> </ul> |          |
| 6.  | <b>D</b> For hospitals that do not use accreditation for deemed status purposes: The hospital compares internal data on the use of restraint and seclusion for behavioral health purposes over time to identify levels of performance, patterns, trends, and variation.   | <b>A</b> |
| 7.  | For hospitals that do not use accreditation for deemed status purposes: Based on analysis of its data on restraint and seclusion use for behavioral health purposes, the hospital identifies opportunities to improve their use.  | <b>A</b> |
| 8.  | For hospitals that do not use accreditation for deemed status purposes: The hospital takes action on opportunities to improve its use of restraint and seclusion for behavioral health purposes.  | <b>A</b> |
| 9.  | For hospitals that do not use accreditation for deemed status purposes: The hospital evaluates the action it takes to improve its use of restraint and seclusion for behavioral health purposes to confirm that the improvements were achieved.   | <b>A</b> |
| 10. | For hospitals that do not use accreditation for deemed status purposes: The hospital takes action when its planned improvements in the use of restraint and seclusion for behavioral health purposes are not achieved or sustained.   | <b>A</b> |

### Standard PC.03.05.01

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.

#### Elements of Performance for PC.03.05.01



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| 1. | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others.                   |  <b>A</b>  |
| 2. | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital does not use restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation.                    |  <b>A</b> |
| 3. | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion only when less restrictive interventions are ineffective.   |  <b>A</b> |
| 4. | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others. |  <b>A</b> |
| 5. | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order.       |  <b>A</b> |





**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard PC.03.05.03**

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion safely.

**Elements of Performance for PC.03.05.03**



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|   | 1. | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements restraint or seclusion using safe techniques identified by the hospital's policies and procedures in accordance with law and regulation. |  <b>A</b> |
|  | 2. | For hospitals that use Joint Commission accreditation for deemed status purposes: The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care.   | <b>C</b>   |



**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard PC.03.05.05**

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital initiates restraint or seclusion based on an individual order.

**Elements of Performance for PC.03.05.05**

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| 1.          | For hospitals that use Joint Commission accreditation for deemed status purposes: A physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation.<br>Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).   | <b>A</b>   |
| 2.          | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital does not use standing orders or PRN (also known as "as needed") orders for restraint or seclusion.   | <b>A</b>   |
| 3.          | For hospitals that use Joint Commission accreditation for deemed status purposes: The attending physician or clinical psychologist is consulted as soon as possible, in accordance with hospital policy, if he or she did not order the restraint or seclusion.<br>Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).  | <b>A</b>   |
| <b>M</b> 4. | For hospitals that use Joint Commission accreditation for deemed status purposes: Unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others may be renewed within the following limits:<br>- 4 hours for adults 18 years of age or older<br>- 2 hours for children and adolescents 9 to 17 years of age<br>- 1 hour for children under 9 years of age<br>Orders may be renewed according to the time limits for a maximum of 24 consecutive hours.   | <b>C</b>   |
| 5.          | For hospitals that use Joint Commission accreditation for deemed status purposes: Unless state law is more restrictive, every 24 hours, a physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with hospital policy and law and regulation.<br>Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). |  <b>A</b> |
| 6.          | For hospitals that use Joint Commission accreditation for deemed status purposes: Orders for restraint used to protect the physical safety of the nonviolent or non-self-destructive patient are renewed in accordance with hospital policy.  |  <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard PC.03.05.07**

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital monitors patients who are restrained or secluded.

**Elements of Performance for PC.03.05.07**

1. For hospitals that use Joint Commission accreditation for deemed status purposes: Physicians, clinical psychologists, or other licensed independent practitioners or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion. (See also PC.03.05.17, EP 3)  
Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).



**Standard PC.03.05.09**

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has written policies and procedures that guide the use of restraint or seclusion.

**Elements of Performance for PC.03.05.09**

1. **D** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's policies and procedures regarding restraint or seclusion include the following: **A**
  - Physician, clinical psychologist, and other authorized licensed independent practitioner training requirements
  - Staff training requirements
  - The determination of who has authority to order restraint and seclusion
  - The determination of who has authority to discontinue the use of restraint or seclusion
  - The determination of who can initiate the use of restraint or seclusion
  - The circumstances under which restraint or seclusion is discontinued
  - The requirement that restraint or seclusion is discontinued as soon as is safely possible
  - A definition of restraint in accordance with 42 CFR 482.13(e)(1)(i)(A–C)
  - A definition of seclusion in accordance with 42 CFR 482.13(e)(1)(ii)
  - A definition or description of what constitutes the use of medications as a restraint in accordance with 42 CFR 482.13(e)(1)(i)(B)
  - A determination of who can assess and monitor patients in restraint or seclusion
  - Time frames for assessing and monitoring patients in restraint or seclusion

Note 1: The definition of restraint per 42 CFR 482.13(e)(1)(i)(A–C) is as follows:  
42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 42 CFR 482.13(e)(1)(i)(B) (A restraint is— ) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.  
42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Note 2: The definition of seclusion per 42 CFR 482.13(e)(1)(ii) is as follows:  
Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior.




Note 3: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
2. For hospitals that use Joint Commission accreditation for deemed status purposes: Physicians, clinical psychologists, and other licensed independent practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working knowledge of the hospital policy regarding the use of restraint and seclusion. **A**

Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

**Standard PC.03.05.11**

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital evaluates and reevaluates the patient who is restrained or secluded.


**Elements of Performance for PC.03.05.11**





1. For hospitals that use Joint Commission accreditation for deemed status purposes: A physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3. Note 1: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance. Note 2: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).  **A**
2. For hospitals that use Joint Commission accreditation for deemed status purposes: When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse or trained physician assistant, he or she consults with the attending physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).  **A**
3. For hospitals that use Joint Commission accreditation for deemed status purposes: The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others, includes the following:
  - An evaluation of the patient's immediate situation
  - The patient's reaction to the intervention
  - The patient's medical and behavioral condition
  - The need to continue or terminate the restraint or seclusion **A**

**Standard PC.03.05.13**

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital continually monitors patients who are simultaneously restrained and secluded.

**Elements of Performance for PC.03.05.13**

1. For hospitals that use Joint Commission accreditation for deemed status purposes: The patient who is simultaneously restrained and secluded is continually monitored by trained staff either in-person or through the use of both video and audio equipment that is in close proximity to the patient. Note: In this element of performance "continually" means ongoing without interruption.  **A**

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard PC.03.05.15**

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital documents the use of restraint or seclusion.

**Elements of Performance for PC.03.05.15**

- M** 1. For hospitals that use Joint Commission accreditation for deemed status purposes: Documentation of restraint and seclusion in the medical record includes the following: **C**
- Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior
  - A description of the patient's behavior and the intervention used
  - Any alternatives or other less restrictive interventions attempted
  - The patient's condition or symptom(s) that warranted the use of the restraint or seclusion
  - The patient's response to the intervention(s) used, including the rationale for continued use of the intervention
  - Individual patient assessments and reassessments
  - The intervals for monitoring
  - Revisions to the plan of care
  - The patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion
  - Injuries to the patient
  - Death associated with the use of restraint or seclusion
  - The identity of the physician, clinical psychologist, or other licensed independent practitioner who ordered the restraint or seclusion
  - Orders for restraint or seclusion
  - Notification of the use of restraint or seclusion to the attending physician
  - Consultations
- Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

**Standard PC.03.05.17**

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital trains staff to safely implement the use of restraint or seclusion.

**Elements of Performance for PC.03.05.17**

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|---|---|---|
| <p><b>M</b> 2.</p> <p><b>M</b> 3.</p> <p>4.</p> <p><b>M</b> 5. <b>D</b></p> | <p>For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital trains staff on the use of restraint and seclusion, and assesses their competence, at the following intervals:</p> <ul style="list-style-type: none"> <li>- At orientation</li> <li>- Before participating in the use of restraint and seclusion</li> <li>- On a periodic basis thereafter</li> </ul> <p>For hospitals that use Joint Commission accreditation for deemed status purposes: Based on the population served, staff education, training, and demonstrated knowledge focus on the following:</p> <ul style="list-style-type: none"> <li>- Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion</li> <li>- Use of nonphysical intervention skills</li> <li>- Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition</li> <li>- Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia)</li> <li>- Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary</li> <li>- Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion</li> <li>- Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification (See also PC.03.05.07, EP 1)</li> </ul> <p>For hospitals that use Joint Commission accreditation for deemed status purposes: Individuals providing staff training in restraint or seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion.</p> <p>For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed.</p> | <p><b>C</b></p> <p><b>C</b></p> <p><b>A</b></p> <p><b>C</b></p> |
|---|---|---|

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard PC.03.05.19**

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

**Elements of Performance for PC.03.05.19**

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|----|--|----------|
| 1. | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports the following information to the Centers for Medicare & Medicaid Services (CMS): <ul style="list-style-type: none"><li>- Each death that occurs while a patient is in restraint or seclusion</li><li>- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion</li><li>- Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death</li></ul> Note: In this element of performance "reasonable to assume" includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation. | <b>A</b> |
| 2. | For hospitals that use Joint Commission accreditation for deemed status purposes: The deaths addressed in PC.03.05.19, EP 1 are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.  | <b>A</b> |

**Standard PC.04.01.01**

The hospital has a process that addresses the patient's need for continuing care, treatment, and services after discharge or transfer.

