Effective 1 January 2011
Joint Commission International

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

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Joint Commission International (JCI) is very pleased to present this fourth edition of the international standards for hospitals. JCI was created in 1998 as the international arm of The Joint Commission (United States), and more than 10 years later, this new edition of the standards once again reaffirms JCI’s mission to improve the safety and quality of patient care around the world.

JCI standards are truly international in their development and revision. The process of developing standards is actively overseen by an expert international task force, whose members are drawn from each of the world’s populated continents. In addition, the standards were evaluated by individuals around the world via an Internet-based field review, as well as considered by JCI Regional Advisory Councils in Asia Pacific, Europe, and the Middle East and other experts from various health care fields. This new edition of the hospital standards joins the suite of JCI standards related to Ambulatory Care, the Care Continuum, Clinical Laboratories, Medical Transport, Primary Care, and Clinical Care Program Certification. JCI standards are the basis for accreditation and certification of individual health care facilities and programs around the world. In addition, JCI standards have been used to develop and to establish accreditation programs in many countries and have been used by public agencies, health ministries, and others seeking to evaluate and to improve the safety and quality of patient care.

This fourth edition reflects the continued dynamic changes occurring around the globe in the acute care environment. This edition also refines the International Patient Safety Goals to strengthen their effectiveness and makes many changes to strengthen the link between quality measurement and quality improvement by requiring use of the tested measures in the Joint Commission International Library of Measures. In addition, many changes have their origin in the knowledge gained from the analysis of patient safety incidents and their root causes. Many of these changes are identified in the Introduction that follows.

As with all JCI standards, this edition contains the complete set of standards, statements of intent for each standard, and measurable elements for assessing compliance with each standard. This structure will permit readers to identify and to understand the specific requirements embodied in the standards.

For further information on the hospital and other accreditation and certification programs of JCI, the International Patient Safety Goals, and other JCI initiatives, assistance in developing a country-specific accreditation program, or support in preparing for accreditation, please contact us at

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JCI well understands that standards are continually a “work in progress.” In that spirit, we welcome comments and suggestions for improvement.

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Introduction

This fourth edition of the Joint Commission International Accreditation Standards for Hospitals contains all the standards, intent statements, measurable elements of standards, accreditation policies and procedures, and a glossary of key terms. This Introduction is designed to provide you with information on the following topics:

- The benefits of accreditation
- Joint Commission International (JCI) and its relationship to The Joint Commission (U.S.A.)
- The international accreditation initiatives of JCI
- The origin of the standards and how they are organized
- How to use this standards manual
- What is new in this fourth edition of the manual

If, after reading this publication, you have questions about the standards or the accreditation process, please contact JCI. Contact information is located in the Foreword (preceding this section).

What is accreditation?

Accreditation is a process in which an entity, separate and distinct from the health care organization, usually nongovernmental, assesses the health care organization to determine if it meets a set of requirements (standards) designed to improve the safety and quality of care. Accreditation is usually voluntary. Accreditation standards are usually regarded as optimal and achievable. Accreditation provides a visible commitment by an organization to improve the safety and quality of patient care, to ensure a safe care environment, and to continually work to reduce risks to patients and staff. Accreditation has gained worldwide attention as an effective quality evaluation and management tool.

What are the benefits of accreditation?

The accreditation process is designed to create a culture of safety and quality within an organization that strives to continually improve patient care processes and results. In doing so, organizations

- improve public trust that the organization is concerned for patient safety and the quality of care;
- provide a safe and efficient work environment that contributes to worker satisfaction;
- negotiate with sources of payment for care with data on the quality of care;
- listen to patients and their families, respect their rights, and involve them in the care process as partners;
- create a culture that is open to learning from the timely reporting of adverse events and safety concerns; and
- establish collaborative leadership that sets priorities for and continuous leadership for quality and patient safety at all levels.
What is JCI’s relationship to The Joint Commission?

JCI is the international arm of The Joint Commission (U.S.A.); JCI’s mission is to improve the quality and safety of health care in the international community.

For more than 75 years, The Joint Commission (U.S.A.) and its predecessor organization have been dedicated to improving the quality and safety of health care services. Today, The Joint Commission is the largest accreditor of health care organizations in the United States—it surveys nearly 16,000 health care programs through a voluntary accreditation process. The Joint Commission and JCI are both nongovernmental, not-for-profit United States corporations.

What are the purpose and the goal of JCI accreditation initiatives?

JCI accreditation is a variety of initiatives designed to respond to a growing demand around the world for standards-based evaluation in health care. The purpose is to offer the international community standards-based, objective processes for evaluating health care organizations. The goal of the program is to stimulate demonstration of continuous, sustained improvement in health care organizations by applying international consensus standards, International Patient Safety Goals, and data measurement support. In addition to the standards for hospitals contained in this fourth edition, JCI has developed standards and accreditation programs for the following:

• Ambulatory Care
• Clinical Laboratories
• Primary Care Centers
• The Care Continuum (home care, assisted living, long term care, hospice care)
• Medical Transport Organizations

JCI also offers certification of clinical care programs, such as programs for stroke care, cardiac care, or joint replacement. JCI accreditation programs are based on an international framework of standards adaptable to local needs.

All the JCI accreditation and certification programs are characterized by the following:

• International consensus standards, developed and maintained by an international task force, and approved by an international Board, are the basis of the accreditation program.
• The underlying philosophy of the standards is based on principles of quality management and continuous quality improvement.
• The accreditation process is designed to accommodate the legal, religious, and/or cultural factors within a country. Although the standards set uniform, high expectations for the safety and quality of patient care, country-specific considerations related to compliance with those expectations are part of the accreditation process.
• The on-site survey team and agenda will vary depending on the organization’s size and type of services provided. For example, a large multispecialty organization may require a four- or five-day survey by a physician, a nurse, and an administrator, while a 50-bed, single-specialty hospital may require a shorter survey by a smaller team.
• JCI accreditation is designed to be valid, reliable, and objective. Based on the analysis of the survey findings, final accreditation decisions are made by an international accreditation committee.
How were the standards initially developed and refined for this fourth edition?

A 12-member International Standards Subcommittee, composed of experienced physicians, nurses, administrators, and public policy experts, guides the development and revision process of the JCI accreditation standards. The subcommittee consists of members from six major world regions: Latin America and the Caribbean, Asia and the Pacific Rim, the Middle East, Central and Eastern Europe, Western Europe, and Africa. The work of the subcommittee is refined based on an international field review of the standards and the input from experts and others with unique content knowledge.

How are the standards organized?

The standards are organized around the important functions common to all health care organizations. The functional organization of standards is now the most widely used around the world and has been validated by scientific study, testing, and application.

The standards are grouped by those functions related to providing patient care and those related to providing a safe, effective, and well-managed organization. These functions apply to the entire organization as well as to each department, unit, or service within the organization. The survey process gathers standards compliance information throughout the entire organization, and the accreditation decision is based on the overall level of compliance found throughout the entire organization.

Are the standards available for the international community to use?

Yes. These standards are available in the international public domain for use by individual health care organizations and by public agencies in improving the quality of patient care. The standards only can be downloaded at no cost from the JCI Web site for consideration of adapting them to the needs of individual countries. The translation and use of the standards as published by JCI requires permission.

When there are national or local laws related to a standard, what applies?

When standard compliance is related to a laws and regulations, whichever sets the higher or stricter requirement applies.

How do I use this standards manual?

This international standards manual can be used to

- guide the efficient and effective management of a health care organization;
- guide the organization and delivery of patient care services and efforts to improve the quality and efficiency of those services;
• review the important functions of a health care organization;
• become aware of those standards that all organizations must meet to be accredited by JCI;
• review the compliance expectations of standards and the additional requirements found in associated
  intent statements;
• become aware of the accreditation policies and procedures and the accreditation process; and
• become familiar with the terminology used in the manual.

What are the “measurable elements” of a standard?

The measurable elements (MEs) of a standard are those requirements of the standard and its intent statement
that will be reviewed and assigned a score during the accreditation survey process. The MEs simply list what is
required to be in full compliance with the standard. Each element is already reflected in the standard or intent
statement. Listing the MEs is intended to provide greater clarity to the standards and help organizations edu-
cate staff about the standards and prepare for the accreditation survey.

What is the Strategic Improvement Plan (SIP)?

A Strategic Improvement Plan (SIP) is a required written plan of action that the organization develops in
response to “not met” findings identified in the JCI Official Survey Findings Report. The written SIP is
expected to
• establish the strategies/approach that the organization will implement to address each “not met” find-
ing;
• describe specific actions the organization will use to achieve compliance with the “not met” stan-
dards/measurable elements cited;
• describe methodology to prevent reoccurrence and to sustain improvement over time; and
• identify the measures that will be used to evaluate the effectiveness of the improvement plan (submis-
sion of data to occur over the subsequent three years).

The SIP must demonstrate that the organization’s actions lead to full compliance with the standards and
measurable elements. The SIP is reviewed and approved by the JCI office staff after the Accreditation
Certification Letter and Gold Seal have been awarded.

How frequently will the standards be updated?

Information and experience related to the standards will be gathered on an ongoing basis. If a standard no
longer reflects contemporary health care practice, commonly available technology, quality management prac-
tices, and so forth, it will be revised or deleted. It is currently anticipated that the standards will be revised
and published at least every three years.

What does the “effective” date on the cover of this
fourth edition of the standards manual mean?

The “effective” date found on the cover means one of two things:
1. For hospitals already accredited under the third edition of the standards, this is the date that they now must be in full compliance with all the standards in the fourth edition. Standards are published at least six months in advance of the effective date to provide time for organizations to come into full compliance with the revised standards by the time they are effective.

2. For hospitals seeking accreditation for the first time, the effective date indicates the date after which all surveys and accreditation decisions will be based on the standards of the fourth edition. Any survey and accreditation decisions before the effective date will be based on the standards of the third edition.

What is new in this fourth edition of the manual?

There have been many changes to this fourth edition of the hospital manual. A thorough review is strongly recommended. In general, there have been two types of changes:

1. Changes that add clarity to standards and facilitate a more objective and consistent survey assessment. Examples of this type of change are the revisions to the FMS requirements for emergency drills for fire safety and disaster preparedness and removal of vague words, such as “appropriateness” or “regular.”

2. Changes that raise the bar on existing requirements or introduce new requirements. Examples of these changes include the following:

   • **International Patient Safety Goal 3 (IPSG.3), Improve the Safety of High-Alert Medications.** The evaluation and scoring of this goal focused only on concentrated electrolytes. The evaluation and scoring now focus on all high-risk medications as defined by organization policy.

   • **International Patient Safety Goal 4 (IPSG.4), Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery.** To help interpret and apply this goal, the intent now contains a definition of surgery that includes invasive procedures.

   • **ACC.1.1.1, Patients with emergent, urgent, or immediate needs are given priority for assessment and treatment.** A new Measurable Element 4 was added to emphasize the need to stabilize emergency patients prior to transfer to another organization using an evidence-based triage process.

   • **ACC.3.3, The clinical records of outpatients receiving continuing care contain a summary of all known significant diagnoses, drug allergies, current medications, and any past surgical procedures and hospitalizations.** This is a new standard to strengthen the integration of outpatient information for patients provided ongoing care from multiple clinics.

   • **ACC.3.5, The organization has a follow-up process for patients who leave against medical advice.** This is a new standard to help reduce the risk to patients if they leave with incomplete or inadequate treatment and to help the hospital learn from follow-up.

   • **ACC.5** This standard has been collapsed from two standards and now addresses all transport vehicles, whether or not the organization owns and operates them.

   • **PFR.2, The organization supports patients’ and families’ rights to participate in the care process.** A new measurable element requires the organization to offer or to facilitate second opinions when requested by the patient.
• AOR5.3.1, There is a process for reporting critical laboratory results in a timely manner as defined by the organization.
  This is a new standard to capture the important patient safety process related to the reporting of critical laboratory test results.

• MMU.4, ME 6, Initial medication orders are compared to the list of medications taken prior to admission.
  This new measurable element is an important step in medication safety and is necessary to facilitate the medication reconciliation process for each patient.

• QPS.5, The organization uses an internal process to validate data.
  This standard has been rewritten to emphasize the organization's responsibility for collecting and validating quality improvement data.

• QPS.5.1, When the organization publishes data or posts data on a public Web site, the leaders of the organization ensure the reliability of the data.
  This standard now states that when an organization publishes or makes public its data, the organization's leaders establish reliability of the data either through their internal process for data validation or by an independent third party.

• QPS.6, The organization uses a defined process for identifying and managing sentinel events.
  The definition of “sentinel event” now includes “infant abduction or infant who was sent home with the wrong parents.”

• QPS.11, An ongoing program of risk management is used to identify and to reduce unanticipated adverse events and other safety risks to patients and staff.
  This standard was significantly expanded to introduce a comprehensive risk management framework as a tool for the reduction of adverse events.

• PCI.7.1.1, There is a policy and procedure in place that identifies the process for managing expired supplies and defines the conditions for the reuse of single-use devices when permitted by laws and regulations.
  The reuse of single-use devices was formerly one measurable element of PCI.7.1; however, due to the importance of this issue and the prevalence of this problem, a separate standard has been created.

• GLD.3.3.1, Contracts and other arrangements are included as part of the organization's quality improvement and patient safety program.
  This new standard expands on the requirements of GLD.3.3 related to leader responsibility for the awarding and monitoring of contracts.

• GLD.3.3.2, Independent practitioners not employed by the organization have the right credentials for the services provided to the organization's patients.
  This standard significantly expands on the requirements to ensure that all independent practitioners have been evaluated by a process as thorough as that described in the SQE standards for medical staff.
• GLD.6, The organization establishes a framework for ethical management that ensures that patient care is provided within business, financial, ethical, and legal norms and that protects patients, their families, and employees.

A new Measurable Element 3 states, “Leaders consider national and international ethical norms when developing the organization’s framework for ethical conduct.” This requirement is intended to introduce the notion of international norms into the thinking and debate on ethics in each health care organization.
Joint Commission
International Policies and Procedures

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Policies and Procedures

Health care organizations wishing to be accredited by Joint Commission International (JCI) must meet the following requirements.

General

General Eligibility Requirements for Survey
Any health care organization may apply for JCI accreditation if it meets the following requirements:
- The organization is currently in operation as a health care provider organization in the country and licensed (if required).
- The organization assumes, or is willing to assume, responsibility for improving the quality of its care and services.
- The organization provides services addressed by JCI standards.

Purpose of Accreditation Surveys
An accreditation survey assesses an organization’s compliance with JCI standards and their intent statements. The survey evaluates the organization’s compliance based on:
- interview with staff and patients and other verbal information;
- on-site observations of patient care processes by surveyors;
- policies, procedures, clinical practice guidelines, and other documents provided by the organization; and
- results of self-assessments when part of the accreditation process.

The on-site survey process, as well as continued self-assessment, helps the organizations identify and correct problems and improve the quality of care and services. In addition to evaluating compliance with standards, their intent statements and the International Patient Safety Goals, surveyors spend time in providing education in support of the organization’s quality improvement activities.