**Elements of Performance for PC.04.01.01**

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|---------------------------|--|----------|
| 1.                        | The hospital describes the reason(s) for and conditions under which the patient is discharged or transferred.  | <b>A</b> |
| 2.                        | The hospital describes the method for shifting responsibility for a patient's care from one clinician, hospital, program, or service to another.   | <b>A</b> |
| 3.                        | The hospital describes the mechanisms for external transfer of the patient.  | <b>A</b> |
| 4.                        | The hospital agrees with the receiving organization about each of their roles to keep the patient safe during transfer.  | <b>A</b> |
| <b>(M)</b> 22.            | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient or the patient's family of his or her freedom to choose among participating Medicare providers and, when possible, respects the patient's and family's preferences when they are expressed. The hospital does not limit the qualified providers that are available to the patient.  | <b>C</b> |
| <b>(M)</b> 23. <b>(D)</b> | For hospitals that use Joint Commission accreditation for deemed status purposes: When the discharge planning evaluation indicates a need for home health care, the hospital includes in the discharge plan a list of participating Medicare home health agencies that are available and serve the patient's geographic area. For patients enrolled in managed care organizations, the hospital lists home health agencies that have a contract with the managed care organization.  | <b>C</b> |
| <b>(M)</b> 24. <b>(D)</b> | For hospitals that use Joint Commission accreditation for deemed status purposes: When the discharge planning evaluation indicates a need for posthospital extended care services, the hospital includes in the discharge plan a list of participating Medicare skilled nursing facilities that are available and in the geographic area requested by the patient. For patients enrolled in managed care organizations, the hospital lists skilled nursing facilities that have a contract with the managed care organization.                                     | <b>C</b> |
| <b>(M)</b> 25.            | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital documents in the patient's medical record that the list of home health agencies or skilled nursing facilities was presented to the patient or to the individual acting on the patient's behalf. The discharge plan identifies disclosable financial interests between the hospital and any home health agency or skilled nursing facility on the list.<br>Note: Disclosure of financial interest is determined in accordance with the provisions in 42 CFR 420.206. | <b>C</b> |
| 26. <b>(D)</b>            | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has written discharge planning policies and procedures applicable to all patients.  | <b>A</b> |

**Standard PC.04.01.03**

The hospital discharges or transfers the patient based on his or her assessed needs and the organization's ability to meet those needs.

**Elements of Performance for PC.04.01.03**








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| <b>M</b> | 1. The hospital begins the discharge planning process early in the patient's episode of care, treatment and services.   | <b>C</b> |
| <b>M</b> | 2. The hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer.   | <b>C</b> |
| <b>M</b> | 3. The patient, the patient's family, licensed independent practitioners, physicians, clinical psychologists, and staff involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer.<br>Note 1: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).<br>Note 2: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the hospital. | <b>C</b> |
| <b>M</b> | 4. Prior to discharge, the hospital arranges or assists in arranging the services required by the patient after discharge in order to meet his or her ongoing needs for care and services.  | <b>C</b> |
|          | 10. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital conducts reassessments of its discharge planning process within its established time frames for reassessment.  | <b>A</b> |
|          | 11. For hospitals that use Joint Commission accreditation for deemed status purposes: The reassessment of the discharge planning process includes a review of discharge plans to determine if the discharge plans meet the needs of patients.   | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard PC.04.01.05**

Before the hospital discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, and services.


**Elements of Performance for PC.04.01.05**

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|  | 1. When the hospital determines the patient's discharge or transfer needs, it promptly shares this information with the patient, and also with the patient's family when it is involved in decision making or ongoing care.                  | <b>C</b>   |
|  | 2. Before the patient is discharged, the hospital informs the patient, and also the patient's family when it is involved in decision making or ongoing care, of the kinds of continuing care, treatment, and services the patient will need. | <b>C</b>   |
|  | 3. Before the patient is discharged or transferred, the hospital provides the patient with information about why he or she is being discharged or transferred.   | <b>C</b>   |
|  | 5. Before the patient is transferred, the hospital provides the patient with information about any alternatives to the transfer.   | <b>C</b>   |
|  | 7. The hospital educates the patient, and also the patient's family when it is involved in decision making or ongoing care, about how to obtain any continuing care, treatment, and services that the patient will need.                     | <b>C</b>   |
|  | 8. The hospital provides written discharge instructions in a manner that the patient and/or the patient's family or caregiver can understand. (See also RI.01.01.03, EP 1)   |  <b>C</b> |

**Standard PC.04.02.01**

When a patient is discharged or transferred, the hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.


**Elements of Performance for PC.04.02.01**

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|  | 1. At the time of the patient's discharge or transfer, the hospital informs other service providers who will provide care, treatment, or services to the patient about the following: <ul style="list-style-type: none"> <li>- The reason for the patient's discharge or transfer</li> <li>- The patient's physical and psychosocial status</li> <li>- A summary of care, treatment, and services it provided to the patient</li> <li>- The patient's progress toward goals</li> <li>- A list of community resources or referrals made or provided to the patient</li> </ul> (See also PC.02.02.01, EP 1) | <b>C</b> |
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**Standard PC.05.01.09**

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital safely provides blood and blood components.

**Elements of Performance for PC.05.01.09**

1.  For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27.  
Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.
2. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27.  
Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.

 **A** **A**



## Performance Improvement

**Standard PI.01.01.01**

The hospital collects data to monitor its performance.

**Elements of Performance for PI.01.01.01**

	1.	The leaders set priorities for data collection. (See also LD.04.04.01, EP 1)	<b>A</b>
	2.	The leaders identify the frequency for data collection. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders that specify the frequency and detail of data collection is the governing body.	<b>A</b>
<b>M</b>	3.	The hospital collects data on the following: Performance improvement priorities identified by leaders. (See also LD.04.04.01, EP 1)	<b>C</b>
	4.	The hospital collects data on the following: Operative or other procedures that place patients at risk of disability or death. (See also LD.04.04.01, EP 2; MS.05.01.01, EP 6)	<b>A</b>
	5.	The hospital collects data on the following: All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.	<b>A</b>
	6.	The hospital collects data on the following: Adverse events related to using moderate or deep sedation or anesthesia. (See also LD.04.04.01, EP 2)	<b>A</b>
	7.	The hospital collects data on the following: The use of blood and blood components. (See also LD.04.04.01, EP 2)	<b>A</b>
	8.	The hospital collects data on the following: All reported and confirmed transfusion reactions. (See also LD.04.04.01, EP 2; LD.04.04.05, EP 6)	<b>A</b>
	11.	The hospital collects data on the following: The results of resuscitation. (See also LD.04.04.01, EP 2)	<b>A</b>
	12.	The hospital collects data on the following: Behavior management and treatment. (See also LD.04.04.01, EP 2)	<b>A</b>
	14.	The hospital collects data on the following: Significant medication errors. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)	<b>A</b>
	15.	The hospital collects data on the following: Significant adverse drug reactions. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)	<b>A</b>
<b>M</b>	16.	The hospital collects data on the following: Patient perception of the safety and quality of care, treatment, and services.	<b>C</b>
	30.	The hospital considers collecting data on the following: - Staff opinions and needs - Staff perceptions of risk to individuals - Staff suggestions for improving patient safety - Staff willingness to report adverse events	<b>A</b>

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

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| 38. | The hospital evaluates the effectiveness of all fall reduction activities including assessment, interventions, and education.<br>Note: Examples of outcome indicators to use in the evaluation include number of falls and number and severity of fall-related injuries.  | <b>A</b> |
| 39. | The hospital collects data on the effectiveness of its response to change or deterioration in a patient's condition.<br>Note: Measures may include length of stay, response time for responding to changes in vital signs, cardiopulmonary arrest, respiratory arrest, and mortality rates before and after implementation of an early intervention plan. | <b>A</b> |

**Standard PI.02.01.01**

The hospital compiles and analyzes data.

**Elements of Performance for PI.02.01.01**

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| <b>M</b> | 1. | The hospital compiles data in usable formats.  | <b>C</b> |
|          | 2. | The hospital identifies the frequency for data analysis.   | <b>A</b> |
| <b>M</b> | 3. | The hospital uses statistical tools and techniques to analyze and display data.  | <b>C</b> |
|          | 4. | The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.  | <b>A</b> |
|          | 5. | The hospital compares data with external sources, when available.  | <b>A</b> |
|          | 6. | The hospital analyzes data from ORYX core measures that, over three or more consecutive quarters for the same measure, identify the hospital as a negative outlier.  | <b>A</b> |
|          | 7. | The hospital analyzes its organ procurement conversion rate data as provided by the organ procurement organization (OPO).<br>(See also TS.01.01.01, EP 1)<br>Note: Conversion rate is defined as the number of actual organ donors over the number of eligible donors defined by the OPO, expressed as a percentage. | <b>A</b> |
|          | 8. | The hospital uses the results of data analysis to identify improvement opportunities. (See also LD.03.02.01, EP 5; PI.03.01.01, EP 1)  | <b>A</b> |

**Standard PI.03.01.01**

The hospital improves performance on an ongoing basis.

**Elements of Performance for PI.03.01.01**

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| 1. | Leaders prioritize the identified improvement opportunities. (See also PI.02.01.01, EP 8; MS.05.01.01, EPs 1-11)     | <b>A</b> |
| 2. | The hospital takes action on improvement priorities. (See also MS.05.01.01, EPs 1-11)                                | <b>A</b> |
| 3. | The hospital evaluates actions to confirm that they resulted in improvements. (See also MS.05.01.01, EPs 1-11)       | <b>A</b> |
| 4. | The hospital takes action when it does not achieve or sustain planned improvements. (See also MS.05.01.01, EPs 1-11) | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard PI.04.01.01**

The hospital uses data from clinical/service screening indicators and human resource screening indicators to assess and continuously improve staffing effectiveness.

Note: This standard is not in effect at this time.

**Elements of Performance for PI.04.01.01**

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| 1. | <p>The hospital identifies two or more inpatient units for which data on staffing effectiveness are to be collected.</p> <p>Note 1: If the hospital has only one inpatient unit, the hospital collects data for that single unit.</p> <p>Note 2: This element of performance is not in effect at this time.</p>  | <b>A</b> |
| 2. | <p>The hospital identifies the inpatient units for staffing effectiveness data collection based on an assessment of relevant information or risk including the following:</p> <ul style="list-style-type: none"> <li>- Type of setting</li> <li>- Patient population served</li> <li>- Knowledge about staffing issues likely to affect patient safety or quality of care</li> <li>- Existing data (for example, incident logs, sentinel event data, performance improvement reports)</li> <li>- Input from clinical staff who provide patient care</li> </ul> <p>Note 1: If the hospital has only one unit, it need not apply these criteria.</p> <p>Note 2: This element of performance is not in effect at this time.</p> | <b>A</b> |
| 3. | <p>A minimum set of four indicators is selected for each of the identified inpatient units.</p> <p>Note 1: Hospitals may choose the same set, the same set in part, or completely different measure sets for each identified unit.</p> <p>Note 2: This element of performance is not in effect at this time.</p>   | <b>A</b> |
| 4. | <p>Of the four indicators required for each unit, two must be clinical/service indicators and two must be human resource indicators.</p> <p>Note: This element of performance is not in effect at this time.</p>   | <b>A</b> |
| 5. | <p>One of the human resource indicators and one of the clinical/service indicators for each population and setting must be selected from The Joint Commission's list of approved indicators. (Refer to the "Staffing Effectiveness Indicators" (SEI) chapter.)</p> <p>Note 1: Additional indicators may be selected from among the hospital's own indicators.</p> <p>Note 2: The Joint Commission's list of approved screening indicators consists of National Quality Forum (NQF) nursing sensitive patient care measures and Joint Commission consensus measures.</p> <p>Note 3: This element of performance is not in effect at this time.</p>  | <b>A</b> |
| 6. | <p>The hospital selects the indicators for each unit based on an assessment of relevant information or risk including the following:</p> <ul style="list-style-type: none"> <li>- Type of setting</li> <li>- Patient population served</li> <li>- Knowledge about staffing issues likely to affect patient safety or quality of care</li> <li>- Existing data (for example, incident logs, sentinel event data, performance improvement reports)</li> <li>- Input from clinical staff who provide patient care</li> </ul> <p>Note: This element of performance is not in effect at this time.</p>  | <b>A</b> |

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| 7.  | <p>The human resource indicators for all identified units include all nursing staff (including registered nurses, licensed practical nurses, and nursing assistants or aides).</p> <p>Note 1: Decisions regarding stratification of data by discipline are left to the hospital. When the hospital chooses to include other practitioner groups in addition to nursing staff, this decision is based on the impact such care/service providers have on patient outcomes.</p> <p>Note 2: This element of performance is not in effect at this time.</p>  | <b>A</b> |
| 8.  | <p>When the hospital chooses indicators for staffing effectiveness, it performs the following:</p> <ul style="list-style-type: none"> <li>- Defines the numerator and denominator</li> <li>- Standardizes the data element definitions for each indicator, including those indicators applied in more than one setting</li> <li>- Determines acceptable ranges, parameters, or trigger levels</li> </ul> <p>Note 1: Acceptable ranges, parameters, or trigger levels may be reflective of past performance, expert opinion, expert literature, or a combination of these. The ranges, parameters, or trigger levels should be reasonable goals that are possible to attain. When desired ranges, parameters, or trigger levels are not met, an investigation into the cause(s) is needed.</p> <p>Note 2: This element of performance is not in effect at this time.</p> | <b>A</b> |
| 9.  | <p>For each inpatient unit selected the hospital analyzes the collected data for all indicators, investigates to identify any staffing effectiveness issues when data varies from expected, and takes action to improve.</p> <p>Note: This element of performance is not in effect at this time.</p>  | <b>A</b> |
| 10. | <p>The hospital reports at least annually to the leaders on the status of staffing effectiveness and any actions taken to resolve identified problems.</p> <p>Note: This element of performance is not in effect at this time.</p>  | <b>A</b> |






# Record of Care, Treatment, and Services

**Standard RC.01.01.01**

The hospital maintains complete and accurate medical records for each individual patient.

**Elements of Performance for RC.01.01.01**

	1.	The hospital defines the components of a complete medical record.	<b>A</b>
<b>M</b>	4.	The medical record contains information unique to the patient, which is used for patient identification.	<b>C</b>
<b>M</b>	5.	The medical record contains the information needed to support the patient's diagnosis and condition.	<b>C</b>
<b>M</b>	6.	The medical record contains the information needed to justify the patient's care, treatment, and services.	<b>C</b>
<b>M</b>	7.	The medical record contains information that documents the course and result of the patient's care, treatment, and services.	<b>C</b>
<b>M</b>	8.	The medical record contains information about the patient's care, treatment, and services that promotes continuity of care among providers.	 <b>C</b>
	9.	The hospital uses standardized formats to document the care, treatment, and services it provides to patients.	<b>A</b>
<b>M</b>	11.	All entries in the medical record are dated.	<b>C</b>
	12.	The hospital tracks the location of all components of the medical record.	<b>A</b>
<b>M</b>	13.	The hospital assembles or makes available in a summary in the medical record all information required to provide patient care, treatment, and services. (See also MM.01.01.01, EP 1)	<b>C</b>
<b>M</b>	19.	For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.	<b>C</b>

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard RC.01.02.01**

Entries in the medical record are authenticated.

**Elements of Performance for RC.01.02.01**

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| <p><b>M</b> 1.</p> <p>2.</p> <p><b>M</b> 3.</p> <p><b>M</b> 4.</p> | <p>Only authorized individuals make entries in the medical record.</p> <p>The hospital defines the types of entries in the medical record made by nonindependent practitioners that require countersigning, in accordance with law and regulation.</p> <p>The author of each medical record entry is identified in the medical record.</p> <p>Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author.<br/>           Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.<br/>           Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped.<br/>           Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: For a five-year period following January 26, 2007, all orders, including verbal orders, are dated and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient (as specified at 42 CFR 482.12(c)), and who, in accordance with hospital policy and law and regulation, is authorized to write orders.</p> | <p><b>C</b></p> <p><b>A</b></p> <p><b>C</b></p> <p><b>C</b></p> |
| <p>5.</p>  | <p>The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it.</p>  | <p><b>A</b></p>   |

**Standard RC.01.03.01**

Documentation in the medical record is entered in a timely manner.

**Elements of Performance for RC.01.03.01**

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| <p>1. <b>D</b></p> <p>2.</p> <p><b>M</b> 3.</p> <p><b>M</b> 4.</p> | <p>The hospital has a written policy that requires timely entry of information into the medical record. (See also PC.01.02.03, EP 1)</p> <p>The hospital defines the time frame for completion of the medical record, which does not exceed 30 days after the patient's discharge.</p> <p>The hospital implements its policy requiring timely entry of information into the patient's medical record. (See also PC.01.02.03, EP 2)</p> <p>For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital records the patient's medical history and physical examination, including updates, in the medical record within 24 hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services.</p> | <p><b>A</b></p> <p><b>A</b></p> <p><b>C</b></p> <p><b>C</b></p> |
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**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard RC.01.04.01**

The hospital audits its medical records.

**Elements of Performance for RC.01.04.01**

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| <p><b>M</b> 1. The hospital conducts an ongoing review of medical records at the point of care, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information. (See also MS.05.01.03, EP 3)</p> <p>3. The hospital measures its medical record delinquency rate at regular intervals, but no less than every three months. (See also MS.05.01.03, EP 3)</p> <p>4. <b>D</b> The medical record delinquency rate averaged from the last four quarterly measurements is 50% or less of the average monthly discharge (AMD) rate. Each individual quarterly measurement is no greater than 50% of the AMD rate.<br/>         Note: To calculate the quarterly and annual average medical record delinquency rate, the Medical Record Statistics Form can be used. This form is available at <a href="http://www.jointcommission.org/NR/rdonlyres/C0A0E231-B35E-4B76-8DE8-050AA5E5418F/0/2008HospitalMRStatFormRev11708.doc">http://www.jointcommission.org/NR/rdonlyres/C0A0E231-B35E-4B76-8DE8-050AA5E5418F/0/2008HospitalMRStatFormRev11708.doc</a>.</p> | <p><b>C</b></p> <p><b>A</b></p> <p><b>A</b></p> |
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**Standard RC.01.05.01**

The hospital retains its medical records.

**Elements of Performance for RC.01.05.01**


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| <p>1. <b>D</b> The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation.</p> <p>8. Original medical records are not released unless the hospital is responding to law and regulation.</p> | <p><b>A</b></p> <p><b>A</b></p> |
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**Standard RC.02.01.01**

The medical record contains information that reflects the patient's care, treatment, and services.