Scope of Accreditation Surveys
The scope of the JCI survey includes all standards-related functions of an applicant organization and all patient care settings. Applicable standards are selected by JCI from this manual based on the scope of services provided by an organization applying for survey.

The on-site survey will consider specific cultural and/or legal factors that may influence or shape decisions regarding the provision of care and/or policies and procedures in an organization.

Outcomes of Accreditation Surveys
The Accreditation Committee of JCI makes accreditation decisions based on the findings of the survey. An organization can receive one of the following two accreditation decisions:

Accredited or Accreditation Denied. These accreditation decisions are based on whether or not the organization meets the decision rules. For a description of the decision rules, please see the Survey Process Guide or access the rules on the JCI Web site.

Accreditation Awards
To gain accreditation, organizations must demonstrate acceptable compliance with all standards and achieve a minimal numerical score on these standards as identified in the decision rules. Accredited organizations receive an Official Survey Findings Report and award certificate. The report indicates the level of compliance with JCI standards achieved by the organization.
Length of Accreditation Awards
An accreditation award is valid for three years unless revoked by JCI. The award is retroactively effective on the first day after JCI completes the organization's survey or, when follow-up is required, completes any required focused surveys.

At the end of the organization's three-year accreditation cycle, the organization must be reevaluated to be eligible for renewal of its accreditation award.

If, during the period of accreditation, the organization undergoes changes in its structure, ownership, or services, it must notify JCI. JCI will then determine the need to re-survey the organization and/or render a new accreditation decision.
Presurvey

How to Apply for Accreditation
A health care organization that wishes to be accredited begins the accreditation process by completing and submitting the application for survey. This document provides the essential information about the health care organization, including ownership, demographics, and types and volume of services provided either directly, under contract, or some other arrangement. The application for survey:
- describes the organization seeking accreditation;
- requires the organization to provide JCI with all official records and reports of relevant licensing, regulatory, or other governmental bodies;
- authorizes JCI to obtain any records and reports about the organization not possessed by the organization; and
- when finalized and accepted by JCI and the applicant, establishes the terms of the relationship between the organization and JCI.

The health care organization may apply in electronic format by downloading an application form at http://www.jointcommissioninternational.org and returning the completed form by facsimile or e-mail to Joint Commission International Accreditation
Fax: +1 630.268.2996
E-mail: jciaccreditation@jcrinc.com

The organization must inform JCI about any changes to the information contained in its application for survey between when the application is submitted and until the survey is conducted.

Scheduling the Survey and Planning the Survey Agenda
JCI and the organization select the survey date (see Accreditation Process Time Line above) and prepare the survey agenda together to meet the organization’s needs and the requirements for an efficient survey. To reduce surveyor travel costs, JCI will make every effort to coordinate the scheduling of surveys of related or independent organizations in a specific country or region.

JCI will assign each organization an accreditation service specialist, who will serve as the primary contact between the organization and JCI. This individual will coordinate survey planning and will be available to the organization to answer any questions about policies, procedures, or accreditation issues.

The accreditation service specialist will work with the organization to prepare a survey agenda based on the size, type, and complexity of the health care organization. The agenda specifies the sites in the organization to be visited, the type of interviews to be conducted, the personnel to be interviewed, and the documents to be provided to the surveyors.

Highly qualified international surveyors will perform the survey. JCI will make every effort to provide surveyors fluent in the language(s) used at the organization. If JCI surveyors with the appropriate language capabilities are not available, JCI will work with the organization to identify qualified interpreters.

Circumstances may arise when the organization or JCI must postpone the scheduled survey or may wish to cancel the scheduled survey. See “JCI Accreditation Fee Structure Policy” below for more details.

Information Accuracy and Truthfulness Policy
Purpose. To ensure the consistent understanding of the expectations associated with the provision of information by organizations participating in the JCI accreditation process and timeliness of their response to requests by the JCI Accreditation Program.
Policy

a) The organization must provide accurate and truthful information at all times in the accreditation process. Falsification is defined as fabrication, in whole or in part, of any information provided by an applicant or accredited organization to the JCI Accreditation Program.

b) If the organization falsifies information relevant to the accreditation, either by commission or omission, its accreditation award will immediately be terminated, or, in the case of a new applicant, the organization will be ineligible for re-evaluation for one year. Examples of fabrication can include altering the content of documents through redrafting, reformatting, or deleting content; knowing false information; or providing, hiding, and removing evidence during a survey.

c) After the organization has submitted an application form, the JCI Accreditation Program must be notified within 30 days of any change or at least 30 days before the scheduled survey date, if there is a change in the organization that modifies the information reported in the Survey Application.

d) Also between surveys, the organization must notify the JCI Accreditation Program within 30 days when there are changes in the organizational structure, ownership, or services.

e) Information that must be reported to the JCI Accreditation Program includes the following:
   1) A change in organization name and/or ownership
   2) Any change of the contact information by JCI Accreditation Program–designated staff and/or leadership
   3) Any personnel change of the JCI Accreditation Program–designated staff and/or leadership
   4) A significant increase or decrease in the volume of services
   5) The addition of a new type of health service or acquisition
   6) The deletion of an existing health service
   7) A significantly altered building/physical plant

f) The JCI Accreditation Program requests that organizations allow only full-time hospital employees who are fully committed to the organization (but are not contracted staff) and who are best suited for the position to be designated the primary JCI accreditation contact individuals for all accreditation-related communications. This will help ensure the continuity of accurate transfer of information between the JCI Accreditation Program and the organization.

g) The JCI Accreditation Program will restrict most accreditation-related communication to the following three primary JCI accreditation contacts listed on the application form: chief executive officer (or equivalent), JCI accreditation survey coordinator, and billing contact. The following communication requirements will apply to the individuals listed as the three primary contacts:
   1) The JCI Accreditation Program primary contacts need to establish a communication mechanism to ensure that all JCI accreditation communications directed to them are responded to within the required time frame.
   2) The JCI Accreditation Program will not respond to accreditation communication from the organization staff outside the JCI accreditation contacts. The JCI Accreditation Program will refer all communication requests to the primary contacts.
   3) The organization is required to submit an updated organization contact information form within 30 days of any change in contact information or personnel for the JCI accreditation primary contacts. The form can be downloaded from the JCI accreditation Internet site and/or JCI Accreditation Resource Center.
   4) The accredited organization is required to submit the completed organization contact information form within the first week of every year.

h) If the JCI Accreditation Program learns that the organization fails to meet one or more of the seven requirements above for this policy, the organization will initially be contacted to discuss the situation and the JCI accreditation requirements. During the discussion, the JCI Accreditation Program staff will remind the leaders that their lack of compliance with the policy could place them in an administrative category, At Risk for Denial of Accreditation, as stated in the policy. If the organization continues to not meet the requirement, staff will place the organization in the At Risk for Denial of Accreditation category and their accreditation decision will be reviewed by the Accreditation Committee to determine the outcome.
Postponement Policy
An organization may postpone scheduled surveys when one or more accepted reasons for postponement occur.

Accepted Reasons for Postponement
- A natural disaster or another major unforeseen event occurs that totally or substantially disrupts operations;
- The organization is involved in a major strike, has ceased accepting patients, and is transferring patients to other facilities; or
- Patients, the organization, or both are being moved to another building during the scheduled survey.

JCI reserves the right to conduct an on-site survey if the organization continues to provide patient care services under such circumstances.

Cancellation Policy
A survey may be canceled by either party without penalty or damages when any of the following events make it impossible, illegal, or unreasonable to go forward:
- Acts of God
- Wars
- Terrorism
- Government regulations
- Disasters
- Strikes
- Civil disorders
- Other emergencies of a similar nature

Cancellation due to any of the reasons cited above must be communicated in writing as soon as practically possible. Further, JCI may follow the advice of relevant ministries concerned with evaluating political and military circumstances with regard to scheduling surveys.

JCI Accreditation Fee Structure Policy
The accreditation survey fee is based on several factors, including the volume and type of services provided by the organization, the number of locations or care setting included in the survey, and the number of surveyors and survey days required to conduct the evaluation of compliance with JCI standards. Surveyor time for report preparation is included in the calculated survey days. The organization is not charged for the cost of a validation survey. The organization is charged for any required focused survey (see below).

Initial and Triennial Accreditation Fee. For most organizations, a three-member survey team conducting a four-day survey will be needed to efficiently conduct a comprehensive evaluation. For larger or smaller organizations, the fees will be adjusted upward or downward, according to the size of the organization. Included in the fees are
- the Survey Process Guide;
- the custom survey agenda;
- all supporting information and assistance regarding the on-site survey process and interpretation of the standards;
- an internationally experienced survey team consisting of one or more of the following individuals, depending on the services provided and standards to be surveyed:
  — Physician
  — Nurse
  — Administrator
  — Someone with special expertise, such as clinical laboratorian, medical transport emergency medical technician, or dispatch operator
Focused Survey Fee. Focused surveys are conducted when JCI becomes aware of potentially serious standards compliance, patient care, or safety issues, or when JCI has other valid reasons for surveying an accredited organization. The focus survey reviews only the standards and/or International Patient Safety Goal requirements in noncompliance at the time of survey or addressed in an incident report. In most cases, a focused survey is conducted by one surveyor during one day. However, JCI reserves the right to assign more than one surveyor or to schedule more than one day when indicated by the number of standards to be surveyed or the variety of survey activities.

Postponement Fee. In rare circumstances, JCI may, at its discretion, approve a request to postpone a survey for an organization not meeting any of the criteria described previously (see Postponement Policy). In such cases, the organization may be charged a fee to defray costs.

Cancellation Fee

Organization-Initiated Cancellation. If the organization cancels the survey 30 or fewer days prior to the first date of the survey for any reason or reasons other than those previously stated (see Cancellation Policy on page 16), JCI accreditation may require payment of one-half of the survey fees to recover costs JCI accreditation will incur.

JCI-Initiated Cancellation. In the event that JCI cancels the survey for any reason or reasons other than those previously stated, the organization will not be charged.

Travel Costs Related to the Accreditation Survey or Focused Survey. In addition to survey fees, the organization is responsible for paying all travel costs for the surveyors. This includes transportation (airfare, train, and car) and reasonable accommodations, including a set daily rate for meals and incidental expenses. This rate will not exceed the current rates set forth by the U.S. Department of State for international travel.

Payment Schedule of Survey Fees. JCI accreditation fees can be billed using one of the two following options. Organizations are asked to identify their preferred option by selecting and signing for the desired option on the last page of their contract.

Option I. Upon acceptance of this agreement, the organization will receive an invoice for 100% of the survey fees (in U.S. dollars) at least 45 days before the start date of the survey. Payment is expected by wire transfer 21 days or more before the start date of the survey. At the conclusion of the survey, if the organization achieves accreditation, the JCI accreditation certificate will be sent immediately to the organization, along with the Official Survey Findings Report. JCI will then bill the organization for the surveyors’ expenses related to travel and maintenance within 30 days of the conclusion of the survey. The surveyors’ expenses must be paid upon receipt of the invoice.

By selecting Option I, the organization is expected to pay the surveyors’ expenses in a timely manner as billed. If the organization does not pay the surveyors’ expenses in a timely basis, JCI will recommend to the Accreditation Committee that the organization’s accreditation certificates be returned to JCI and the accreditation status of the organization be removed.

OR

Option II. Survey fees will be paid via two separate invoices; a third invoice will be sent to the organization for the surveyors’ expense for travel and maintenance.
a) Upon acceptance of this agreement, the organization will receive an invoice for the first half of the accreditation survey fee. This invoice for the first 50% of the survey fees will be billed approximately 45 days before the survey, with payment expected by wire transfer within 21 days before the start date of the survey. Payment of the first half of the accreditation survey fee must be received by the JCI Finance Department at least three weeks before the survey begins. If the first half of the accreditation survey fee is not received three weeks before the designated survey start date, JCI may reschedule the survey to another available date.

b) At the conclusion of the survey, the second invoice for the remaining 50% of the survey fees will be billed to the organization. Additionally, the surveyors’ expenses for travel and maintenance will be billed within 30 days following the survey. All payments for fees and expenses must be paid upon receipt of the invoice.

Once the accreditation decision is rendered and JCI has received payment for all the survey fees, the Official Survey Findings Report and accreditation certificates for the organization will be mailed.

**Note:** It is important to keep payments up-to-date, as JCI policy requires payment for one phase of work before beginning new phases. Delay in submitting payment of the first half of the accreditation fee may result in greater cost to the organization for the surveyors’ travel expenses due to the tendency for airlines to charge a higher ticket fee when travel arrangements are made closer to the actual date of travel.

Payment in full is due upon receipt by your institution of JCI invoices. After 30 days, penalty charges may be added to the invoice.

**On-Site Survey Process**

**General Information**

(For detailed information, see the relevant Survey Process Guide.)

The surveyors will visit the organization during the dates established and according to the prepared agenda. The surveyors may ask to interview any personnel during the survey to visit any other unit or location of the organization not on the agenda, or request additional information. The organization must cooperate with the surveyors to provide accurate information about the organization and its compliance with the standards. Delays in providing the required information will be considered noncooperation, which may result in premature termination of the accreditation process.

The tracer methodology is the foundation of the JCI on-site survey (see Survey Process Guide for full explanation). The tracer methodology does the following:

- Incorporates the use of information provided in the accreditation survey application
- Follows the experience of care for a number of patients through the organization’s entire health care process
- Allows the surveyors to identify performance issues in one or more steps of the patient care process or in the interfaces between processes

The surveyors will confer with the organization’s chief executive officer and other leaders at a leadership conference at the end of each survey. During this conference, the surveyors will provide preliminary information about their findings. This information is strictly preliminary and should not be considered final until review by JCI Accreditation Program has been completed.
If, during the survey, the surveyors identify any condition they believe poses a serious threat to public or patient safety, they will notify the JCI Accreditation Program. JCI will decide whether to issue an expedited denial of accreditation decision and to inform relevant public authorities.

Observation of the On-Site Survey Process
JCI management and supervisory personnel may observe an accreditation survey. The organization or JCI may request that one or more other individuals observe the survey process. The requesting party must obtain the express written consent of the other party in order to facilitate the observance. This written consent should be obtained at least five days prior to survey. Observers, which include consultants or advisors hired by the organization and employees of another organization, will not have an interactive role in the survey process. As such, they will not participate in the discussions, interviews, or other activities conducted during the survey. Costs associated with the observation will be borne by the requesting party.

Surveyor Training During the On-Site Survey Process
JCI reserves the right to assign one or more surveyors in training to accompany the designated survey team. This individual(s) may participate in the survey process under the direct supervision and guidance of the survey team. All cost associated with this training activity will be borne by JCI.

JCI Focused Survey Policy
Purpose. A focused survey is an on-site survey that is limited in scope, content, and length and designed to gather information on a specific issue(s) or limited number of standards or measurable elements.

Policy. JCI may conduct a focused survey for the following reasons:
- As follow-up to a full survey (initial or triennial)
- When it becomes aware of potentially serious standards compliance or patient care or safety issues
- When it has other valid reasons for surveying an accredited/certified organization
- When it assigns the administrative classification At Risk for Denial of Accreditation to an organization (see At Risk for Denial of Accreditation Policy on page 23)

In most cases, a focused survey is conducted by one surveyor during one day. However, the JCI Accreditation Program reserves the right to require more than one surveyor or more than one day when indicated by the number of standards to be surveyed or the variety of survey activities.