**Elements of Performance for RC.02.01.01**













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| <b>M</b> | 1. The medical record contains the following demographic information: <ul style="list-style-type: none"> <li>- The patient's name, address, and date of birth, and the name of any legally authorized representative</li> <li>- The patient's sex</li> <li>- The legal status of any patient receiving behavioral health care services</li> <li>- The patient's language and communication needs</li> </ul>  | <b>C</b>  |
| <b>M</b> | 2. The medical record contains the following clinical information: <ul style="list-style-type: none"> <li>- The reason(s) for admission for care, treatment, and services</li> <li>- The patient's initial diagnosis, diagnostic impression(s), or condition(s)</li> <li>- Any findings of assessments and reassessments (See also PC.01.02.01, EPs 1 and 4; PC.03.01.03, EPs 1 and 8)</li> <li>- Any allergies to food</li> <li>- Any allergies to medications</li> <li>- Any conclusions or impressions drawn from the patient's medical history and physical examination</li> <li>- Any diagnoses or conditions established during the patient's course of care, treatment, and services</li> <li>- Any consultation reports</li> <li>- Any observations relevant to care, treatment, and services</li> <li>- The patient's response to care, treatment, and services</li> <li>- Any emergency care, treatment, and services provided to the patient before his or her arrival</li> <li>- Any progress notes</li> <li>- All orders</li> <li>- Any medications ordered or prescribed</li> <li>- Any medications administered, including the strength, dose, and route</li> <li>- Any access site for medication, administration devices used, and rate of administration</li> <li>- Any adverse drug reactions</li> <li>- Treatment goals, plan of care, and revisions to the plan of care (See also PC.01.03.01, EPs 1 and 23)</li> <li>- Results of diagnostic and therapeutic tests and procedures</li> <li>- Any medications dispensed or prescribed on discharge</li> <li>- Discharge diagnosis</li> <li>- Discharge plan and discharge planning evaluation</li> </ul> <p>(See also PC.01.02.03, EPs 6-8)</p> | <div style="display: inline-block; border: 1px solid black; padding: 2px; text-align: center;">3</div> <b>C</b> |





- M** 4. As needed to provide care, treatment, and services, the medical record contains the following additional information:  **C**
- Any advance directives (See also RI.01.05.01, EP 11)
  - Any informed consent, when required by hospital policy (See also RI.01.03.01, EP 13)
- Note: The properly executed informed consent is placed in the patient's medical record prior to surgery, except in emergencies.
- Any records of communication with the patient, such as telephone calls or e-mail
  - Any patient-generated information
- M** 21. The medical record of a patient who receives urgent or immediate care, treatment, and services contains all of the following: **C**
- The time and means of arrival
  - Indication that the patient left against medical advice, when applicable
  - Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services
  - A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment, or services

**Standard RC.02.01.03**

The patient's medical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.

**Elements of Performance for RC.02.01.03**

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|   | 1. | The hospital documents in the patient's medical record any operative or other high-risk procedure and/or the administration of moderate or deep sedation or anesthesia.   |  <b>A</b>   |
|    | 2. | A licensed independent practitioner involved in the patient's care documents the provisional diagnosis in the medical record before an operative or other high-risk procedure is performed.   | <b>C</b>   |
|    | 3. | The patient's medical history and physical examination are recorded in the medical record before an operative or other high-risk procedure is performed. (See also PC.01.02.03, EPs 4 and 5)  |  <b>C</b>   |
|    | 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.<br>Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital.<br>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. |  <b>C</b>   |
|    | 6. | The operative or other high-risk procedure report includes the following information:<br>- The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)<br>- The name of the procedure performed<br>- A description of the procedure<br>- Findings of the procedure<br>- Any estimated blood loss<br>- Any specimen(s) removed<br>- The postoperative diagnosis  |  <b>C</b>   |
|  | 7. | When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.   |  <b>C</b> |
|  | 8. | The medical record contains the following postoperative information:<br>- The patient's vital signs and level of consciousness (See also PC.03.01.05, EP 1; PC.03.01.07, EP 1)<br>- Any medications, including intravenous fluids and any administered blood, blood products, and blood components<br>- Any unanticipated events or complications (including blood transfusion reactions) and the management of those events  |  <b>C</b> |



**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

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| <p><b>M</b> 9.</p> <p><b>M</b> 10.</p> <p><b>M</b> 11.</p> <p><b>M</b> 15. <b>D</b></p> | <p>The medical record contains documentation that the patient was discharged from the post-sedation or postanesthesia care area either by the licensed independent practitioner responsible for his or her care or according to discharge criteria. (See also PC.03.01.07, EP 4)</p> <p>The medical record contains documentation of the use of approved discharge criteria that determine the patient's readiness for discharge. (See also PC.03.01.07, EP 4)</p> <p>The postoperative documentation contains the name of the licensed independent practitioner responsible for discharge.</p> <p>For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a complete and up-to-date operating room register that includes the following:</p> <ul style="list-style-type: none"> <li>- Patient's name</li> <li>- Patient's hospital identification number</li> <li>- Date of operation</li> <li>- Inclusive or total time of operation</li> <li>- Name of surgeon and any assistants</li> <li>- Name of nursing personnel</li> <li>- Type of anesthesia used and name of person administering it</li> <li>- Operation performed</li> <li>- Pre- and postoperative diagnosis</li> <li>- Age of patient</li> </ul> <p>Note: A postoperative summary may be considered equivalent if all items listed in this element of performance are included.</p> | <p><b>C</b></p> <p><b>C</b></p> <p><b>C</b></p> <p><b>C</b></p> |
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**Standard RC.02.01.05**

For hospitals that do not use accreditation for deemed status purposes: The medical record contains documentation of the use of restraint and/or seclusion.

**Elements of Performance for RC.02.01.05**

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|  | 1. For hospitals that do not use accreditation for deemed status purposes: The hospital documents the use of restraint for non-behavioral health purposes in the medical record, including the following: <ul style="list-style-type: none"><li>- Orders for use</li><li>- Results of patient monitoring</li><li>- Reassessment</li><li>- Unanticipated changes in the patient's condition</li></ul> (See also PC.03.02.03, EP 1; PC.03.02.07, EPs 1 and 2) | <b>C</b> |
|  | 2. For hospitals that do not use accreditation for deemed status purposes: The hospital documents any use of restraint protocol(s) for non-behavioral health purposes in the medical record. (See also PC.03.02.05, EPs 1 and 11)   | <b>C</b> |

- M** 3. For hospitals that do not use accreditation for deemed status purposes: The hospital documents the use of restraint and/or seclusion for behavioral health purposes in the medical record, including the following: **C**
- Each episode of restraint and/or seclusion
  - The circumstances that led to the use of restraint and/or seclusion
  - Consideration or failure of nonphysical interventions
  - The rationale for the type of physical intervention used
  - Written orders for the use of restraint and/or seclusion (See also PC.03.03.13, EPs 1-3)
  - Each verbal order received from a licensed independent practitioner (See also PC.03.03.17, EP 1)
  - Each in-person evaluation and reevaluation of the patient
  - Each 15-minute assessment of the patient's status (See also PC.03.03.07, EP 5)
  - Continuous monitoring of the patient (See also PC.03.03.25, EPs 1 and 2)
  - Any preexisting medical conditions or any physical disabilities that would place the patient at greater risk during restraint and/or seclusion
  - Any history of sexual or physical abuse that would place the patient at greater psychological risk during restraint and/or seclusion
  - That the patient and/or the patient's family was informed of the hospital's policy on the use of behavioral restraint and/or seclusion
  - That the patient's family was notified of the use of restraint and/or seclusion
  - Behavior criteria for discontinuing restraint and/or seclusion
  - That the patient was informed of the behavior criteria he or she needed to meet in order for restraint and/or seclusion to be discontinued
  - Assistance provided to the patient to help him or her meet the behavior criteria for discontinuing the use of restraint and/or seclusion
  - Debriefing the patient with staff following an episode of restraint and/or seclusion (See also PC.03.03.29, EP 1)
  - Any injuries the patient sustained and the treatment for these injuries
  - The patient's death, should this occur while the patient is under the care of the hospital
4. For hospitals that do not use accreditation for deemed status purposes: The method(s) used to document restraint and/or seclusion facilitates the collection and analysis of data for performance improvement activities. **A**

**Standard RC.02.01.07**

The medical record contains a summary list for each patient who receives continuing ambulatory care services.

**Elements of Performance for RC.02.01.07**

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| <b>M</b> | 1. A summary list is initiated for the patient by his or her third visit.  | <b>C</b> |
| <b>M</b> | 2. The patient's summary list contains the following information:<br>- Any significant medical diagnoses and conditions<br>- Any significant operative and invasive procedures<br>- Any adverse or allergic drug reactions<br>- Any current medications, over-the-counter medications, and herbal preparations | <b>C</b> |
| <b>M</b> | 3. The patient's summary list is updated whenever there is a change in diagnoses, medications, or allergies to medications, and whenever a procedure is performed.   | <b>C</b> |
| <b>M</b> | 4. The summary list is readily available to practitioners who need access to the information of patients who receive continuing ambulatory care services in order to provide care, treatment, and services.  | <b>C</b> |

**Standard RC.02.03.07**

Qualified staff receive and record verbal orders.

**Elements of Performance for RC.02.03.07**

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| <b>D</b> | 1. The hospital identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation.  | <b>A</b> |
| <b>M</b> | 2. Only authorized staff receive and record verbal orders.  | <b>C</b> |
| <b>M</b> | 3. Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders.  | <b>C</b> |
| <b>M</b> | 4. Verbal orders are authenticated within the time frame specified by law and regulation.<br>Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: If there is no state law that designates a specific time frame for authentication of verbal orders, the verbal orders are authenticated within 48 hours.<br>Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: In some instances, the ordering practitioner may not be able to authenticate his or her verbal order (for example, the ordering practitioner gives a verbal order that is written and transcribed, and then he or she is "off duty" for the weekend or an extended period of time). In such cases, for a temporary period expiring on January 26, 2012, it is acceptable for another practitioner who is responsible for the patient's care to authenticate the verbal order of the ordering practitioner. | <b>C</b> |
| <b>M</b> | 6. For hospitals that use Joint Commission accreditation for deemed status purposes: Documentation of verbal orders includes the time the verbal order was received.  | <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard RC.02.04.01**

The hospital documents the patient's discharge information.

**Elements of Performance for RC.02.04.01**

- M** 3. In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following:
- The reason for hospitalization
  - The procedures performed
  - The care, treatment, and services provided
  - The patient's condition and disposition at discharge
  - Information provided to the patient and family
  - Provisions for follow-up care
- Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.
- Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.











# Rights and Responsibilities of the Individual

**Standard RI.01.01.01**

The hospital respects, protects, and promotes patient rights.







**Elements of Performance for RI.01.01.01**





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| 1.  |  The hospital has written policies on patient rights.   | <b>A</b> |
| 2.  | The hospital informs the patient of his or her rights. (See also RI.01.01.03, EPs 1-3)   | <b>A</b> |
|  | 4. The hospital treats the patient in a dignified and respectful manner that supports his or her dignity.  | <b>C</b> |
|  | 5. The hospital respects the patient's right to and need for effective communication. (See also RI.01.01.03, EP 1)   | <b>C</b> |
|  | 6. The hospital respects the patient's cultural and personal values, beliefs, and preferences.   | <b>C</b> |
|  | 7. The hospital respects the patient's right to privacy. (See also IM.02.01.01, EPs 1-5)<br>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. | <b>C</b> |
| 8.  | The hospital respects the patient's right to pain management. (See also HR.01.04.01, EP 4; PC.01.02.07, EP 1; MS.03.01.03, EP 2)   | <b>A</b> |
|  | 9. The hospital accommodates the patient's right to religious and other spiritual services.  | <b>C</b> |
| 10.   | The hospital allows the patient to access, request amendment to, and obtain information on disclosures of his or her health information, in accordance with law and regulation.  | <b>A</b> |

**Standard RI.01.01.03**

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

**Elements of Performance for RI.01.01.03**

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|  | 1. The hospital provides information in a manner tailored to the patient's age, language, and ability to understand. (See also RI.01.01.01, EPs 2 and 5; PC.04.01.05, EP 8)      |  <b>C</b> |
|  | 2. The hospital provides interpreting and translation services, as necessary. (See also RI.01.01.01, EP 2)   |  <b>C</b> |
|  | 3. The hospital 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) |  <b>C</b> |






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**Standard RI.01.02.01**

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

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

**Elements of Performance for RI.01.02.01**

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| 1.  | The hospital involves the patient in making decisions about his or her care, treatment, and services, including the right to have his or her own physician promptly notified of his or her admission to the hospital.  |  <b>A</b> |
| 2.  |  The hospital provides the patient with written information about the right to refuse care, treatment, and services.  | <b>A</b>   |
| 3.  | The hospital respects the patient's right to refuse care, treatment, and services, in accordance with law and regulation.  |  <b>A</b> |
| 6.  | When a patient is unable to make decisions about his or her care, treatment, and services, the hospital involves a surrogate decision-maker in making these decisions. (See also RI.01.03.01, EP 6)  |  <b>A</b> |
| 7.  | When a surrogate decision-maker is responsible for making care, treatment, and services decisions, the hospital respects the surrogate decision-maker's right to refuse care, treatment, and services on the patient's behalf, in accordance with law and regulation.  |  <b>A</b> |
| 8.  | The hospital involves the patient's family in care, treatment, and services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.   | <b>A</b>   |
| 20. | The hospital provides the patient or surrogate decision-maker with the information about the outcomes of care, treatment, and services that the patient needs in order to participate in current and future health care decisions.   | <b>A</b>   |
| 21. | The hospital informs the patient or surrogate decision-maker about unanticipated outcomes of care, treatment, and services that relate to sentinel events considered reviewable by The Joint Commission. (Refer to the "Sentinel Events" (SE) chapter for a definition of reviewable sentinel events.)   | <b>A</b>   |
| 22. | The licensed independent practitioner responsible for managing the patient's care, treatment, and services, or his or her designee, informs the patient about unanticipated outcomes of care, treatment, and services related to sentinel events when the patient is not already aware of the occurrence or when further discussion is needed.<br>Note: In settings where there is no licensed independent practitioner, the staff member responsible for managing the care of the patient is responsible for sharing information about such outcomes. | <b>A</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required






**Standard RI.01.03.01**





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

**Rationale for RI.01.03.01**

Obtaining informed consent presents an opportunity to establish a mutual understanding between the patient and the licensed independent practitioner or other licensed practitioners with privileges about the care, treatment, and services that the patient will receive. Informed consent is not merely a signed document. It is a process that considers patient needs and preferences, compliance with law and regulation, and patient education. Utilizing the informed consent process helps the patient to participate fully in decisions about his or her care, treatment, and services.

**Elements of Performance for RI.01.03.01**

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| 1.     | The hospital has a written policy on informed consent.   | <b>A</b>   |
| 2.  | The hospital's written policy identifies the specific care, treatment, and services that require informed consent, in accordance with law and regulation.  | <b>A</b>   |
| 3.  | The hospital's written policy describes circumstances that would allow for exceptions to obtaining informed consent.   | <b>A</b>   |
| 4.  | The hospital's written policy describes the process used to obtain informed consent.   | <b>A</b>   |
| 5.  | The hospital's written policy describes how informed consent is documented in the patient record.<br>Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record.   | <b>A</b>   |
| 6.  | The hospital's written policy describes when a surrogate decision-maker may give informed consent. (See also RI.01.02.01, EP 6)  | <b>A</b>   |
| 7.  | The informed consent process includes a discussion about the patient's proposed care, treatment, and services.   |  <b>A</b>   |
| 9.  | The informed consent process includes a discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.   |  <b>A</b>   |
| 11.   | The informed consent process includes a discussion about reasonable alternatives to the patient's proposed care, treatment, and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.  |  <b>A</b> |
| 12.   | The informed consent process includes a discussion about any circumstances under which information about the patient must be disclosed or reported.<br>Note: Such circumstances may include requirements for disclosure of information regarding cases of HIV, tuberculosis, viral meningitis, and other diseases that are reported to organizations such as health departments or the Centers for Disease Control and Prevention. | <b>A</b>   |
|  13. | Informed consent is obtained in accordance with the hospital's policy and processes and, except in emergencies, prior to surgery. (See also RC.02.01.01, EP 4)   | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard RI.01.03.03**

The hospital honors the patient's right to give or withhold informed consent to produce or use recordings, films, or other images of the patient for purposes other than his or her care.

**Elements of Performance for RI.01.03.03**

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|-------------|--|----------|
| 1. <b>D</b> | Occasionally, hospitals make and use 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). When this occurs, and the patient is able to give consent, the hospital obtains and documents informed consent prior to producing the recordings, films, or other images.<br>Note: The term recordings, films, or other images refers to photographic, video, electronic, or audio media. | <b>A</b> |
| 2. <b>D</b> | When recordings, films, or other images of patients are made for external use, the hospital obtains and documents informed consent prior to producing the recordings, films, or other images. This informed consent includes an explanation of how the recordings, films, or other images will be used.<br>Note: Recordings, films, or other images made for external use are those that will be heard or seen by the public (for example, commercial filming, television programs, or marketing materials).               | <b>A</b> |
| 3.          | When a patient is unable to give informed consent prior to the production of recordings, films, or other images, the production may occur provided that doing so is permitted by the hospital's written policy, which is established through an ethical mechanism (for example, an ethics committee) that includes community input.  | <b>A</b> |
| 4.          | When a patient is unable to give informed consent prior to the production of recordings, films, or other images, the product remains in the hospital's possession and is not used for any purpose until and unless informed consent is obtained.   | <b>A</b> |
| 5.          | When a patient is unable to give informed consent prior to the production of recordings, films, or other images and informed consent for use cannot subsequently be obtained, the hospital either destroys the product or removes the nonconsenting patient from the product.  | <b>A</b> |
| 6.          | The hospital informs the patient of his or her right to request cessation of the production of the recordings, films, or other images.   | <b>A</b> |
| 7. <b>D</b> | Before engaging in the production of recordings, films, or other images of patients, anyone who is not already bound by the hospital's confidentiality policy signs a confidentiality statement to protect the patient's identity and confidential information.  | <b>A</b> |
| <b>M</b> 8. | The organization accommodates the patient's right to rescind consent before the recording, film, or image is used.   | <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard RI.01.03.05**

The hospital protects the patient and respects his or her rights during research, investigation, and clinical trials.