An organization is charged for a focused survey regardless of the outcome. An organization can determine the cost of such a survey by contacting the JCI Accreditation Program.

There are two types of focused surveys used to evaluate an organization: follow-up and for-cause surveys. The specific reasons for each of these types of focused surveys are described below.

Follow-Up Focused Survey. The need for surveyor observation, staff or patient interviews, or the inspection of the physical facility to confirm that an organization has taken sufficient action to achieve acceptable compliance with any JCI standards and/or International Patient Safety Goal(s) identified as “not met” or “partially met” at the time of initial or triennial full survey.

For-Cause Focused Survey. The receipt of information regarding the occurrence of any event or series of events in an accredited organization that creates either of the following significant situations:
- Concern of a continuing and/or immediate threat to patient/public/staff health and safety within the organization
- To confirm/investigate an applicable condition(s) that resulted in the organization being classified as At Risk for Denial of Accreditation and not covered by a follow-up focused survey or the Threat to Health and Safety Policy
**Procedure.** Procedure for follow-up and for-cause focused surveys are as follows:

1. JCI will notify the organization’s CEO within 10 days at the close of an initial or triennial full survey of any requirement for a **follow-up focused survey** to reevaluate all the measurable elements found to be “not met.” This follow-up survey will be performed within 90 days after the Official Survey Findings Report is sent to the organization. The composition of the survey team will be determined by the accreditation office based on the number and type of findings and number of measurable elements to be reevaluated.

2. JCI will notify the organization’s CEO of the need for a **for-cause focused survey** within 45 days when an organization has been classified as At Risk for Denial of Accreditation. The senior executive director, accreditation and standards, accreditation program executive director, and associate directors will evaluate the relevant information regarding an organization and make recommendations to the JCI president and CEO or chair of the Accreditation Committee regarding appropriate actions for “at risk” organizations.

3. The recommendation for a for-cause focused survey to the JCI president and CEO by the senior executive director, accreditation and standards, and executive director, accreditation and standards, may support that the for-cause focused survey be “unannounced” when one or more of the following conditions is perceived to exist:
   - The risk to the health and safety of patients, the public, and staff is ongoing, immediate, and significant.
   - The risk situation is best evaluated outside normal schedules and procedures at the organization.
   - The organization’s senior leaders do not need to be present for the appropriate evaluation of the risks.
   - The organization has the potential to orchestrate situations and conditions that make a thorough risk analysis difficult or not possible.
   - JCI surveyors are in the region or area of the organization, and visas or other administrative barriers are not an issue.

4. When an organization is considered “at risk” for a potential threat to health and safety, the JCI Threat to Health and Safety Policy is immediately put into effect.

5. On completion of the for-cause focused survey, the senior executive director, accreditation and standards, accreditation program executive director, and associate directors will evaluate the relevant information regarding an organization and make recommendations to the JCI president and CEO and the Accreditation Committee. As appropriate, the recommendations state whether the organization should be awarded initial accreditation, denied accreditation, allowed to maintain current accreditation status, or if JCI should revoke the current accreditation.

6. The JCI Accreditation Committee will review follow-up focused survey reports in the following situations:
   - The Committee will review all reports of organizations that fail to meet the accreditation decision rules and staff recommend Denial of Accreditation, including following a focused survey conducted as a follow-up, for-cause, or extension survey.
   - The Committee will review the reports of any organization for which staff believe there are special or unusual compliance issues, including being designated as an organization that is At Risk for Denial of Accreditation.
   - The Committee reviews the report of any organization that challenges or disputes the findings contained in the Official Survey Findings Report. Appeal of accreditation decisions will follow the approved policy, Appeal of Decisions When JCI Accreditation is Denied or Withdrawn (see page 24).

7. The JCI Accreditation Committee will consider the JCI staff recommendation at its next scheduled meeting and determine the final accreditation decision.
8. The organization is advised of the accreditation decision within 60 days of the completion of the focused survey and 10 days following Accreditation Committee action. Staff take appropriate follow-up actions.

Extension Survey

Policy. JCI may conduct an extension survey when an organizational evaluation is determined to be necessary by any of the following factors:

- A change in organization ownership
- A significant altered building/physical plant; or an organization has offered at least 25% of its services at a new location or in a significantly altered physical plant
- A significant increase or decrease in the volume of services
- An organization has expanded its capacity to provide services by 25% or greater, as measured by patient volume or other relevant measures
- The addition of a new type of health service
- The deletion of an existing health service
- An organization has merged with, consolidated with, or acquired an unaccredited site, service, or program for which there are applicable JCI standards

Procedure. Organizations must notify JCI of any significant changes that occur between surveys, as required by JCI’s policy on Reporting Requirements Between Surveys (see page 26) Information submitted will be reviewed by JCI Accreditation Program staff to determine if a full or focused accreditation survey is necessary to evaluate the changes described by the organization.

Validation Survey

Purpose. The purpose of the validation survey is to evaluate the effectiveness of the JCI survey process in assessing international standards compliance in health care organizations, as part of our internal quality improvement efforts. Organizations that volunteer for a validation survey will not be invoiced.

Process. Organizations that have achieved JCI accreditation will be invited to volunteer for a validation survey immediately following the initial or triennial re-survey. Validation surveys will be conducted within 60 to 180 days following initial or triennial re-surveys. The length and components of the survey will replicate the organization’s most recent initial or triennial survey process. The surveyors assigned to conduct the validation survey will have no information about the results of the organization’s most recent triennial survey, and the organization will be requested not to share that information with them in any way.

The participating organization’s accreditation decision will not be affected by the findings of a validation survey in accordance with the decision rules applicable to an initial or triennial re-survey. However, if any condition is identified during survey that is believed to pose a serious threat to public or patient health or safety, the JCI Accreditation Program will be notified, and the JCI threat to health and safety protocol will be implemented. At the completion of the survey, the surveyors will orally report their observations to organization leadership. A written report will not be left on site.

Organizations that volunteer for a validation survey will be requested not to divulge the results of the validation survey to any person or organization outside of their own. Similarly, JCI will not release any information about this survey to the public. Organizations that volunteer for a validation survey will not incur any cost.

Threat to Health and Safety Policy

Purpose. To provide JCI surveyors with a process to respond to a situation that they believe poses a serious threat to public or patient health or safety in an organization that they are surveying.
**Policy.** The JCI Accreditation Program may consider for accreditation purposes a surveyor's findings, a complaint to the organization or JCI, or other information received by JCI as relevant in deciding whether some aspect of an organization's operation may result in or is likely to result in serious injury, harm, impairment, or death to patients, staff, or the public and that immediate action must be taken.

**Responsibilities.** JCI surveyors are responsible for reporting all situations for which they believe there is a potential of serious injury, harm, impairment or death to a patient, staff, or public at an organization for which they are surveying.

**Procedure.** The procedure for threat to health and safety is as follows:

1. The surveyor will notify the JCI Accreditation Program immediately if any condition is identified that is believed to pose such a serious threat to public or patient health or safety.
2. The JCI Accreditation Program's executive director may request the survey team leader, if a survey is in progress, to coordinate a conference call from the JCI Accreditation Program to the organization to discuss the findings with the organization's senior leadership.
3. The survey shall continue, and all subsequent findings are immediately reported to the JCI Accreditation Program.
4. JCI’s senior executive director, accreditation and standards, will make a recommendation to the president and CEO of JCI regarding whether a threat to health or safety status should be declared.
5. The president and CEO, or the chair of the Accreditation Committee, if the president is not available, after consultation with the senior executive director, accreditation and standards, can then issue a decision disclosable to the public that any existing accreditation status is no longer effective, pending subsequent review by the JCI Accreditation Committee.
6. The president and CEO, or the chair of the Accreditation Committee, can then issue an expedited Accreditation Denied decision.
7. The senior executive director, accreditation and standards, promptly informs the organization's CEO (and appropriate governmental authorities if applicable) of this decision and the findings that led to this action.
8. The JCI Accreditation Committee confirms or reverses the decision at its next meeting, or a special meeting can be convened at the request of the president and CEO or senior executive director, accreditation and standards, based on the level of threat to health or safety. The JCI Accreditation Committee will consider information received from the accredited organization and then decide whether to immediately deny accreditation or take whatever action it deems appropriate. The Accreditation Committee may then issue an expedited Accreditation Denied decision.

In these situations, the corrective action is considered when a single issue leads to the adverse finding and the organization demonstrates that it
- took immediate action to completely remedy the situation;
- prepared a thorough and credible root cause analysis;
- adopted systems changes to prevent a future recurrence of the problem; and
- a scheduled focus survey verified the implementation of each of the above corrective actions.

**Confidentiality**

JCI keeps confidential the following information received or developed during the accreditation process:
- The Official Survey Findings Report, unless the organization wishes to use its accreditation to fulfill government requirements (for example, for licensure). JCI will release additional information, up to and including the Official Survey Findings Report, to the relevant government agency with the accredited organization's authorization.
• Information learned from the organization before, during, or following the accreditation survey, which is used to determine compliance with specific accreditation standards
• An organization's root cause analysis or action plan prepared in response to a sentinel event or in response to other circumstances specified by JCI
• All other material that may contribute to the accreditation decision (for example, surveyor notes)
• Written staff analyses and Accreditation Committee minutes and agenda materials
• The identity of any individual who files a complaint about an accredited organization, unless JCI has the express permission of the submitter or unless required by law

JCI will provide the following to the public:
• An accredited organization's status; that is, whether the organization is accredited, was denied accreditation, or if accreditation was withdrawn by JCI and, upon request
• The number of complaints an organization has had that met the JCI criteria for review
• The status of an organization noted on the JCI Web site as either Accredited (and date) or Accreditation Withdrawn (and date). The status of Accreditation Withdrawn will be posted on the JCI Web site for one year.

JCI will provide to the individual submitting a complaint that met the criteria for review
• the applicable standards reviewed;
• any standards for which Recommendations for Improvement were issued as a result of the review; and, when applicable
• any change in the organization's accreditation status.

The accredited organization may release more detailed information, up to and including its Official Survey Findings Report, to whomever it wishes. However, when an organization disseminates inaccurate information about its accreditation, JCI reserves the right to clarify information that would otherwise be considered confidential.

**At Risk for Denial of Accreditation Policy**

**Purpose.** The policy allows the JCI Accreditation Program staff to identify specific conditions that, if present in an accredited organization, could individually or collectively demonstrate the need for additional oversight to ensure that the organization's quality and patient safety program are not in jeopardy.

**Policy.** At Risk for Denial for Accreditation is an administrative classification that results when JCI Accreditation Program staff determine that one or more of the following seven conditions are present:

1. An immediate threat to patient safety, public health, or staff safety exists within the organization.
2. An individual who does not possess a license, registration, or certification is providing or has provided health care services in the organization that would, under applicable laws and regulations, require such a license, registration, or certification and that placed the organization's patients at risk for a serious adverse outcome.
3. JCI is reasonably persuaded that the organization submitted falsified documents or misrepresented information in seeking to achieve or to retain accreditation, as required by the Information Accuracy and Truthfulness Policy.
4. The number of noncompliant standards (not met or partially met) at the time of survey is above the mean (three or more standard deviations) for organizations in the same program surveyed during the previous 24 months.
5. The organization does not possess a license, certificate, and/or permit, as, or when, required by applicable laws and regulations, to provide the health care services for which the organization is seeking accreditation.
6. The organization has not met the accreditation policy for Reporting Requirements Between Surveys (see page 26).
7. The organization fails to submit an acceptable Strategic Improvement Plan (SIP) within 120 days of the organization’s survey.

**Responsibilities.** JCI Accreditation Program staff and surveyors may identify the conditions during an on-site survey, during the review of a survey report or postsurvey follow-up activity, or from a complaint submitted against the organization. Surveyors will confirm/investigate the applicable condition either while on site conducting a survey or as part of a focused survey. Recommendations of the JCI Accreditation Program staff will be reviewed by the Accreditation Committee.

**Procedure.** When one or more of the seven conditions listed above is identified, JCI Accreditation Program staff notify the executive director, JCI accreditation, and/or the senior executive director, accreditation and standards, to review the situation. Based on the outcome of the review, the JCI president and CEO may be notified, depending on the risk(s) identified.

A determination will be made as to the next steps, such as asking the organization for clarifying information, scheduling a follow-up focused survey, a for-cause focused survey, or other appropriate activity.

When the surveyors find that the condition has been substantiated and not resolved, Denial of Accreditation will be recommended to the Accreditation Committee. The organization has the right to appeal this decision as described in the JCI policy on Appeal of Decisions When JCI Accreditation Is Denied or Withdrawn (see page 24).

**Postsurvey**

**Revision of the Official Survey Findings Report**
The organization has seven days from the last day of the survey to request, in writing or by e-mail, revision of the report related to survey findings. This revision request must be accompanied by appropriate data and information to support the request. The Accreditation Committee considers this request for revision and makes the final decision.

**The Accreditation Decision (Decision Rules)**
The JCI Accreditation Committee makes accreditation decisions based on the findings of the survey. An organization can receive one of the following two accreditation decisions:

- **Accredited or Accreditation Denied.** These accreditation decisions are based on whether the organization meets the decision rules. For a description of the decision rules, please see the Survey Process Guide or access the rules on the JCI Web site.

**Appeal of Decisions When JCI Accreditation Is Denied or Withdrawn**
If, based on a full, focused, or other survey activity, or a threat-to-life situation, there is a decision to deny or to withdraw accreditation, an organization has 20 calendar days from receipt of its Official Survey Findings Report or notice of accreditation withdrawal to notify JCI, in writing or by e-mail, of its intent to appeal the decision.

An organization then has an additional 60 days to submit to JCI, in writing or by e-mail, acceptable data and information to support its appeal. If, after JCI review of any submitted materials, the decision to deny or to withdraw accreditation is confirmed, an organization may, at its own expense, appear before the JCI Accreditation Committee to support its appeal. The following outlines the review and appeal procedure:
**Notification to Organization of Areas of Noncompliance with JCI Standards or Conditions Related to Threat to Life.** If JCI staff, based on survey findings, survey documents, and any other relevant materials or information received from any source, determine, in accordance with decision rules approved by the JCI Accreditation Committee, to recommend to the JCI Accreditation Committee that the organization be denied accreditation or have its accreditation withdrawn, staff will outline its findings and determination. The organization may then
- a) accept the findings and determination; or
- b) submit to JCI evidence of its compliance with the cited JCI standards at the time of survey that is not reflected in the Official Survey Findings Report, along with an explanation of why such information was not available at the time of survey; or
- c) submit to JCI evidence related to the findings of a threat-to-life situation.

**Consideration of the Organization's Response.** JCI will review the submissions and, in accordance with the decision rules approved by the JCI Accreditation Committee, will then
- a) recommend to the JCI Accreditation Committee that the organization be accredited; or
- b) recommend that the organization be denied accreditation.