**Elements of Performance for RI.01.03.05**

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|----------------------|---|----------|
| 1.                   | The hospital reviews all research protocols and weighs the risks and benefits to the patient participating in the research.   | <b>A</b> |
| 2.                   | To help the patient determine whether or not to participate in research, investigation, or clinical trials, the hospital provides the patient with all of the following information:<br>- An explanation of the purpose of the research<br>- The expected duration of the patient's participation<br>- A clear description of the procedures to be followed<br>- A statement of the potential benefits, risks, discomforts, and side effects<br>- Alternative care, treatment, and services available to the patient that might prove advantageous to the patient | <b>A</b> |
| 3.                   | The hospital informs the patient that refusing to participate in research, investigation, or clinical trials, or discontinuing participation at any time will not jeopardize his or her access to care, treatment, and services unrelated to the research.  | <b>A</b> |
| <b>M</b> 4. <b>D</b> | The hospital documents the following in the research consent form: That the patient received information to help determine whether or not to participate in the research, investigation, or clinical trials.  | <b>C</b> |
| 5. <b>D</b>          | The hospital documents the following in the research consent form: That the patient was informed that refusing to participate in research, investigation, or clinical trials, or discontinuing participation at any time will not jeopardize his or her access to care, treatment, and services unrelated to the research.  | <b>C</b> |
| 6. <b>D</b>          | The hospital documents the following in the research consent form: The name of the person who provided the information and the date the form was signed.  | <b>C</b> |
| 7. <b>D</b>          | The research consent form describes the patient's right to privacy, confidentiality, and safety.  | <b>A</b> |
| <b>M</b> 9. <b>D</b> | The hospital keeps all information given to subjects in the medical record or research file along with the consent forms.   | <b>C</b> |

**Standard RI.01.04.01**

The hospital respects the patient's right to receive information about the individual(s) responsible for, as well as those providing, his or her care, treatment, and services.

















**Elements of Performance for RI.01.04.01**





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|---|----|--|---|
|  | 1. | The hospital informs the patient of the name of the physician, clinical psychologist, or other practitioner who has primary responsibility for his or her care, treatment, or services.<br>Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). | C |
|  | 2. | The hospital informs the patient of the name of the physician(s), clinical psychologist(s), or other practitioner(s) who will provide his or her care, treatment, and services.<br>Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).         | C |

**Standard RI.01.05.01**

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

**Elements of Performance for RI.01.05.01**

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|---|---|--|
| 1.  |  The hospital has written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services, in accordance with law and regulation.                          | <b>A</b>   |
| 4.  | For outpatient hospital settings: The hospital's written advance directive policies specify whether the hospital will honor advance directives.<br>Note: It is up to the hospital to determine in which of its outpatient settings, if any, it will honor advance directives.                         | <b>A</b>   |
|    | 5. The hospital implements its advance directive policies.  |  <b>C</b> |
|    | 6.  The hospital provides patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services.                                     | <b>C</b>   |
|    | 8. Upon admission, the hospital provides the patient with information on the extent to which the hospital is able, unable, or unwilling to honor advance directives.  | <b>C</b>   |
|    | 9.  The hospital documents whether or not the patient has an advance directive.  | <b>C</b>   |
|    | 10. Upon request, the hospital refers the patient to resources for assistance in formulating advance directives.  | <b>C</b>   |
|    | 11. Staff and licensed independent practitioners who are involved in the patient's care, treatment, and services are aware of whether or not the patient has an advance directive. (See also RC.02.01.01, EP 4)   | <b>C</b>   |
| 12.   | The hospital honors the patient's right to formulate or review and revise his or her advance directives.  | <b>A</b>   |
| 13.   | The hospital honors advance directives, in accordance with law and regulation and the hospital's capabilities.  |  <b>A</b> |
|   | 15.  The hospital documents the patient's wishes concerning organ donation when he or she makes such wishes known to the hospital or when required by the hospital's policy, in accordance with law and regulation. | <b>C</b>   |
|  | 16. The hospital honors the patient's wishes concerning organ donation within the limits of the hospital's capability and in accordance with law and regulation.  | <b>C</b>   |
| 17.   | The existence or lack of an advance directive does not determine the patient's right to access care, treatment, and services.   | <b>A</b>   |
|  | 19. For outpatient hospital settings: The hospital communicates its policy on advance directives upon request or when warranted by the care, treatment, and services provided.  | <b>C</b>   |
|  | 20. For outpatient hospital settings: Upon request, the hospital refers patients to resources for assistance with formulating advance directives.   | <b>C</b>   |



**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

21. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital defines how it obtains and documents permission to perform an autopsy.

**A****Standard RI.01.06.03**

The patient has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.








**Elements of Performance for RI.01.06.03**





1. The hospital determines how it will protect the patient from neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services. **A**
2. The hospital evaluates all allegations, observations, and suspected cases of neglect, exploitation, and abuse that occur within the hospital. (See also PC.01.02.09, EP 1)  **A**
3. The hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events, or as required by law. (See also PC.01.02.09, EPs 6 and 7)  **A**

**Standard RI.01.06.05**

The patient has the right to an environment that preserves dignity and contributes to a positive self-image.

**Elements of Performance for RI.01.06.05**

-  1. The hospital's environment of care supports the patient's positive self-image and dignity. **C**
-  2. For hospital settings that provide longer-term care (more than 30 days): The number of patients in a room is based on the patients' ages, developmental levels, clinical conditions, and diagnosis needs, and the hospital's goals. **C**
-  4. The hospital allows the patient to keep and use personal clothing and possessions, unless this infringes on others' rights or is medically or therapeutically contraindicated, based on the setting or service. **C**
-  15. The hospital offers patients telephone and mail service, based on the setting and population. **C**
-  16. The hospital provides access to telephones for patients who desire private telephone conversations in a private space, based on the setting and population. **C**
17. For hospital settings that provide longer-term care (more than 30 days): When the hospital restricts a patient's visitors, mail, telephone calls, or other forms of communication, the restrictions are determined with the patient's participation and, when appropriate, his or her family's participation. **A**
-  18. For hospital settings that provide longer-term care (more than 30 days): When the hospital restricts a patient's visitors, mail, telephone calls, or other forms of communication, the restrictions and their justification are documented in the medical record. **C**
-  19. For hospital settings that provide longer-term care (more than 30 days): When the hospital restricts a patient's visitors, mail, telephone calls, or other forms of communication, the restrictions are evaluated for therapeutic effectiveness. **C**

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

**Standard RI.01.07.01**

The patient and his or her family have the right to have complaints reviewed by the hospital.

**Rationale for RI.01.07.01**

A business is often judged by how it handles dissatisfied customers; the same is true for health care organizations. Addressing complaints promptly helps to satisfy the needs of patients and their families during a vulnerable time in their lives, and may also prevent adverse events from occurring in the organization. Complaints can range from the straightforward, such as the temperature of a patient's room, to the complex, such as the patient's care being adversely impacted by practitioners' failure to effectively communicate. Regardless of the complexity of the complaint, patients and their families expect the organization to work toward a resolution as quickly as possible.

**Elements of Performance for RI.01.07.01**

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|-----------------------|--|----------|
| 1.                    | The hospital establishes a complaint resolution process. (See also LD.04.01.07, EP 1; MS.09.01.01, EP 1)<br>Note: The governing body is responsible for the effective operation of the complaint resolution process unless it delegates this responsibility in writing to a complaint resolution committee.  | <b>A</b> |
| <b>M</b> 2.           | The hospital informs the patient and his or her family about the complaint resolution process. (See also MS.09.01.01, EP 1)  | <b>C</b> |
| <b>M</b> 4.           | The hospital reviews and, when possible, resolves complaints from the patient and his or her family. (See also MS.09.01.01, EP 1)  | <b>C</b> |
| <b>M</b> 6.           | The hospital acknowledges receipt of a complaint that the hospital cannot resolve immediately and notifies the patient of follow-up to the complaint.  | <b>C</b> |
| <b>M</b> 7.           | The hospital provides the patient with the phone number and address needed to file a complaint with the relevant state authority. (See also MS.09.01.01, EP 1)   | <b>C</b> |
| 10.                   | The hospital allows the patient to voice complaints and recommend changes freely without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care. (See also MS.09.01.01, EP 1)   | <b>A</b> |
| <b>M</b> 18. <b>D</b> | For hospitals that use Joint Commission accreditation for deemed status purposes: In its resolution of complaints, the hospital provides the individual with a written notice of its decision, which contains the following:<br>- The name of the hospital contact person<br>- The steps taken on behalf of the individual to investigate the complaint<br>- The results of the process<br>- The date of completion of the complaint process | <b>C</b> |
| 19.                   | For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital determines time frames for complaint review and response.   | <b>A</b> |
| 20.                   | For hospitals that use Joint Commission accreditation for deemed status purposes: The process for resolving complaints includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the quality improvement organization (QIO).  | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

**Standard RI.01.07.03**

The patient has the right to access protective and advocacy services.

**Elements of Performance for RI.01.07.03**

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|----|--|----------|
| 1. | When the hospital serves a population of patients that need protective services (for example, guardianship or advocacy services, conservatorship, or child or adult protective services), it provides resources to help the family and the courts determine the patient's needs for such services. | <b>A</b> |
| 2. | (D) The hospital maintains a list of names, addresses, and telephone numbers of patient advocacy groups, such as a state authority or a protection and advocacy network.   | <b>A</b> |
| 3. | The hospital gives the list of patient advocacy groups to the patient when requested.  | <b>A</b> |

**Standard RI.01.07.07**

For hospital settings that provide longer term care (more than 30 days): The hospital protects the rights of patients who work for or on behalf of the hospital.

**Elements of Performance for RI.01.07.07**



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|----|---|----------|
| 1. | (D) For hospital settings that provide longer term care (more than 30 days): The hospital has a written policy that addresses situations in which patients work for or on behalf of the hospital. | <b>A</b> |
| 2. | (M) For hospital settings that provide longer term care (more than 30 days): The hospital implements its policy regarding patients who work for or on behalf of the hospital.                     | <b>C</b> |
| 3. | For hospital settings that provide longer term care (more than 30 days): Wages paid to patients who work for or on behalf of the hospital are in accordance with law and regulation.              | <b>A</b> |
| 4. | (M) For hospital settings that provide longer term care (more than 30 days): The hospital incorporates work performed by the patient for or on behalf of the hospital into the plan of care.      | <b>C</b> |
| 5. | For hospital settings that provide longer term care (more than 30 days): Patients have the right to refuse to work for or on behalf of the hospital.  | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

## Standard RI.02.01.01

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

### Elements of Performance for RI.02.01.01

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|--|---|---|
| 1.   |  The hospital has a written policy that defines the patient's responsibilities, including but not limited to providing information, asking questions, following instructions, accepting consequences, following rules and regulations, showing respect and consideration, acknowledging when he or she does not understand the treatment course or care decision, and meeting financial commitments. | A |
|  2. | The hospital informs the patient about his or her responsibilities in accordance with its policy.<br>Note: Information about patient responsibilities can be shared verbally, in writing, or both.  | C |





## Transplant Safety

**Standard TS.01.01.01**

The hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs and tissues.

**Elements of Performance for TS.01.01.01**

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|---|----------|
| 1. <b>D</b> The hospital has a written agreement with an organ procurement organization (OPO) and follows its rules and regulations. (See also PI.02.01.01, EP 7)   | <b>A</b> |
| 2. <b>D</b> The hospital's written policies and procedures identify the organ procurement organization (OPO) with which it is affiliated.   | <b>A</b> |
| 3. <b>D</b> The hospital has a written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes.<br>Note 1: This process should not interfere with organ procurement.<br>Note 2: It is not necessary for a hospital to have a separate agreement with a tissue bank if it has an agreement with its organ procurement organization (OPO) to provide tissue procurement services, nor is it necessary for a hospital to have a separate agreement with an eye bank if its OPO provides eye procurement services. The hospital is not required to use the OPO for tissue or eye procurement, and is free to have an agreement with the tissue bank or eye bank of its choice.   | <b>A</b> |
| 4. <b>D</b> The hospital works with the organ procurement organization (OPO) and tissue and eye banks to do the following:<br>- Review death records in order to improve identification of potential donors.<br>- Maintain potential donors while the necessary testing and placement of potential donated organs, tissues, and eyes takes place in order to maximize the viability of donor organs for transplant.<br>- Educate staff about issues surrounding donation.<br>- Develop a written donation policy that addresses opportunities for asystolic recovery that is mutually agreed upon by the hospital, its medical staff, and the designated OPO. When the hospital and its medical staff agree not to provide for asystolic recovery and cannot achieve agreement with the designated OPO, the hospital documents its efforts to reach an agreement with its OPO, and the donation policy addresses the hospital's justification for not providing for asystolic recovery. | <b>A</b> |
| 5. Staff education includes training in the use of discretion and sensitivity to the circumstances, beliefs, and desires of the families of potential organ, tissue, or eye donors.   | <b>A</b> |
| 6. <b>D</b> The hospital develops, in collaboration with the designated organ procurement organization, written procedures for notifying the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes.   | <b>A</b> |
| 7. The individual designated by the hospital to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor.<br>Note: A designated requestor is an individual who has completed a course offered or approved by the organ procurement organization. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation.  | <b>A</b> |

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| 8.   | The individual designated by the hospital documents that the patient or family accepts or declines the opportunity for the patient to become an organ, tissue, or eye donor.   | <b>A</b> |
| 9.  | <p>The hospital notifies the organ procurement organization (OPO) of patients who have died and of mechanically ventilated patients whose death is imminent, according to the following:</p> <ul style="list-style-type: none"> <li>- Clinical triggers defined jointly with its medical staff and the designated OPO</li> <li>- Within the time frames (ideally, within one hour of death for patients who have expired) jointly agreed on by the hospital and the designated OPO</li> <li>- For mechanically ventilated patients, prior to the withdrawal of life-sustaining therapies including medical or pharmacological support</li> </ul> | <b>A</b> |
| 10.   | In Department of Defense hospitals, Veterans Affairs medical centers, and other federally administered health care agencies, notification to the organ procurement organization of patients who have died or whose death is imminent is done according to procedures approved by the respective agency.  | <b>A</b> |
| 11.   | The organ procurement organization determines medical suitability of organs for organ donation and, in the absence of alternative arrangements by the hospital, it determines the medical suitability of tissue and eyes for donation.   | <b>A</b> |
| 12.  | The hospital maintains records of potential organ, tissue, or eye donors whose names have been sent to the organ procurement organization and tissue and eye banks.  | <b>A</b> |

### Standard TS.02.01.01

The hospital complies with organ transplantation responsibilities.









#### Elements of Performance for TS.02.01.01





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| 1. | <p>The hospital performing organ transplants belongs to and abides by the rules of the Organ Procurement and Transplantation Network (OPTN) established under section 372 of the Public Health Service (PHS) Act.</p> <p>Footnote: The term “rules of the OPTN” means those rules provided for in regulations issued by the Secretary in accordance with section 372 of the PHS Act which are enforceable under 42 CFR 121.10. No hospital is considered to be out of compliance with section 1138(a)(1)(B) of the Act, or with the requirements of this paragraph, unless the Secretary has given the OPTN formal notice that he or she approves the decision to exclude the hospital from the OPTN and has notified the hospital in writing.</p> | <b>A</b> |
| 2. | If requested, the hospital provides all data related to organ transplant to the Organ Procurement and Transplantation Network (OPTN), the Scientific Registry, or the hospital's designated organ procurement organization (OPO).  | <b>A</b> |


**Standard TS.03.01.01**

The hospital uses standardized procedures for managing tissues.

**Elements of Performance for TS.03.01.01**

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|--|---|--|
| 1.   | The hospital assigns responsibility to one or more individuals for overseeing the acquisition, receipt, storage, and issuance of tissues throughout the hospital.<br>Note: Responsibility for this oversight involves coordinating efforts to provide standardized practices throughout the hospital. A hospital may have a centralized process (one department responsible for the ordering, receipt, storage, and issuance of tissue throughout the hospital) or a decentralized process (multiple departments responsible for the ordering, receipt, storage, and issuance of tissue throughout the hospital).   | <b>A</b>   |
| 2.    | The hospital develops and maintains standardized written procedures for the acquisition, receipt, storage, and issuance of tissues. (See also TS.03.02.01, EP 5)  | <b>A</b>   |
| 3.   | The hospital confirms that tissue suppliers are registered with the U.S. Food and Drug Administration (FDA) as a tissue establishment and maintain a state license when required.<br>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.<br>Footnote: For U.S. Food and Drug Administration (FDA) registration, the supplier registration status may also be checked annually by using the FDA's online database: <a href="http://www.fda.gov/cber/tissue/tissregdata.htm">http://www.fda.gov/cber/tissue/tissregdata.htm</a> . | <b>A</b>   |
| 4.   | The hospital coordinates its acquisition, receipt, storage, and issuance of tissues throughout the hospital.  | <b>A</b>   |
| 5.   | The hospital follows the tissue suppliers' or manufacturers' written directions for transporting, handling, storing, and using tissue.  |  <b>A</b> |
|  6.      | The hospital documents the receipt of all tissues. (See also TS.03.02.01, EPs 3 and 6)  | <b>C</b>   |
|  7.      | The hospital verifies at the time of receipt that package integrity is met and transport temperature range was controlled and acceptable for tissues requiring a controlled environment. This verification is documented. (See also TS.03.02.01, EP 6)<br>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.<br>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. | <b>C</b>   |
|  8.  | The hospital maintains daily records to demonstrate that tissues requiring a controlled environment are stored at the required temperatures. (See also TS.03.02.01, EP 5)<br>Note 1: Types of tissue storage include room temperature, refrigerated, frozen (for example, deep freezing colder than -40°C), and liquid nitrogen storage.<br>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.   | <b>C</b>   |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

9. The hospital continuously monitors the temperature of refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues. **A**  
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.  **A**  
Note: For tissue stored at room temperature, alarm systems are not required.
11. The hospital complies with state and/or federal regulations when it acts as a tissue supplier. **A**  
Note: The U.S. Food and Drug Administration (FDA) considers the routine policy or practice of shipping tissue to another facility as distribution which requires FDA registration. Returning unused tissue back to the tissue supplier is not considered distribution and does not require FDA registration.  
Footnote: Please refer to the following Web site: <http://www.fda.gov/cber/tissue/tisreg.htm>.

**Standard TS.03.02.01**

The hospital traces all tissues bi-directionally.





**Elements of Performance for TS.03.02.01**





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|  | 1.  The hospital's records allow any tissue to be traced from the donor or tissue supplier to the recipient(s) or other final disposition, including discard, and from the recipient(s) or other final disposition back to the donor or tissue supplier.   | <b>A</b> |
|  | 2.  The hospital identifies, in writing, the materials and related instructions used to prepare or process tissues.  | <b>C</b> |
|  | 3.  The hospital documents the dates, times, and staff involved when tissue is accepted, prepared, and issued. (See also TS.03.01.01, EP 6)  | <b>C</b> |
|  | 4. The hospital documents in the recipient's medical record the tissue type and its unique identifier.   | <b>A</b> |
|  | 5. The hospital retains tissue records on storage temperatures, outdated procedures, manuals, and publications for a minimum of 10 years. If required by state and/or federal laws, hospitals may have to retain tissue records longer than 10 years. (See also TS.03.01.01, EPs 2 and 8)  | <b>A</b> |
|  | 6. The hospital retains tissue records for a minimum of 10 years beyond the date of distribution, transplantation, disposition, or expiration of tissue (whichever is latest). If required by state and/or federal laws, hospitals may have to retain tissue records longer than 10 years. Records are kept on all of the following:<br>- The tissue supplier<br>Note: For medical devices, the manufacturer may be the tissue supplier.<br>- The original numeric or alphanumeric donor and lot identification<br>- The name(s) of the recipient(s) or the final disposition of each tissue<br>- The expiration dates of all tissues<br>(See also TS.03.01.01, EPs 6 and 7)   | <b>A</b> |
|  | 7. The hospital completes and returns tissue usage information cards requested by the tissue supplier.<br>Footnote: 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:<br>- To track products if the disclosure is made to a person required or directed by the FDA to track the product<br>- 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)(iii)(B) and (C)) | <b>A</b> |

**Standard TS.03.03.01**

The hospital investigates adverse events related to tissue use or donor infections.