**Action by the JCI Accreditation Committee.** The JCI Accreditation Committee may then
- a) accredit the organization;
- b) deny accreditation to the organization;
- c) defer consideration while additional information regarding the organization's compliance status or the threat to-life situation is gathered and reviewed by JCI accreditation staff; or
- d) order a re-survey or focused survey of the organization and an evaluation of the results to the extent deemed appropriate by the JCI accreditation staff.

If an organization withdraws from the accreditation process after the survey has taken place, the JCI Accreditation Committee will make its decision based on the full accreditation survey findings and follow-up and will render the decision to the organization.

**Information on Accreditation Status Available to the Public**

JCI is committed to making relevant and accurate information about surveyed organizations available to the public. Information about an organization's performance not only helps practitioners improve their services but also helps educate users of the organization. Such information may also help patients and payers make informed choices in selecting health care organizations and/or practitioners.

However, it is important that confidentiality be maintained for certain information to encourage openness in the accreditation process. This openness facilitates improvement of the quality of health care to benefit the public. Please refer to the section on confidentiality for specific information on this issue.

**Accreditation Award Display and Use**

JCI provides each organization with a certificate of accreditation at the time of initial accreditation and at the time of accreditation renewal. There is no charge for the certificate. Additional copies of certificates may be purchased by contacting JCI. The certificate and all copies remain JCI's property. They must be returned if:
- the organization is issued a new certificate reflecting a name change; or
- the organization's accreditation is withdrawn or denied for any reason.

An organization accredited by JCI must be accurate in describing to the public the nature and meaning of its accreditation award. Therefore, an organization must not misrepresent its accreditation status or the facilities and services to which the accreditation award applies. JCI will supply each organization receiving accreditation with appropriate guidelines for announcing the accreditation award.
Maintaining Accreditation

JCI will continue to monitor accredited organizations and certified programs for compliance with all the International Patient Safety Goals and relevant JCI standards on an ongoing basis throughout the three-year accreditation cycle.

Reporting Requirements Between Surveys

Purpose. To provide ongoing communication throughout the three-year accreditation cycle between the accredited organization and JCI Accreditation Program to ensure the organization continues to meet the accreditation requirements after becoming accredited.

Policy. Accreditation is neither automatically transferred nor continued if significant changes occur within the accredited organization. Such changes may necessitate a full or focused accreditation survey if the program has

- instituted a new service or program for which JCI has standards, including any additions or deletions of type of health service(s);
- made a change in the organization/program name and/or ownership, including any significant number of changes in the management and clinical staff or operating policies and procedures;
- made a change in the contact person(s) that the organization/program has designated for all accreditation-related communications;
- made a change in the organization’s or program’s leadership and/or any personnel designated as JCI primary contacts;
- offered at least 25% of its services at a new location or in a significantly altered building/physical facility;
- significantly increased the volume of services, such as expanding its capacity to provide services, or use of its services, by 25% or more as measured by beds, patient visits, pieces of equipment, or other relevant measures;
- significantly decreased the volume of services, such as reducing its capacity to provide services, or use of its services, by 25% or more as measured by beds, patient visits, pieces of equipment, or other relevant measures;
- developed a more intensive level of service (for example, from outpatient cardiac rehabilitation to inpatient invasive diagnostic cardiology);
- merged with, consolidated with, or acquired an unaccredited site, service, or program for which there are applicable JCI standards;
- a local, regional or national regulatory or licensing body has conducted an investigation or inspection resulting in recommendations for improvement or an adverse outcome that necessitates an immediate change in the organizations (for example, mandated closure of all or part of the organization or a department(s), program(s) or service(s) that prohibits the organization from providing care to patients); and/or
- a physician’s license, registration, or certification to practice medicine and to provide care to the organization’s patients has been either revoked, cancelled, terminated or limited by a legal/regulatory authority(s) or by the organization and the physician is still providing care in the organization.

When any of these changes occur, the organization/program must notify JCI in writing not more than 30 days after such a change occurs. An organization/program that fails to provide timely notification to JCI of these changes, based on compliance with the Information Accuracy and Truthfulness Policy, will be placed in the administrative category At Risk for Denial of Accreditation, as stated in the policy.

Responsibilities. The JCI Standards Department will ensure that the policy is published in each accreditation manual. The policy is located in the front matter of the manual under JCI accreditation policies and procedures.
**JCI Sentinel Event Policy**

**Sentinel Events.** In support of its mission to improve the safety and quality of health care provided to the international community, JCI reviews organization activities in response to sentinel events in its accreditation process. This includes all initial accreditation surveys, triennial accreditation surveys, and, as appropriate, focused surveys. The following apply:

- A sentinel event is an unanticipated occurrence involving death or major permanent loss of function unrelated to the natural course of the patient’s illness or underlying condition.
- A sentinel event may occur due to wrong-site, wrong-procedure, wrong-patient surgery.
- Such events are called *sentinel* because they signal a need for immediate investigation and response.
- The terms *sentinel event* and *medical error* are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events.

**Goals of the Sentinel Event Policy.** The policy has four goals:
1. To have a positive impact in improving patient care, treatment, and services and preventing sentinel events.
2. To focus the attention of an organization that has experienced a sentinel event on understanding the causes that underlie the event and on changing the organization’s systems and processes to reduce the probability of such an event in the future.
3. To increase general knowledge about sentinel events, their causes, and strategies for prevention.
4. To maintain the confidence of the public and internationally accredited organizations in the accreditation process.

**Standards Relating to Sentinel Events.** The standards related to quality and safety in this publication contain requirements that specifically relate to the management of sentinel events.

**Definition of a Sentinel Event.** The standards in this publication related to quality and safety require every accredited organization to establish which unanticipated events are significant and the process for their intense analysis. While the determination of what constitutes a significant event must be consistent with the general definition of sentinel event as described in this policy, accredited organizations have some latitude in setting more specific parameters to define “unanticipated” and “major permanent loss of function.” At a minimum, an organization must include those events that are subject to review listed below:

- Unanticipated death unrelated to the natural course of the patient’s illness or underlying condition
- Major permanent loss of function unrelated to the natural course of the patient’s illness or underlying condition
- Wrong-site, wrong-procedure, wrong-patient surgery

**Expectations for an Organization’s Response to a Sentinel Event.** Accredited organizations are expected to identify and to respond appropriately to all sentinel events (as established by the organization in accordance with the previous paragraph) occurring in the organization or associated with services that the organization provides, or provides for. Appropriate response includes conducting a timely, thorough, and credible root cause analysis; developing an action plan designed to implement improvements to reduce risk; implementing the improvements; and monitoring the effectiveness of those improvements.

**Root Cause Analysis.** Root cause analysis is a process for identifying the basis or causal factors that bring about variation in performance, including the occurrence, or possible occurrence, of a sentinel event. A root cause analysis focuses primarily on systems and processes, not on individual performance.

**Action Plan.** The product of the root cause analysis is an action plan that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.
Survey Process. When conducting an accreditation survey, JCI seeks to evaluate the organization’s compliance with the applicable standards and to score those standards based on performance throughout the organization over time (for example, the preceding 12 months for a triennial re-survey or the preceding four months for an initial survey). If in the course of conducting the usual survey activities a sentinel event is identified, the surveyor will take the following steps:

- Inform the CEO that the event has been identified.
- Inform the CEO that the event will be reported to the JCI Accreditation Program for further review and follow-up under the provisions of the Sentinel Event Policy.

During the on-site survey, surveyors will assess the organization’s compliance with sentinel event-related standards in the following ways:

- Review the organization’s process for responding to a sentinel event.
- Interview the organization’s leaders and staff about their expectations and responsibilities for identifying, reporting, and responding to sentinel events.
- Ask for an example of a root cause analysis that has been conducted in the past year to assess the adequacy of the organization’s process for responding to a sentinel event.
- Review additional examples if needed to more fully assess the organization’s understanding of and ability to conduct root cause analyses. In selecting an example, the organization may choose a “closed case” to demonstrate its process for responding to a sentinel event.

How JCI Becomes Aware of a Sentinel Event. Each organization is encouraged, but not required, to report to JCI any sentinel event meeting the above criteria for reviewable sentinel events. Alternatively, JCI may become aware of a sentinel event by some other means, such as communication from a patient, a family member, an employee of the organization, a surveyor, or through the media.

Reasons for Reporting a Sentinel Event to JCI. Although self-reporting a sentinel event is not required and there is no difference in the expected response, time frames, or review procedures whether the organization voluntarily reports the event or JCI becomes aware of the event by some other means, there are two major advantages to the organization that self-reports a sentinel event:

1. Early reporting provides an opportunity for consultation with JCI Accreditation Program staff during the development of the root cause analysis and action plan.
2. The organization’s message to the public that it is doing everything possible to ensure that such an event will not happen again is strengthened by its acknowledgement and collaboration with JCI to understand how the event happened and what can be done to reduce the risk of such an event in the future.

Reviewable Sentinel Events. The definition of a reviewable sentinel event takes into account a wide array of occurrences applicable to a wide variety of health care organizations. These occurrences may apply to a particular organization. Thus, one of the following occurrences may apply to your particular organization. The following sentinel events are subject to review by JCI and include any occurrence that meets the following criteria:

- The event has resulted in an unanticipated death unrelated to the natural course of the patient’s illness or underlying condition (for example, suicide).
- The event has resulted in major permanent loss of function unrelated to the natural course of the patient’s illness or underlying condition.
- The event resulted from wrong-site, wrong-patient, wrong-procedure surgery.
- The event has resulted in an infant abduction or infant who was sent home with the wrong parents.

Required Response to a Reviewable Sentinel Event. If JCI becomes aware (either through voluntary self-reporting or otherwise) of a sentinel event that meets the above criteria and the event has occurred in an accredited organization, the organization is expected to do the following:
• Prepare a thorough and credible action plan within 45 calendar days of the event or of becoming aware of the event.
• Submit to JCI its root cause analysis and action plan, or otherwise provide for JCI evaluation of its response to the sentinel event.

Review of Root Cause Analysis and Action Plan. A root cause analysis will be considered acceptable if it has the following characteristics:

• The analysis focuses primarily on systems and processes, not individual performance.
• The analysis extends from specific causes in the clinical care process to common causes in the organizational process.
• The analysis repeatedly digs deeper.
• The analysis identifies changes that could be made in systems and processes (either through redesign or development of new systems or processes) that would reduce the risk of such events occurring in the future.

All root cause analyses and action plans will be considered and treated as confidential by JCI.

Follow-Up Activities. After JCI has determined that an organization has conducted an acceptable root cause analysis and developed an acceptable action plan, JCI will notify the organization that the root cause analysis and action plan are acceptable and will assign an appropriate follow-up activity, typically a written progress report due in four months.

Implementing the Sentinel Event Policy. If an organization wishes to report an occurrence in the subset to sentinel events that are subject to review by JCI, the organization can submit the report to the JCI Accreditation Program by mail, electronic, or by facsimile transmission. If JCI becomes aware of a sentinel event subject to review under the sentinel event policy that was not reported to JCI by the organization, the CEO of the organization is contacted, and a preliminary assessment of the sentinel event is made. An event that occurred more than one year before the date JCI became aware of the event will not, in most cases, be reviewed under the Sentinel Event Policy. In such a case, a written response will be requested from the organization, including a summary of the processes in place to prevent similar occurrences.

Based on available factual information received about the event, JCI staff will apply the above definition to determine that an event is reviewable under the Sentinel Event Policy. Challenges to a determination that an event is reviewable will be resolved through consultation with the JCI executive director and JCI chief medical officer.

Initial On-Site Review of a Sentinel Event. An initial on-site review of a sentinel event will usually not be conducted unless it is determined that there is a potential ongoing immediate threat to patient health and safety or potentially significant noncompliance with JCI standards. Immediate threat-to-life incidents include situations in which the organization's noncompliance with one or more standards has caused, or is likely to cause, major permanent loss of function, impairment, or death to a patient and is likely to continue.

Complaints are assigned this priority if the information indicates immediate corrective action is necessary. All are immediately referred to JCI executive leadership for authorization to conduct a focused survey. If a focused survey is conducted, the organization will be billed an appropriate amount based on the established fee schedule to cover the cost of conducting such a survey.

Disclosable Information. If JCI receives an inquiry about the accreditation decision of an organization that has experienced a reviewable sentinel event, the organization's accreditation decision will be reported in the usual manner without making reference to the sentinel event. If the inquirer specifically references the specific sentinel event, JCI will acknowledge that it is aware of the event and currently working or has worked with the organization through the sentinel event review process.
Complaint Management/Quality Monitoring

Responding to a Complaint About a JCI-Accredited Organization. The JCI Accreditation Office of Quality and Safety Monitoring triages and reviews complaints, concerns, and inquiries related to accredited health care organizations, as received from a variety of sources. These complaints may be submitted by patients, families, and health care practitioners, by governmental agencies in the form of reports, or through information from the media. The term *complaint* therefore covers a broad spectrum of information received by JCI Accreditation Program.

Upon JCI Accreditation Program’s review of a complaint, a number of actions may result. These include recording the information for trending purposes and possible action in the future, obtaining the involved health care organization’s response to the complaint, and conducting a for-cause survey. If JCI Accreditation Program determines that the organization should respond to the complaint, the organization will be so notified. The request for a response will be e-mailed to the organization’s CEO with the following information:

- The complaint itself
- A summary of the complaint, if the complainant requested anonymity

If a health care organization is required to respond to the complaint, it is required to do so usually within 30 days of being notified. For more serious issues, the organization may be required to respond to the complaint within seven days of being notified, or sooner. When a response in a short time frame is required, the organization will be so notified.

Once a response is received, it is evaluated for compliance with JCI accreditation standards, as applicable. If additional information is required, the organization will be notified.

When the organization’s response is complete and has been accepted, a letter indicating acceptance is e-mailed to the CEO, and the case is considered closed.

JCI Accreditation Program requires accredited organization to communicate to hospital employees, visitors, and patients that when complaints are not resolved to their satisfaction, individuals may choose to report their complaints to the JCI Accreditation Program.

JCI Accreditation Program’s policies prohibit organizations from taking retaliatory action against employees who submit complaints to the JCI Accreditation Program and prohibit the JCI Accreditation Program from disclosing to a complainant whether a complaint is substantiated.

Accreditation Renewal Process

The JCI Accreditation Program sends the organization a Request to Re-Survey before the organization’s triennial accreditation due date. The organization is responsible for completing and returning the Request for Re-Survey to JCI by a specified date. JCI then schedules the survey. Every effort is made to schedule the triennial survey to occur at the approximate conclusion of the previous three-year accreditation cycle. JCI will work with the organization and other organizations in the country or region that are also due for surveys to schedule the appropriate survey date(s). An organization’s previous accreditation status may remain in effect up to two months after the subsequent full accreditation survey to accomplish any required follow-up. If, during the period of accreditation, JCI receives information that the organization is substantially out of compliance with current accreditation standards, JCI will determine the need to re-survey the organization and/or render a new accreditation decision.

Effective Date of Standards Policy

*Purpose.* To define the date by which accredited organizations will be expected to be in full compliance with revised standards and the date in which organizations seeking accreditation may be surveyed under new or revised standards.
**Definition.** *Effective date* is defined as the date published on the cover of standards editions, after which all related accreditation activities are conducted using those standards.

**Policy**
1. The effective date for the first edition of standards for a new JCI Accreditation Program is set as the publication date of the standards manual.
2. The effective date of subsequent editions of standards is set by staff as six months following the official publication of the standards.
3. Accreditation surveys of all types are conducted under the standards in effect at the time of the survey. No surveys are to be conducted using standards no longer in effect or not yet effective.
4. Standards will be published at least six months in advance of the effective date to provide time for organizations to come into full compliance with the revised standards by the effective date.

**Procedure.** Each edition of a standards manual, upon approval of the standards by the JCI Accreditation Committee, is submitted to the Publications Department for final editing and printing. The Publications Department and JCI Accreditation Program staff determine the anticipated publication date. The official effective date is then set as six months following the date of publication. The effective date will be the first day of the indicated month unless otherwise noted.
Section I: Patient-Centered Standards
Overview

This chapter addresses the International Patient Safety Goals (IPSG), as required for implementation as of 1 January 2011 in all organizations accredited by Joint Commission International (JCI) under the International Standards for Hospitals.

The purpose of the IPSG is to promote specific improvements in patient safety. The goals highlight problematic areas in health care and describe evidence- and expert-based consensus solutions to these problems. Recognizing that sound system design is intrinsic to the delivery of safe, high-quality health care, the goals generally focus on systemwide solutions, wherever possible.

The goals are structured in the same manner as the other standards, including a standard (goal statement), an intent statement, and measurable elements. The goals are scored similar to other standards as “met,” “partially met,” or “not met.” The Accreditation Decision Rules include compliance with the IPSG as a separate decision rule.

Goals

The following is a list of all goals. They are presented here for your convenience without their requirements, intent statements, or measurable elements. For more information about these goals, please see the next section in this chapter, Goals, Requirements, Intents, and Measurable Elements.

**IPSG.1** Identify Patients Correctly

**IPSG.2** Improve Effective Communication

**IPSG.3** Improve the Safety of High-Alert Medications

**IPSG.4** Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery

**IPSG.5** Reduce the Risk of Health Care–Associated Infections

**IPSG.6** Reduce the Risk of Patient Harm Resulting from Falls
Goal 1: Identify Patients Correctly

Standard IPSG.1
The organization develops an approach to improve accuracy of patient identifications.

Intent of IPSG.1
Wrong-patient errors occur in virtually all aspects of diagnosis and treatment. Patients may be sedated, disoriented, or not fully alert; may change beds, rooms, or locations within the hospital; may have sensory disabilities; or may be subject to other situations that may lead to errors in correct identification. The intent of this goal is twofold: 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.

Policies and/or procedures are collaboratively developed to improve identification processes, in particular, the processes used to identify a patient when giving medications, blood, or blood products; taking blood and other specimens for clinical testing; or providing any other treatments or procedures. The policies and/or procedures require at least two ways to identify a patient, such as the patient's name, identification number, birth date, a bar-coded wristband, or other ways. The patient's room number or location cannot be used for identification. The policies and/or procedures clarify the use of two different identifiers in different locations within the organization, such as in ambulatory care or other outpatient services, the emergency department, or operating theatre. Identification of the comatose patient with no identification is also included. A collaborative process is used to develop the policies and/or procedures to ensure they address all possible identification situations.

Measurable Elements of IPSG.1
- 1. Patients are identified using two patient identifiers, not including the use of the patient's room number or location.
- 2. Patients are identified before administering medications, blood, or blood products.
- 3. Patients are identified before taking blood and other specimens for clinical testing. (Also see AOP.5.6, ME 2)
- 4. Patients are identified before providing treatments and procedures.
- 5. Policies and procedures support consistent practice in all situations and locations.

Goal 2: Improve Effective Communication

Standard IPSG.2
The organization develops an approach to improve the effectiveness of communication among caregivers.

Intent of IPSG.2
Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces errors and results in improved patient safety. Communication can be electronic, verbal, or written. The most error-prone communications are patient care orders given verbally and those given over the telephone, when permitted under local laws and regulations. Another error-prone communication is the report back of critical test results, such as the clinical laboratory telephoning the patient care unit to report the results of a STAT test.
The organization collaboratively develops a policy and/or procedure for verbal and telephone orders that includes the writing down (or entering into a computer) of the complete order or test result by the receiver of the information; the receiver reading back the order or test result; and the confirmation that what has been written down and read back is accurate. The policy and/or procedure identify permissible alternatives when the read-back process may not always be possible, such as in the operating theatre and in emergency situations in the emergency department or intensive care unit.

**Measurable Elements of IPSG.2**

- 1. The complete verbal and telephone order or test result is written down by the receiver of the order or test result. *(Also see MCI.19.2, ME 1)*
- 2. The complete verbal and telephone order or test result is read back by the receiver of the order or test result. *(Also see AOP5.3.1, intent statement)*
- 3. The order or test result is confirmed by the individual who gave the order or test result.
- 4. Policies and procedures support consistent practice in verifying the accuracy of verbal and telephone communications. *(Also see AOP5.3.1, intent statement)*

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**Goal 3: Improve the Safety of High-Alert Medications**

**Standard IPSG.3**

The organization develops an approach to improve the safety of high-alert medications.

**Intent of IPSG.3**

When medications are part of the patient treatment plan, appropriate management is critical to ensuring patient safety. High-alert medications are those medications involved in a high percentage of errors and/or sentinel events, medications that carry a higher risk for adverse outcomes, as well as look-alike/sound-alike medications. Lists of high-alert medications are available from organizations such as the World Health Organization or the Institute for Safe Medication Practices. A frequently cited medication safety issue is the unintentional administration of concentrated electrolytes (for example, potassium chloride [equal to or greater than 2 mEq/ml concentrated], potassium phosphate [equal to or greater than 3 mmol/ml], sodium chloride [greater than 0.9% concentrated], and magnesium sulfate [equal to or greater than 50% concentrated]). Errors can occur when staff are not properly oriented to the patient care unit, when contract nurses are used and not properly oriented, or during emergencies. The most effective means to reduce or to eliminate these occurrences is to develop a process for managing high-alert medications that includes removing the concentrated electrolytes from the patient care unit to the pharmacy.

The organization collaboratively develops a policy and/or procedure that identifies the organization's list of high-alert medications based on its own data. The policy and/or procedure also identifies any areas where concentrated electrolytes are clinically necessary as determined by evidence and professional practice, such as the emergency department or operating theatre, and identifies how they are clearly labeled and how they are stored in those areas in a manner that restricts access to prevent inadvertent administration.

**Measurable Elements of IPSG.3**

- 1. Policies and/or procedures are developed to address the identification, location, labeling, and storage of high-alert medications.
- 2. The policies and/or procedures are implemented.
3. Concentrated electrolytes are not present in patient care units unless clinically necessary, and actions
are taken to prevent inadvertent administration in those areas where permitted by policy.

4. Concentrated electrolytes that are stored in patient care units are clearly labeled and stored in a man-
ner that restricts access.

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**Goal 4: Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery**

**Standard IPSG.4**
The organization develops an approach to ensuring correct-site, correct-procedure, and correct-patient surgery.

**Intent of IPSG.4**
Wrong-site, wrong-procedure, wrong-patient surgery is an alarmingly common occurrence in health care
organizations. These errors are the result of ineffective or inadequate communication between members of the
surgical team, lack of patient involvement in site marking, and lack of procedures for verifying the operative
site. In addition, inadequate patient assessment, inadequate medical record review, a culture that does not
support open communication among surgical team members, problems related to illegible handwriting, and
the use of abbreviations are frequent contributing factors.

Organizations need to collaboratively develop a policy and/or procedure that is effective in eliminating this
alarming problem. The policy includes a definition of surgery that incorporates at least those procedures that
investigate and/or treat diseases and disorders of the human body through cutting, removing, altering, or
insertion of diagnostic/therapeutic scopes. The policy applies to any location in the organization where these
procedures are performed.

Evidence-based practices are described in The (US) Joint Commission’s Universal Protocol for Preventing
Wrong Site, Wrong Procedure, Wrong Person Surgery™.

The essential processes found in the Universal Protocol are
- marking the surgical site;
- a preoperative verification process; and
- a time-out that is held immediately before the start of a procedure.

Marking the surgical site involves the patient and is done with an instantly recognizable mark. The mark
should be consistent throughout the organization; should be made by the person performing the procedure;
should take place with the patient awake and aware; if possible, and must be visible after the patient is
prepped and draped. The surgical site is marked in all cases involving laterality, multiple structures (fingers,
toes, lesions), or multiple levels (spine).

The purpose of the preoperative verification process is to
- verify the correct site, procedure, and patient;
- ensure that all relevant documents, images, and studies are available, properly labeled, and displayed;
  and
- verify any required special equipment and/or implants are present.

The time-out permits any unanswered questions or confusion to be resolved. The time-out is conducted in
the location the procedure will be done, just before starting the procedure, and involves the entire operative
team. The organization determines how the time-out process is to be documented.
Measurable Elements of IPSG.4

1. The organization uses an instantly recognizable mark for surgical-site identification and involves the patient in the marking process.

2. The organization uses a checklist or other process to verify preoperatively the correct site, correct procedure, and correct patient and that all documents and equipment needed are on hand, correct, and functional.

3. The full surgical team conducts and documents a time-out procedure just before starting a surgical procedure.

4. Policies and procedures are developed that will support uniform processes to ensure the correct site, correct procedure, and correct patient, including medical and dental procedures done in settings other than the operating theatre.

Goal 5: Reduce the Risk of Health Care–Associated Infections

Standard IPSG.5

The organization develops an approach to reduce the risk of health care–associated infections.

Intent of IPSG.5

Infection prevention and control are challenging in most health care settings, and rising rates of health care–associated infections are a major concern for patients and health care practitioners. Infections common to all health care settings include catheter-associated urinary tract infections, bloodstream infections, and pneumonia (often associated with mechanical ventilation).

Central to the elimination of these and other infections is proper hand hygiene. Internationally acceptable hand-hygiene guidelines are available from the World Health Organization (WHO), the United States Centers for Disease Control and Prevention (US CDC) and various other national and international organizations.

The organization has a collaborative process to develop policies and/or procedures that adapt or adopt currently published and generally accepted hand-hygiene guidelines and for the implementation of those guidelines with the organization.

Measurable Elements of IPSG.5

1. The organization has adopted or adapted currently published and generally accepted hand-hygiene guidelines.

2. The organization implements an effective hand-hygiene program.

3. Policies and/or procedures are developed that support continued reduction of health care–associated infections.
Goal 6: Reduce the Risk of Patient Harm Resulting from Falls

Standard IPSG.6
The organization develops an approach to reduce the risk of patient harm resulting from falls.

Intent of IPSG.6
Falls account for a significant portion of injuries in hospitalized patients. In the context of the population it serves, the services it provides, and its facilities, the organization should evaluate its patients’ risk for falls and take action to reduce the risk of falling and to reduce the risk of injury should a fall occur. The evaluation could include fall history, medications-and-alcohol-consumption review, gait and balance screening, and walking aids used by the patient. The organization establishes a fall-risk reduction program based on appropriate policies and/or procedures. The program monitors both the intended and unintended consequences of measures taken to reduce falls. For example, the inappropriate use of physical restraints or fluid intake restriction may result in injury, impaired circulation, or compromised skin integrity. The program is implemented.

Measurable Elements of IPSG.6

1. The organization implements a process for the initial assessment of patients for fall risk and reassessment of patients when indicated by a change in condition or medications, among others. (Also see AOP.1.6, ME 4)

2. Measures are implemented to reduce fall risk for those assessed to be at risk. (Also see AOP.1.6, ME 5)

3. Measures are monitored for results, both successful fall injury reduction and any unintended related consequences.

4. Policies and/or procedures support continued reduction of risk of patient harm resulting from falls in the organization.
Access to Care and Continuity of Care (ACC)

Overview

A health care organization should consider the care it provides as part of an integrated system of services, health care practitioners and professionals, and levels of care, which make up a continuum of care. The goal is to correctly match the patient's health care needs with the services available, to coordinate the services provided to the patient in the organization, and then to plan for discharge and follow-up. The result is improved patient care outcomes and more efficient use of available resources.

Information is essential for making correct decisions about
- which patient needs can be met by the health care organization;
- the efficient flow of services to the patient; and
- the transfer or discharge of the patient to his or her home or to another care setting.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

Admission to the Organization

ACC.1 Patients are admitted to receive inpatient care or registered for outpatient services based on their identified health care needs and the organization's mission and resources.

ACC.1.1 The organization has a process for admitting inpatients and for registering outpatients.

ACC.1.1.1 Patients with emergent, urgent, or immediate needs are given priority for assessment and treatment.

ACC.1.1.2 Patient needs for preventive, palliative, curative, and rehabilitative services are prioritized based on the patient's condition at the time of admission as an inpatient to the organization.

ACC.1.1.3 The organization considers the clinical needs of patients when there are waiting periods or delays for diagnostic and/or treatment services.
ACC.1.2 At admission as an inpatient, patients and families receive information on the proposed care, the expected outcomes of that care, and any expected cost to the patient for the care.

ACC.1.3 The organization seeks to reduce physical, language, cultural, and other barriers to access and delivery of services.

ACC.1.4 Admission or transfer to or from units providing intensive or specialized services is determined by established criteria.

Continuity of Care

ACC.2 The organization designs and carries out processes to provide continuity of patient care services in the organization and coordination among health care practitioners.

ACC.2.1 During all phases of inpatient care, there is a qualified individual identified as responsible for the patient’s care.

Discharge, Referral, and Follow-Up

ACC.3 There is a policy guiding the referral or discharge of patients.

ACC.3.1 The organization cooperates with health care practitioners and outside agencies to ensure timely and appropriate referrals.

ACC.3.2 The clinical records of inpatients contain a copy of the discharge summary.

ACC.3.2.1 The discharge summary of inpatients is complete.

ACC.3.3 The clinical records of outpatients receiving continuing care contain a summary of all known significant diagnoses, drug allergies, current medications, and any past surgical procedures and hospitalizations.

ACC.3.4 Patients and, as appropriate, their families are given understandable follow-up instructions.

ACC.3.5 The organization has a process for the management and follow-up of patients who leave against medical advice.

Transfer of Patients

ACC.4 Patients are transferred to other organizations based on status and the need to meet their continuing care needs.

ACC.4.1 The referring organization determines that the receiving organization can meet the patient’s continuing care needs.

ACC.4.2 The receiving organization is given a written summary of the patient’s clinical condition and the interventions provided by the referring organization.

ACC.4.3 During direct transfer, a qualified staff member monitors the patient’s condition.

ACC.4.4 The transfer process is documented in the patient’s record.

Transportation

ACC.5 The process for referring, transferring, or discharging patients, both inpatients and outpatients, includes planning to meet the patient’s transportation needs.
Standards, Intents, and Measurable Elements

Admission to the Organization

Standard ACC.1
Patients are admitted to receive inpatient care or registered for outpatient services based on their identified health care needs and the organization's mission and resources.