**Elements of Performance for TS.03.03.01**

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|--|--|
| 1.  The hospital has a written procedure to investigate tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue.   | <b>A</b>   |
| 2. The hospital investigates tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue. (See also IC.01.03.01, EP 3)  | <b>A</b>   |
| 3. As soon as the hospital becomes aware of a post-transplant infection or other adverse event related to the use of tissue, it reports the infection or adverse event to the tissue supplier.   |  <b>A</b> |
| 4. The hospital sequesters tissue whose integrity may have been compromised or that is reported by the tissue supplier as a suspected cause of infection.  |  <b>A</b> |
| 5. The hospital identifies and informs tissue recipients of infection risk when donors are subsequently found to have human immunodeficiency virus (HIV), human T-lymphotropic virus-I/II (HTLV-I/II), viral hepatitis, or other infectious agents known to be transmitted through tissue. |  <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required



## Waived Testing

## 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

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|-------------|--|-------------------|
| 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)   | <b>A</b>          |
| 2.          | <p><b>D</b> The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, establishes written policies and procedures for waived testing that address the following:</p> <ul style="list-style-type: none"> <li>- Clinical usage and limitations of the test methodology</li> <li>- Need for confirmatory testing 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)</li> <li>- Specimen type, collection, and identification, and required labeling</li> <li>- Specimen preservation, if applicable</li> <li>- Instrument maintenance and function checks, such as calibration</li> <li>- Storage conditions for test components</li> <li>- Reagent use, including not using a reagent after its expiration date</li> <li>- Quality control (including frequency and type) and remedial action</li> <li>- Test performance</li> <li>- Result reporting, including not reporting individual patient results unless quality control is acceptable</li> <li>- Equipment performance evaluation</li> </ul> <p>Note: The designee should be knowledgeable by virtue of training, experience, and competence about the waived testing performed.</p> | <b>A</b>          |
| 3.          | <b>D</b> 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).  | <b>A</b>          |
| 4.          | <p><b>D</b> The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, approves in writing policies and procedures for waived testing at the following times:</p> <ul style="list-style-type: none"> <li>- Before initial use of the test for patient testing</li> <li>- Periodically thereafter, as defined by the person whose name appears on the CLIA certificate but at least once every three years</li> <li>- When changes in procedures occur (for example, when manufacturers' updates to package inserts include procedural changes or when a different manufacturer is used)</li> </ul>   | <b>A</b>          |
| 5.          | Current and complete policies and procedures are available for use during testing to the person performing the waived test.  | <b>A</b>          |
| <b>M</b> 6. | <p>Written policies, procedures, and manufacturers' instructions for waived testing are followed. (See also WT.04.01.01, EPs 3-5)</p> <p>Note: Manufacturers' recommendations and suggestions are surveyed as requirements.</p>  | <b>3</b> <b>C</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

- |          |    |   |                   |
|----------|----|---|-------------------|
| <b>M</b> | 7. | The criteria for confirmatory testing are followed as specified in the waived testing written procedures.                   | <b>3</b> <b>C</b> |
| <b>M</b> | 8. | Clinical use of results is consistent with the hospital's policies and the manufacturers' recommendations for waived tests. | <b>3</b> <b>C</b> |

### Standard WT.02.01.01

The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate identifies the staff responsible for performing and supervising waived testing.

Note 1: Responsible staff may be employees of the hospital, contracted staff, or employees of a contracted service.

Note 2: Responsible staff may be identified within job descriptions or by listing job titles or individual names.

#### Elements of Performance for WT.02.01.01

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|----|----------|--|----------|
| 1. | <b>D</b> | The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, identifies, in writing, the staff responsible for performing waived testing.  | <b>A</b> |
| 2. | <b>D</b> | The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, identifies, in writing, the staff responsible for supervising waived testing. | <b>A</b> |

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

## Standard WT.03.01.01

Staff and licensed independent practitioners performing waived tests are competent.

### Elements of Performance for WT.03.01.01

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|--------------------------|---|------------|
| 1.                       | The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, provides orientation and training to, and assesses the competency of, staff and licensed independent practitioners who perform waived testing.   | <b>A</b>   |
| <b>(M)</b> 2. <b>(D)</b> | Staff and licensed independent practitioners who perform waived testing have received orientation in accordance with the hospital's specific services. The orientation for waived testing is documented.  | <b>C</b>   |
| <b>(M)</b> 3. <b>(D)</b> | 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.   | <b>C</b>   |
| <b>(M)</b> 4. <b>(D)</b> | 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.   | <b>C</b>   |
| 5.                       | Competency for waived testing is assessed using at least two of the following methods per person per test:<br>- Performance of a test on a blind specimen<br>- Periodic observation of routine work by the supervisor or qualified designee<br>- Monitoring of each user's quality control performance<br>- Use of a written test specific to the test assessed   | <b>3 A</b> |
| <b>(M)</b> 6. <b>(D)</b> | Competence for waived testing is assessed according to hospital policy at defined intervals, but at least at the time of orientation and annually thereafter. This competency is documented.<br>Note 1: When a licensed independent practitioner performs waived testing that does not involve an instrument and the test falls within his or her specialty, the hospital may use the medical staff credentialing and privileging process to document evidence of training and competency in lieu of annual competency assessment. In this circumstance, individual practitioner privileges include the specific waived tests appropriate to the scope of practice that he or she is authorized to perform. At the discretion of the person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate or according to hospital policy, more stringent competency requirements may be implemented.<br>Note 2: Provider-performed microscopy (PPM) procedures are not waived tests. | <b>C</b>   |







**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **(M)** indicates Measure of Success if needed; **(D)** indicates that documentation is required





## Standard WT.04.01.01

The hospital performs quality control checks for waived testing on each procedure.

Note: Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.

### Elements of Performance for WT.04.01.01

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|--|--|---|
| 1.   |  The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate establishes a written quality control plan for waived testing that specifies the method(s) for controlling procedures for quality, establishes timetables, and explains the rationale for choice of procedures and timetables. (See also LD.04.01.01, EP 1) | A   |
| 2.   | The documented quality control rationale for waived testing is based on the following: <ul style="list-style-type: none"> <li>- How the test is used</li> <li>- Reagent stability</li> <li>- Manufacturers' recommendations</li> <li>- The hospital's experience with the test</li> <li>- Currently accepted guidelines</li> </ul>   | A   |
|  3. | For non-instrument-based waived testing, quality control checks are performed at the frequency and number of levels recommended by the manufacturer and as defined by the hospital's policies. (See also WT.01.01.01, EP 6)<br>Note: If these elements are not defined by the manufacturer, the hospital defines the frequency and number of levels for quality control.   |  C |
|  4. | For instrument-based waived testing, quality control checks are performed each day on each instrument used for patient testing or per manufacturers' instructions, if more stringent. (See also WT.01.01.01, EP 6)<br>Note: Quality control checks are not required on an individual instrument on days when it is not used for patient testing.   |  C |
| 5.   | For instrument-based waived testing, quality control checks require two levels of control, if commercially available. (See also WT.01.01.01, EP 6)   |  A |

**KEY:** A indicates scoring category A; C indicates scoring category C;  indicates situational decision rules apply;  indicates direct impact requirements apply;  indicates Measure of Success if needed;  indicates that documentation is required

## Standard WT.05.01.01

The hospital maintains records for waived testing.

### Elements of Performance for WT.05.01.01

- |                   |                      |  |                 |
|-------------------|----------------------|--|-----------------|
| <p><b>(M)</b></p> | <p>1. <b>(D)</b></p> | <p>Quality control results, including internal and external controls for waived testing, are documented.<br/>           Note 1: Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.<br/>           Note 2: Quality control results may be located in the medical record.</p>  | <p><b>C</b></p> |
| <p><b>(M)</b></p> | <p>2.</p>            | <p>Test results for waived testing are documented in the patient's medical record.</p>   | <p><b>C</b></p> |
|                   | <p>3.</p>            | <p>Quantitative test result reports in the medical record for waived testing are accompanied by reference intervals (normal values) specific to the test method used and the population served.<br/>           Note 1: Semiquantitative results, such as urine macroscopic and urine dipsticks, are not required to comply with this element of performance.<br/>           Note 2: If the reference intervals (normal values) are not documented on the same page as and adjacent to the waived test result, they must be located elsewhere within the permanent medical record. The result must have a notation directing the reader to the location of the reference intervals (normal values) in the medical record.</p> | <p><b>A</b></p> |
|                   | <p>4.</p>            | <p>Individual test results for waived testing are associated with quality control results and instrument records.<br/>           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.</p>  | <p><b>A</b></p> |
|                   | <p>5.</p>            | <p>Quality control result records, test result records, and instrument records for waived testing are retained for at least two years.</p>   | <p><b>A</b></p> |