Intent of ACC.1
Matching patient needs with the health care organization's mission and resources depends on obtaining information on the patient's needs and condition through screening, usually at the point of first contact. The screening may be through triage criteria, visual evaluation, a physical examination, or the results of previously conducted physical, psychological, clinical laboratory, or diagnostic imaging evaluations. The screening can occur at a referring source, during emergency transport, or when the patient arrives at the organization. It is important that decisions to treat, to transfer, or to refer are made only after the results of screening evaluations are available. Only those patients for whom the organization has the clinical capability to provide the needed services, consistent with its mission, are considered for inpatient admission or registered for outpatient services. When the organization requires particular screening tests or evaluations prior to admission or registration, this is stated in a written policy. (Also see AOP.1, intent statement)

Measurable Elements of ACC.1

- 1. Screening is initiated at the point of first contact within or outside the organization.
- 2. Based on the results of screening, it is determined if the needs of the patient match the organization's mission and resources. (Also see GLD.3.2, ME 2)
- 3. Patients are accepted only if the organization can provide the necessary services and the appropriate outpatient or inpatient setting for care.
- 4. There is a process to provide the results of diagnostic tests to those responsible for determining if the patient is to be admitted, transferred, or referred.
- 5. Policies identify which screening and diagnostic tests are standard before admission.
- 6. Patients are not admitted, transferred, or referred before the test results required for these decisions are available.

Standard ACC.1.1
The organization has a process for admitting inpatients and for registering outpatients.

Intent of ACC.1.1
The process for admitting inpatients to the organization for care and for registering outpatients for services is standardized through written policies and procedures. Staff responsible for the process are familiar with and follow the standardized procedures.

The policies and procedures address
- registration for outpatient services or admission for inpatient services;
- admission directly from the emergency service to an inpatient unit; and
- the process for holding patients for observation.
The policies also address how patients are managed when inpatient facilities are limited or no space is available to admit patients or to admit patients to the appropriate unit. (Also see COP.1, ME 1)

**Measurable Elements of ACC.1.1**
- 1. The outpatient registration process is standardized.
- 2. The inpatient admitting process is standardized. (Also see GLD.6.1, ME 3)
- 3. There is a process for admitting emergency patients to inpatient units.
- 4. There is a process for holding patients for observation.
- 5. There is a process for managing patients when bed space is not available on the desired service or unit or elsewhere in the facility.
- 6. Written policies and procedures support the processes for admitting inpatients and registering outpatients.
- 7. Staff are familiar with the policies and procedures and follow them.

**Standard ACC.1.1.1**
Patients with emergent, urgent, or immediate needs are given priority for assessment and treatment.

**Intent of ACC.1.1.1**
Patients with emergent, urgent, or immediate needs (such as airborne infections) are identified by an evidence-based triage process. Once identified as emergent, urgent, or requiring immediate needs, these patients are assessed and receive care as quickly as necessary. Such patients may be assessed by a physician or other qualified individual before other patients, receive diagnostic services as rapidly as possible, and begin treatment to meet their needs. The triage process may include physiologic-based criteria, where possible and appropriate. The organization trains staff to determine which patients need immediate care and how their care is given priority.

When the organization is not able to meet the needs of the patient with an emergency condition and the patient requires transfer to a higher level of care, the transferring organization must provide stabilizing treatment within its capacity prior to transport.

**Measurable Elements of ACC.1.1.1**
- 1. The organization uses an evidence-based triage process to prioritize patients with immediate needs.
- 2. Staff are trained to use the criteria.
- 3. Patients are prioritized based on the urgency of their needs.
- 4. Emergency patients are assessed and stabilized within the capacity of the organization prior to transfer. (Also see ACC.4, MEs 1, 2, and 5, and ACC.4.2, MEs 3 and 4)

**Standard ACC.1.1.2**
Patient needs for preventive, palliative, curative, and rehabilitative services are prioritized based on the patient’s condition at the time of admission as an inpatient to the organization.

**Intent of ACC.1.1.2**
When patients are considered for admission as an inpatient to the organization, the screening assessment helps staff identify and prioritize the preventive, curative, rehabilitative, and palliative services needed by the patient and select the most appropriate service or unit to meet the patient’s most urgent or priority needs.
Measurable Elements of ACC.1.1.2
- 1. The screening assessment helps staff identify the patient’s needs.
- 2. The service or unit selected to meet these needs is based on the screening assessment findings.
- 3. Patients’ needs related to preventive, curative, rehabilitative, and palliative services are prioritized.

Standard ACC.1.1.3
The organization considers the clinical needs of patients when there are waiting periods or delays for diagnostic and/or treatment services.

Intent of ACC.1.1.3
Patients are informed when there are known long waiting periods for diagnostic and/or treatment services or when obtaining the planned care may require placement on a waiting list. Patients are informed of the associated reasons for the delay or wait and are informed of available alternatives. This requirement applies to inpatient and outpatient care and/or diagnostic services; not to minor waits in providing outpatient care or inpatient care, such as when a physician is behind schedule. For some services, such as oncology or transplant, delays may be consistent with national norms for those services and thus different than the delays for such services as diagnostic.

Measurable Elements of ACC.1.1.3
- 1. Inpatients and outpatients are informed when there will be a delay in care and/or treatment.
- 2. Patients are informed of the reasons for the delay or wait and provided with information on available alternatives consistent with their clinical needs.
- 3. The information is documented in the patient’s record.
- 4. Written policies and/or procedures support consistent practice.

Standard ACC.1.2
At admission as an inpatient, patients and families receive information on the proposed care, the expected outcomes of care, and any expected cost to the patient for care.

Intent of ACC.1.2
During the admission process, patients and their families receive sufficient information to make knowledgeable decisions. Information is provided about the proposed care, the expected outcomes, and any expected cost to the patient or family for the care when not paid for by a public or private source. When financial constraints related to the cost of care are present, the organization seeks ways to overcome those constraints. Such information can be in written form or provided verbally, noting such in the patient’s record.

Measurable Elements of ACC.1.2
- 1. The patient and family are provided with information at admission. (*Also see* MCI.2, intent statement)
- 2. The information includes information on the proposed care. (*Also see* MCI.2, MEs 1 and 2)
- 3. The information includes information on the expected outcomes of care.
- 4. The information includes information on any expected costs to the patient or family.
- 5. The information is sufficient for the patient and family to make knowledgeable decisions. (*Also see* AOP.4.1, ME 3)
Standard ACC.1.3
The organization seeks to reduce physical, language, cultural, and other barriers to access and delivery of services.

Intent of ACC.1.3
Organizations frequently serve communities with a diverse population. Patients may be aged, have disabilities, speak multiple languages or dialects, be culturally diverse, or present other barriers that make the process of accessing and receiving care very difficult. The organization has identified those barriers and has implemented processes to eliminate or to reduce these barriers for patients seeking care. The organization also takes action to reduce the impact of these barriers on the delivery of services.

Measurable Elements of ACC.1.3
1. The leaders and staff of the organization identify the most common barriers in its patient population.
2. There is a process to overcome or limit barriers for patients seeking care.
3. There is a process to limit the impact of barriers on the delivery of services.
4. These processes are implemented.

Standard ACC.1.4
Admission or transfer to or from units providing intensive or specialized services is determined by established criteria.

Intent of ACC.1.4
Units or services that provide intensive care (for example, a postsurgical intensive care unit) or that provide specialized services (for example, the care of burn patients or organ transplant units) are costly and usually are limited in space and staffing. Also, when present, emergency departments with observation beds and clinical research units must ensure appropriate patient selection for the units or beds. Each organization must establish criteria for determining those patients who require the level of care provided in such units. To ensure consistency, the criteria should be physiologic-based where possible and appropriate. Appropriate individuals from the emergency, intensive, or specialized services participate in developing the criteria. The criteria are used to determine direct entry to the unit, for example, directly from the emergency service. The criteria are also used to determine transfer into the unit from within the organization or outside the organization. The criteria are also used to determine when a patient no longer requires the services of the unit and can be transferred to another level of care.

When the organization conducts research or provides specialized patient care services or programs, admission or transfer into such programs is through established criteria or an established protocol. Appropriate individuals from the research or other programs are involved in developing the criteria or protocol. Admission to such programs is documented in the patient’s record and includes the criteria or protocol conditions under which the patient was admitted or transferred.

Measurable Elements of ACC.1.4
1. The organization has established entry and/or transfer criteria for its intensive and specialized services or units, including research and other programs to meet special patient needs.
2. The criteria are physiologic-based where possible and appropriate.
3. Appropriate individuals are involved in developing the criteria.
4. Staff are trained to apply the criteria.

5. The records of patients who are admitted to units providing intensive/specialized services contain evidence that they meet the criteria for services.

6. The records of patients who are transferred or discharged from units providing intensive/specialized services contain evidence that they no longer meet the criteria for services.

**Continuity of Care**

**Standard ACC.2**

The organization designs and carries out processes to provide continuity of patient care services in the organization and coordination among health care practitioners.

**Intent of ACC.2**

As patients move through a health care organization from admission to discharge or transfer, several departments and services and many different health care practitioners may be involved in providing care. Throughout all phases of care, patient needs are matched with appropriate resources in and, when necessary, outside the organization. This is usually accomplished by using established criteria or policies that determine the appropriateness of transfers within the organization. (*Also see ACC.1.4 related to criteria for admission to or from intensive and specialized units*)

For patient care to appear seamless, the organization needs to design and to implement processes for continuity and coordination of care among physicians, nurses, and other health care practitioners in
- emergency services and inpatient admission;
- diagnostic services and treatment services;
- surgical and nonsurgical treatment services;
- outpatient care programs; and
- other organizations and other care settings.

The leaders of the various settings and services work together to design and to implement the processes. The processes may be supported with explicit transfer criteria or by policies, procedures, or guidelines. The organization identifies individuals responsible for coordinating services. These individuals may coordinate all patient care (for example, between departments) or may be responsible for coordinating the care of individual patients (for example, case manager).

**Measurable Elements of ACC.2**

1. The leaders of services and settings design and implement processes that support continuity and coordination of care, including those identified in the intent statement.

2. Established criteria or policies determine the appropriateness of transfers within the organization.

3. Continuity and coordination are evident throughout all phases of patient care.

4. Continuity and coordination are evident to the patient. (*Also see PFR.2, ME 1, and PFR.2.1, ME 2*)
Standard ACC.2.1
During all phases of inpatient care, there is a qualified individual identified as responsible for the patient’s care.

Intent of ACC.2.1
To maintain continuity of care throughout the patient’s stay in the organization, the individual with overall responsibility for coordination and continuity of the patient’s care or particular phase of the patient’s care is clearly identified. This individual may be a physician or other qualified individual. The responsible individual is identified in the patient’s record or in another manner made known to the organization’s staff. The responsible individual is expected to provide documentation related to the patient’s plan of care. A single individual providing the oversight of care during the entire hospital stay will improve continuity, coordination, patient satisfaction, quality, and potentially the outcomes and thus is desirable for certain complex patients and others the organization may identify. This individual would need to collaborate and to communicate with the other health care practitioners. In addition, organization policy identifies the process for the transfer of responsibility from the responsible individual to another individual during vacations, holidays, and other periods. The policy identifies those consultants, on-call physicians, locum tenens, or others who take responsibility and how they are to assume that responsibility and to document their participation/coverage.

When a patient moves from one phase of care to another (for example, from surgical to rehabilitation), the individual responsible for the patient’s care may change or the same individual may continue overseeing all the patient’s care.

Measurable Elements of ACC.2.1
1. The individual responsible for the coordination of the patient’s care is identified and available through all phases of inpatient care. (Also see COP.2.1, ME 5 for physician responsibility, and PFR.6.1, ME 2)
2. The individual is qualified to assume responsibility for the patient’s care.
3. The individual is identified to the organization’s staff.
4. The individual provides documentation in the clinical record related to the patient’s plan of care.
5. The transfer of responsibility from individual to individual of the patient’s care is described in organization policy.

Discharge, Referral, and Follow-Up

Standard ACC.3
There is a policy guiding the referral or discharge of patients.

Intent of ACC.3
Referring or discharging a patient to a health care practitioner outside the organization, another care setting, home, or family is based on the patient’s health status and need for continuing care or services. The patient’s physician or individual responsible for his or her care must determine readiness for discharge based on the policies and relevant criteria or indications of referral and discharge established by the hospital. Criteria may also be used to indicate when a patient is ready for discharge. Continuing needs may mean referral to a medical specialist, rehabilitation therapist, or even preventive health needs coordinated in the home by the family. An organized
process is required to ensure that any continuing needs are met by appropriate health care practitioners or outside organizations. The process includes referring patients to sources of care outside the region when required. When indicated, the organization begins to plan for the continuing needs as early in the care process as possible. The family is included in the discharge planning process as appropriate to the patient and his or her needs.

When the organization permits patients to leave the hospital for a period of time—for example, on a weekend “pass”—there is a policy and procedure to guide this process.

**Measurable Elements of ACC.3**

- 1. Patients are referred and/or discharged based on their health status and needs for continuing care. (*Also see* AOP.1.10, ME 1; AOP.1.11, ME 1; and GLD.6.1, ME 3)
- 2. The patient's readiness for discharge is determined by the use of relevant criteria or indications that ensure patient safety.
- 3. When indicated, planning for referral and/or discharge begins early in the care process and, when appropriate, includes the family. (*Also see* AOP.1.11, ME 2; AOP.2, ME 2; and PFR.2, ME 1)
- 4. Patients are referred and/or discharged according to their needs. (*Also see* AOP.1.10, ME 2; AOP.1.11, ME 2; and AOP.2, ME 2)
- 5. Organization policy guides the process for patients being permitted to leave the organization during the planned course of treatment on an approved pass for a defined period of time.

**Standard ACC.3.1**
The organization cooperates with health care practitioners and outside agencies to ensure timely and appropriate referrals.

**Intent of ACC.3.1**
Timely referral to the practitioner, organization, or agency that can best meet the patient’s continuing needs takes planning. The organization becomes familiar with the health care practitioners in its community to understand the types of patients treated and services provided and to build formal or informal relationships with those practitioners. When patients come from a different community, the organization attempts to make a referral to a qualified individual or agency in the patient’s home community.

Also, patients may need support services and medical services at discharge. For example, patients may need social, nutritional, financial, psychological, or other support at discharge. The availability and actual use of these support services may, to a large degree, determine the need for continuing medical services. The discharge planning process includes the type of support service needed and the availability of such services.

**Measurable Elements of ACC.3.1**

- 1. The discharge planning process includes the need for both support services and continuing medical services.
- 2. The organization identifies the health care practitioners, organizations, and individuals in its community that are most associated with the organization's services and patient population. (*Also see* PFE.3, ME 2)
- 3. Referrals outside the organization are to specific individuals and agencies in the patient’s home community whenever possible.
- 4. Referrals are made, when possible, for support services.
Standard ACC.3.2
The clinical records of inpatients contain a copy of the discharge summary.

Intent of ACC.3.2
A summary of the patient's care is prepared at discharge from the organization. Any qualified individual can compile the discharge summary, such as the patient's physician, a house medical officer, or a clerk.

The copy of the discharge summary is placed in the patient's record. A copy is given to the patient and, as appropriate, the patient's family, when indicated by organization policy or common practice consistent with laws and culture. A copy of the discharge summary is also provided to the practitioner who will be responsible for the continuing care of the patient or his or her follow-up.

Measurable Elements of ACC.3.2
- 1. A discharge summary is prepared at discharge by a qualified individual.
- 2. The summary contains follow-up instructions.
- 3. A copy of the discharge summary is placed in the patient record.
- 4. Unless contrary to organization policy, laws, or culture, the patient is given a copy of the discharge summary.
- 5. A copy of the discharge summary is provided to the practitioner responsible for the patient's continuing or follow-up care.
- 6. Policy and procedure define when the discharge summary must be completed and in the record.

Standard ACC.3.2.1
The discharge summary of inpatients is complete.

Intent of ACC.3.2.1
The discharge summary provides an overview of the patient's stay within the organization. The summary can be used by the practitioner responsible for providing follow-up care. The summary includes the following:
   a) Reason for admission, diagnoses, and comorbidities
   b) Significant physical and other findings
   c) Diagnostic and therapeutic procedures performed
   d) Significant medications, including discharge medications (that is, all the medications to be taken at home)
   e) The patient's condition/status at the time of discharge
   f) Follow-up instructions

Measurable Elements of ACC.3.2.1
- 1. The discharge summary contains reason for admission, diagnoses, and comorbidities.
- 2. The discharge summary contains significant physical and other findings.
- 3. The discharge summary contains diagnostic and therapeutic procedures performed.
- 4. The discharge summary contains significant medications, including discharge medications.
- 5. The discharge summary contains the patient's condition/status at the time of discharge.
- 6. The discharge summary contains follow-up instructions.
Standard ACC.3.3
The clinical records of outpatients receiving continuing care contain a summary of all known significant diagnoses, drug allergies, current medications, and any past surgical procedures and hospitalizations.

Intent of ACC.3.3
When the organization provides ongoing care and treatment for outpatients, over time, there may be an accumulated number of diagnoses, medications, and an evolving clinical history and physical exam findings. It is important to maintain a current summary of the patient’s profile in order to facilitate continuity of care. The summary contains the following, for example:

- Significant diagnoses
- Drug allergies
- Current medication(s)
- Past surgical procedures
- Past hospitalizations

The organization must decide the format and content of the summary and for which continuing care patients the summary will be started (for example, patients seen frequently over a longer period of time for multiple problems, multiple visits, multiple clinics, and the like). The organization also decides what is considered a current summary, how the summary is maintained, and who maintains it.

Measurable Elements of ACC.3.3
- 1. The organization identifies for which continuing care patients a summary will be initiated.
- 2. The organization identifies how the summary is maintained and who maintains it.
- 3. The organization has identified the format and content of the summary.
- 4. The organization defines what is considered current.
- 5. Clinical records contain the completed summary list per organization policy.

Standard ACC.3.4
Patients and, as appropriate, their families are given understandable follow-up instructions.

Intent of ACC.3.4
For patients not directly referred or transferred to another health care practitioner, clear instructions on where and how to receive continuing care are essential to ensure optimal outcomes of care and that all care needs are met.

The instructions include the name and location of sites for continuing care, any return to the organization for follow-up, and when urgent care should be obtained. Families are included in the process when a patient’s condition or abilities prevent him or her from understanding the follow-up instructions. Families are also included when they play a role in the continuing care process.

The organization provides the instructions to the patient and, as appropriate, his or her family in a simple, understandable manner. The instructions are provided in writing or in the form most understandable to the patient.

Measurable Elements of ACC.3.4
- 1. Follow-up instructions are provided in a form and manner the patient and/or family understands.
- 2. The instructions include any return for follow-up care.
- 3. The instructions include when to obtain urgent care.
- 4. Families are provided the instructions for care as necessary to the patient’s condition.
Standard ACC.3.5
The organization has a process for the management and follow-up of patients who leave against medical advice.

Intent of ACC.3.5
When inpatients or outpatients choose to leave the hospital against medical advice, there are risks related to inadequate treatment that may result in permanent harm or death. Hospitals need to understand the reasons that patients leave against medical advice in order to be able to better communicate with them. If the patient has a family physician who is known to the organization, then the organization, in order to reduce the risk of harm, should notify that physician. The process is consistent with applicable laws and regulations.

Measurable Elements of ACC.3.5
- 1. There is a process for the management and follow-up of inpatients and outpatients who leave against medical advice. (Also see PFR.2, ME 1, and PFR.2.2, intent statement)
- 2. When there is a known family physician, the individual is notified. (Also see PFR 2.2, MEs 1 and 2)
- 3. The process is consistent with applicable laws and regulations.

Transfer of Patients

Standard ACC.4
Patients are transferred to other organizations based on status and the need to meet their continuing care needs.

Intent of ACC.4
Transferring a patient to an outside organization is based on the patient’s status and need for continuing health care services. Transfer may be in response to a patient’s need for specialized consultation and treatment, urgent services, or less-intensive services, such as sub-acute care or longer term rehabilitation. (Also see ACC.1.1.1, ME 4) A transfer process is required to ensure that outside organizations meet any continuing needs. Such a process addresses
  - how responsibility is transferred between practitioners and settings;
  - criteria for when transfer is necessary to meet the patient’s needs;
  - who is responsible for the patient during transfer;
  - what supplies and equipment are required during transfer; and
  - what is to be done when transfer to another source of care is not possible.

Measurable Elements of ACC.4
- 1. Transfers of patients are based on the patient’s needs for continuing care. (Also see ACC.1.1.1, ME 4, and GLD.6.1, ME 3)
- 2. The transfer process addresses how responsibility for continuing care is moved to another practitioner or setting. (Also see ACC.1.1.1, ME 4, and GLD.6.1, ME 3)
- 3. The transfer process addresses who is responsible during transfer and what supplies and equipment are required during transport. (Also see GLD.6.1, ME 3)
- 4. The transfer process addresses the situation in which transfer is not possible. (Also see GLD.6.1, ME 3)
5. Patients are appropriately transferred to other organizations. (*Also see* ACC.1.1.1, ME 4)

**Standard ACC.4.1**

The referring organization determines that the receiving organization can meet the patient's continuing care needs.

**Intent of ACC.4.1**

When referring a patient to another organization, the referring organization must determine if the receiving organization provides services to meet the patient's needs and has the capacity to receive the patient. This determination is usually made well in advance, and the willingness to receive patients and to transfer conditions are described in formal or informal affiliations or agreements. This advance determination ensures continuity of care and that the patient’s care needs will be met.

**Measurable Elements of ACC.4.1**

- 1. The referring organization determines that the receiving organization can meet the needs of the patient to be transferred.
- 2. Formal or informal arrangements are in place with receiving organizations when patients are frequently transferred to the receiving organization. (*Also see* GLD.3.3.1, intent statement)

**Standard ACC.4.2**

The receiving organization is given a written summary of the patient's clinical condition and the interventions provided by the referring organization.

**Intent of ACC.4.2**

To ensure continuity of care, patient information is transferred with the patient. A copy of the discharge summary or other written clinical summary is provided to the receiving organization with the patient. The summary includes the patient's clinical condition or status, the procedures and other interventions provided, and the continuing patient needs.

**Measurable Elements of ACC.4.2**

- 1. Patient clinical information or a clinical summary is transferred with the patient.
- 2. The clinical summary includes patient status.
- 3. The clinical summary includes procedures and other interventions provided. (*Also see* ACC.1.1.1, ME 4)
- 4. The clinical summary includes the patient's continuing care needs. (*Also see* ACC.1.1.1, ME 4)

**Standard ACC.4.3**

During direct transfer, a qualified staff member monitors the patient's condition.

**Intent of ACC.4.3**

Transferring a patient directly to another health care organization may be a brief process with an alert and talking patient, or it may involve moving a comatose patient who needs continuous nursing or medical oversight. In either case, the patient requires monitoring, but the qualifications of the individual doing the monitoring are significantly different. Thus, the condition and status of the patient determine the appropriate qualifications of the staff member monitoring the patient during transfer.
Measurable Elements of ACC.4.3

- 1. All patients are monitored during direct transfer.
- 2. The qualifications of the staff member are appropriate for the patient's condition.

### Standard ACC.4.4

The transfer process is documented in the patient's record.

### Intent of ACC.4.4

The record of each patient transferred to another health care organization contains documentation of the transfer. The documentation includes the name of the organization and the name of the individual agreeing to receive the patient, the reason(s) for the transfer, and any special conditions for transfer (such as when space at the receiving organization is available, or the patient's status). Also, it is noted if the patient's condition or status changed during transfer (for example, the patient dies or requires resuscitation). Any other documentation required by organization policy (for example, a signature of the receiving nurse or physician, the name of the individual who monitored the patient during transport) is included in the record.

Measurable Elements of ACC.4.4

- 1. The records of transferred patients note the name of the health care organization and name of the individual agreeing to receive the patient.
- 2. The records of transferred patients contain documentation or other notes as required by the policy of the transferring organization.
- 3. The records of transferred patients note the reason(s) for transfer.
- 4. The records of transferred patients note any special conditions related to transfer.
- 5. The records of transferred patients contain documentation of any change in patient condition or status during transfer.

### Transportation

### Standard ACC.5

The process for referring, transferring, or discharging patients, both inpatients and outpatients, includes planning to meet the patient's transportation needs.

### Intent of ACC.5

The organization's process for referring, transferring, or discharging patients includes an understanding of the transportation needs of the patient. The type of transportation will vary and may be by ambulances or other vehicles owned by the hospital or by a source designated by the family, or the family and/or friends may provide the transportation. The transportation selected will depend on the patient's condition and status.

When the transport vehicles are owned by the hospital, they need to be in compliance with all applicable laws and regulations related to their operation, condition, and maintenance. The organization identifies the transportation situations that have a risk of infection and implements strategies to reduce infection risk. (Also see the PCI chapter for compliance with infection control standards appropriate for use.) The required drugs, medications, and other supplies needed within the vehicle are based on the types of patients transported.
For example, simply taking geriatric patients home from outpatient visits is very different than transferring an infectious disease or burn patient to another hospital.

If the hospital contracts for transport services, the hospital must be assured that the contractor meets similar standards for patient and vehicle safety.

In all cases, the hospital evaluates the quality and safety of the transportation services. This includes the receipt of, evaluation of, and response to complaints regarding the transportation provided or arranged.

**Measurable Elements of ACC.5**

1. There is an assessment of transportation needs when any patient is referred to another source of care, transferred to another care setting, or ready to go home following an inpatient admission or outpatient visit.

2. The transportation provided or arranged is appropriate to the needs and condition of the patient.

3. Transport vehicles owned by the hospital meet relevant laws and regulations related to their operation, condition, and maintenance.

4. Contracted transportation services meet the hospital’s requirements for quality and safe transport. *(Also see GLD.3.3.1, intent statement)*

5. All vehicles used for transportation, contracted or hospital owned, have appropriate equipment, supplies, and medications to meet the needs of the patient being transported.

6. There is a process in place to monitor the quality and safety of transportation provided or arranged by the hospital, including a complaint process. *(Also see GLD.3.3.1, intent statement)*
Overview

Each patient is unique, with his or her own needs, strengths, values, and beliefs. Health care organizations work to establish trust and open communication with patients and to understand and protect each patient’s cultural, psychosocial, and spiritual values.

Patient care outcomes are improved when patients and, as appropriate, their families or those who make decisions on their behalf are involved in care decisions and processes in a way that matches cultural expectations.

To promote patient rights in a health care organization, one starts by defining those rights, then educating patients and staff about those rights. Patients are informed of their rights and how to act on them. Staff are taught to understand and to respect patients’ beliefs and values and to provide considerate and respectful care that protects patients’ dignity.

This chapter addresses processes to
- identify, protect, and promote patient rights;
- inform patients of their rights;
- include the patient’s family, when appropriate, in decisions about the patient’s care;
- obtain informed consent; and
- educate staff about patient rights.

How these processes are carried out in an organization depends on its country’s laws and regulations and any international conventions, treaties, or agreements on human rights endorsed by its country.

These processes are related to how an organization provides health care in an equitable manner, given the structure of the health care delivery system and the health care financing mechanisms of the country. This chapter also addresses the rights of patients and families related to research and to the donation and transplantation of organs and tissues.
Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

PFR.1  The organization is responsible for providing processes that support patients’ and families’ rights during care.

PFR.1.1  Care is considerate and respectful of the patient’s personal values and beliefs.

PFR.1.1.1  The organization has a process to respond to patient and family requests for pastoral services or similar requests related to the patient's spiritual and religious beliefs.

PFR.1.2  Care is respectful of the patient’s need for privacy.

PFR.1.3  The organization takes measures to protect patients’ possessions from theft or loss.

PFR.1.4  Patients are protected from physical assault.

PFR.1.5  Children, disabled individuals, the elderly, and other populations at risk receive appropriate protection.

PFR.1.6  Patient information is confidential.

PFR.2  The organization supports patients’ and families' rights to participate in the care process.

PFR.2.1  The organization informs patients and families, in a method and language they can understand, about the process of how they will be told of medical conditions and any confirmed diagnosis, how they will be told of planned care and treatment, and how they can participate in care decisions, to the extent they wish to participate.

PFR.2.1.1  The organization informs patients and families about how they will be told about the outcomes of care and treatment, including unanticipated outcomes, and who will tell them.

PFR.2.2  The organization informs patients and families about their rights and responsibilities related to refusing or discontinuing treatment.

PFR.2.3  The organization respects patient wishes and preferences to withhold resuscitative services and to forgo or to withdraw life-sustaining treatments.

PFR.2.4  The organization supports the patient’s right to appropriate assessment and management of pain.

PFR.2.5  The organization supports the patient’s right to respectful and compassionate care at the end of life.

PFR.3  The organization informs patients and families about its process to receive and to act on complaints, conflicts, and differences of opinion about patient care and the patient’s right to participate in these processes.

PFR.4  Staff members are educated about their roles in identifying patients’ values and beliefs and protecting patients’ rights.
**PFR.5** All patients are informed about their rights and responsibilities in a manner and language they can understand.

**Informed Consent**

**PFR.6** Patient informed consent is obtained through a process defined by the organization and carried out by trained staff in a language the patient can understand.

**PFR.6.1** Patients and families receive adequate information about the illness, proposed treatment(s), and health care practitioners so that they can make care decisions.

**PFR.6.2** The organization establishes a process, within the context of existing law and culture, for when others can grant consent.

**PFR.6.3** General consent for treatment, if obtained when a patient is admitted as an inpatient or is registered for the first time as an outpatient, is clear in its scope and limits.

**PFR.6.4** Informed consent is obtained before surgery, anesthesia, use of blood and blood products, and other high-risk treatments and procedures.

**PFR.6.4.1** The organization lists those categories or types of treatments and procedures that require specific informed consent.

**Research**

**PFR.7** The organization informs patients and families about how to gain access to clinical research, clinical investigation, or clinical trials involving human subjects.

**PFR.7.1** The organization informs patients and families about how patients who choose to participate in clinical research, investigation, or clinical trials are protected.

**PFR.8** Informed consent is obtained before a patient participates in clinical research, clinical investigation, and clinical trials.

**PFR.9** The organization has a committee or another way to oversee all research in the organization involving human subjects.

**Organ Donation**

**PFR.10** The organization informs patients and families about how to choose to donate organs and other tissues.

**PFR.11** The organization provides oversight of the harvesting and transplantation of organs and tissues.
Standards, Intents, and Measurable Elements

Standard PFR.1
The organization is responsible for providing processes that support patients’ and families’ rights during care.

Intent of PFR.1
An organization’s leaders are primarily responsible for how an organization will treat its patients. Thus, the leaders need to know and to understand patient and family rights and their organization’s responsibilities as identified in laws and regulations. The leaders then provide direction to ensure that staff throughout the organization assume responsibility for protecting these rights. To effectively protect and to advance patient rights, the leaders work collaboratively and seek to understand their responsibilities in relation to the community served by the organization.

The organization respects the right of patients, and in some circumstances the right of the patient’s family, to have the prerogative to determine what information regarding their care would be provided to family or others, and under what circumstances. For example, the patient may not wish to have a diagnosis shared with family.

Patient and family rights are a fundamental element of all contacts among an organization, its staff, and patients and families. Thus, policies and procedures are developed and implemented to ensure that all staff members are aware of and respond to patient and family rights issues when they interact with and care for patients throughout the organization. The organization uses a collaborative and inclusive process to develop the policies and procedures, and, when appropriate, include patients and families in the process.

Measurable Elements of PFR.1

- 1. The organization’s leaders work collaboratively to protect and to advance patient and family rights.
- 2. The leaders understand patient and family rights as identified in laws and regulations and in relation to the cultural practices of the community or individual patients served. (Also see GLD.6, ME 1)
- 3. The organization respects the right of patients, and in some circumstances the right of the patient’s family, to have the prerogative to determine what information regarding their care would be provided to family or others, and under what circumstances.
- 4. Staff members are knowledgeable about the policies and procedures related to patient rights and can explain their responsibilities in protecting patient rights.
- 5. Policies and procedures guide and support patient and family rights in the organization.

Standard PFR.1.1
Care is considerate and respectful of the patient’s personal values and beliefs.

Standard PFR.1.1.1
The organization has a process to respond to patient and family requests for pastoral services or similar requests related to the patient’s spiritual and religious beliefs.

Intent of PFR.1.1 and PFR.1.1.1
Each patient brings his or her own set of values and beliefs to the care process. Some values and beliefs are commonly held by all patients and are frequently cultural and religious in origin. Other values and beliefs are those of the patient alone. All patients are encouraged to express their beliefs in ways that respect the beliefs of others.
Strongly held values and beliefs can shape the care process and how patients respond to care. Thus, each health care practitioner seeks to understand the care and services he or she provides within the context of the patient’s values and beliefs.

When a patient or family wishes to speak with someone related to religious or spiritual needs, the organization has a process to respond to the request. The process may be carried out through on-site religious staff, local sources, or family-referred sources. The process to respond is more complex, for example, when the organization or country does not officially “recognize” and/or have sources related to a religion or belief for which there may be a request.

**Measurable Elements of PFR.1.1**

- 1. There is a process to identify and to respect patient values and beliefs, and when applicable, those of the patient’s family. (*Also see PFE.2.1, ME 1, and COP 7, ME 1*)
- 2. Staff use the process and provide care that is respectful of the patient’s values and beliefs.

**Measurable Elements of PFR.1.1.1**

- 1. The organization has a process designed to respond to routine as well as complex requests related to religious or spiritual support.
- 2. The organization responds to requests for religious or spiritual support.

**Standard PFR.1.2**

Care is respectful of the patient’s need for privacy.

**Intent of PFR.1.2**

Patient privacy, especially during clinical interviews, examinations, procedures/treatments, and transport, is important. Patients may desire privacy from other staff, other patients, and even from family members. Also, patients may not wish to be photographed, recorded, or participate in accreditation survey interviews. Although there are some common approaches to providing privacy for all patients, individual patients may have different or additional privacy expectations and needs according to the situation, and these expectations and needs may change over time. Thus, as staff members provide care and services to patients, they inquire about the patient’s privacy needs and expectations related to the care or service. This communication between a staff member and his or her patient builds trust and open communication and does not need to be documented.

**Measurable Elements of PFR.1.2**

- 1. Staff members identify patient expectations and needs for privacy during care and treatment. (*Also see PFR.2.5*)
- 2. A patient’s expressed need for privacy is respected for all clinical interviews, examinations, procedures/treatments, and transport.

**Standard PFR.1.3**

The organization takes measures to protect patients’ possessions from theft or loss.

**Intent of PFR.1.3**

The organization communicates its responsibility, if any, for the patient’s possessions to patients and families. When the organization takes responsibility for any or all of the patient’s personal possessions brought into the organization, there is a process to account for the possessions and to ensure they will not be lost or stolen.
This process considers the possessions of emergency patients, same-day surgery patients, inpatients, those patients unable to make alternative safekeeping arrangements, and those incapable of making decisions regarding their possessions.

**Measurable Elements of PFR.1.3**

- 1. The organization has determined its level of responsibility for patients’ possessions.
- 2. Patients receive information about the organization’s responsibility for protecting personal belongings.
- 3. Patients’ possessions are safeguarded when the organization assumes responsibility or when the patient is unable to assume responsibility.

**Standard PFR.1.4**

Patients are protected from physical assault.

**Intent of PFR.1.4**

The organization is responsible for protecting patients from physical assault by visitors, other patients, and staff. This responsibility is particularly relevant to infants and children, the elderly, and others unable to protect themselves or to signal for help. The organization seeks to prevent assault through such processes as investigating individuals in the facility without identification, monitoring remote or isolated areas of the facility, and quickly responding to those thought to be in danger of assault.

**Measurable Elements of PFR.1.4**

- 1. The organization has a process to protect patients from assault.
- 2. Infants, children, the elderly, and others less able or unable to protect themselves are addressed in the process.
- 3. Individuals without identification are investigated.
- 4. Remote or isolated areas of the facility are monitored.

**Standard PFR.1.5**

Children, disabled individuals, the elderly, and other populations at risk receive appropriate protection.

**Intent of PFR.1.5**

Each organization identifies its vulnerable and at-risk patient groups and establishes processes to protect the rights of individuals in these groups. Vulnerable patient groups and the organization’s responsibility may be identified in laws and regulations. Staff members understand their responsibilities in these processes. At least children, disabled individuals, the elderly, and other identified populations at risk are protected. Comatose patients and individuals with mental or emotional disabilities, when present in the organization, are also included. Such protection extends beyond physical assault to other areas of safety, such as protection from abuse, negligent care, withholding of services, or assistance in the event of a fire.

**Measurable Elements of PFR.1.5**

- 1. The organization identifies its vulnerable patient groups. (*Also see COP.3.1 through COP.3.9*)
- 2. Children, disabled individuals, the elderly, and others identified by the organization are protected. (*Also see COP.3.8*)
- 3. Staff members understand their responsibilities in the protection processes.
Standard PFR.1.6
Patient information is confidential.

Intent of PFR.1.6
Medical and other health information, when documented and collected, is important for understanding the patient and his or her needs and for providing care and services over time. This information may be in paper or electronic form or a combination of the two. The organization respects such information as confidential and has implemented policies and procedures that protect such information from loss or misuse. The policies and procedures reflect information that is released as required by laws and regulations.

Staff respects patient confidentiality by not posting confidential information on the patient’s door or at the nursing station and by not holding patient-related discussions in public places. Staff are aware of laws and regulations governing the confidentiality of information and inform the patient about how the organization respects the confidentiality of information. Patients are also informed about when and under what circumstances information may be released and how their permission will be obtained.

The organization has a policy that indicates if patients have access to their health information and the process to gain access when permitted. (Also see MCI.10, ME 2, and MCI.16, intent statement)

Measurable Elements of PFR.1.6
1. Patients are informed about how their information will be kept confidential and about laws and regulations that require the release of and/or require confidentiality of patient information.
2. Patients are requested to grant permission for the release of information not covered by laws and regulations.
3. The organization respects patient health information as confidential.

Standard PFR.2
The organization supports patients’ and families’ rights to participate in the care process.

Intent of PFR.2
Patients and families participate in the care process by making decisions about care, asking questions about care, and even refusing diagnostic procedures and treatment. The organization supports and promotes patient and family involvement in all aspects of care by developing and implementing related policies and procedures. Policies and procedures address the patient’s right to seek a second opinion without fear of compromise to their care within or outside the organization. All staff members are trained on the policies and procedures and on their role in supporting patients’ and families’ rights to participate in the care process.

Measurable Elements of PFR.2
1. Policies and procedures are developed to support and to promote patient and family participation in care processes. (Also see ACC.2, ME 4; ACC.3.5, ME 1; COP.7.1, ME 5; PFE.2, ME 5; PFE.5, ME 2; PFR.2; and ACC.3, ME 3)
2. Policies and procedures address the patient’s right to seek a second opinion without fear of compromise to their care within or outside the organization.
3. Staff members are trained on the policies and procedures and their role in supporting patient and family participation in care processes.
Standard PFR.2.1
The organization informs patients and families, in a method and language they can understand, about the process of how they will be told of medical conditions and any confirmed diagnosis, how they will be told of planned care and treatment, and how they can participate in care decisions, to the extent they wish to participate.

Intent of PFR.2.1
For patients and families to participate in care decisions, they need basic information about the medical conditions found during assessment, including any confirmed diagnosis when appropriate, and on the proposed care and treatment. Patients and families understand when they will be told this information and who is responsible for telling them. Patients and families understand the type of decisions that must be made about care and how to participate in those decisions. In addition, patients and families need to understand the organization’s process to obtain consent and which care processes, tests, procedures, and treatments require their consent.

Although some patients may not wish to personally know a confirmed diagnosis or to participate in the decisions regarding their care, they are given the opportunity and can choose to participate through a family member, friend, or a surrogate decision maker. (Also see PFE.5, ME 3)

Measurable Elements of PFR.2.1
1. Patients and families understand how and when they will be told of medical conditions and any confirmed diagnosis when appropriate. (Also see AOP.4.1, ME 2, and PFE.2, ME 6)
2. Patients and families understand how and when they will be told of planned care and treatment(s). (Also see AOP.4.1, ME 3, and ACC.2, ME 4)
3. Patients and families understand when consent will be requested and the process used to give consent. (Also see PFE.2, ME 4)
4. Patients and families understand their right to participate in care decisions to the extent they wish. (Also see PFR.2, ME 1; AOP.4.1, ME 3; COP.7.1, ME 5; ACC.3, ME 3; and PFE.2, ME 7)

Standard PFR.2.1.1
The organization informs patients and families about how they will be told about the outcomes of care and treatment, including unanticipated outcomes, and who will tell them.

Intent of PFR.2.1.1
During the care process, patients, and, when appropriate, their families, have a right to be told of the outcomes of the planned care and treatment. It is also important that they be told of any unanticipated outcomes of the care and treatment, such as unanticipated events during surgery or with prescribed medications or other treatments. It should be clear to the patients how they will be told and who will tell them of the expected and any unanticipated outcomes.

Measurable Elements of PFR.2.1.1
1. Patients and families understand how they will be told and who will tell them of the outcomes of care and treatment. (Also see COP.2.4, ME 1)
2. Patients and families understand how they will be told and who will tell them of any unanticipated outcomes of care and treatment. (Also see COP.2.4, ME 2)
**Standard PFR.2.2**

The organization informs patients and families about their rights and responsibilities related to refusing or discontinuing treatment.

**Intent of PFR.2.2**

Patients, or those making decisions on their behalf, may decide not to proceed with the planned care or treatment or to continue care or treatment after it has been initiated. The organization informs patients and families about their rights to make these decisions, the potential outcomes of these decisions, and their responsibilities related to such decisions. Patients and families are informed about any care and treatment alternatives. *(Also see ACC.3.5, ME 1)*

**Measurable Elements of PFR.2.2**

1. The organization informs patients and families about their rights to refuse or to discontinue treatment. *(Also see ACC.3.5, ME 2)*
2. The organization informs patients about the consequences of their decisions. *(Also see ACC.3.5, ME 2)*
3. The organization informs patients and families about their responsibilities related to such decisions.
4. The organization informs patients about available care and treatment alternatives.

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**Standard PFR.2.3**

The organization respects patient wishes and preferences to withhold resuscitative services and to forgo or to withdraw life-sustaining treatments.

**Intent of PFR.2.3**

Decisions about withholding resuscitative services or forgoing or withdrawing life-sustaining treatment are among the most difficult choices facing patients, families, health care professionals, and organizations. No single process can anticipate all the situations in which such decisions must be made. For this reason, it is important for the organization to develop a framework for making these difficult decisions. The framework

- helps the organization identify its position on these issues;
- ensures that the organization’s position conforms to its community’s religious and cultural norms and to any legal or regulatory requirements, in particular when legal requirements for resuscitation are not consistent with the patient’s wishes;
- addresses situations in which these decisions are modified during care; and
- guides health professionals through the ethical and legal issues in carrying out such patient wishes.

To ensure that the decision-making process related to carrying out the patient’s wishes is applied consistently, the organization develops policies and procedures through a process that includes many professionals and viewpoints. The policies and procedures identify lines of accountability and responsibility and how the process is documented in the patient’s record.

**Measurable Elements of PFR.2.3**

1. The organization has identified its position on withholding resuscitative services and forgoing or withdrawing life-sustaining treatments.
2. The organization’s position conforms to its community’s religious and cultural norms and any legal or regulatory requirements.
3. The organization guides health professionals on the ethical and legal considerations in carrying out such patient wishes.
4. Patient/family decisions about resuscitative services are documented in the clinical record.
5. Policies and procedures support consistent practice.
Standard PFR.2.4
The organization supports the patient’s right to appropriate assessment and management of pain.

Intent of PFR.2.4
Pain is a common part of the patient experience, and unrelieved pain has adverse physical and psychological effects. A patient’s response to pain is frequently within the context of societal norms and cultural and religious traditions. Thus, patients are encouraged and supported in their reporting of pain. The organization’s care processes recognize and reflect the right of all patients to appropriate assessment and management of pain. (Also see COP.6)

Measurable Elements of PFR.2.4
- 1. The organization respects and supports the patient’s right to appropriate assessment and management of pain. (Also see COP.7.1, ME 1)
- 2. The organization’s staff understand the personal, cultural, and societal influences on the patient’s right to report pain and accurately assess and manage pain.

Standard PFR.2.5
The organization supports the patient’s right to respectful and compassionate care at the end of life.

Intent of PFR.2.5
Dying patients have unique needs for respectful, compassionate care. Concern for the patient’s comfort and dignity guides all aspects of care during the final stages of life. To accomplish this, all staff members are made aware of patients’ unique needs at the end of life. These needs include treatment of primary and secondary symptoms; pain management (also see AOP.1.7 and COP.6); response to the patient’s and family’s psychological, social, emotional, religious, and cultural concerns (also see PFR.1.1, PFR.1.1.1, and PFR.1.2); and involvement in care decisions (also see COP.7, intent statement).

Measurable Elements of PFR.2.5
- 1. The organization recognizes that dying patients have unique needs.
- 2. The organization’s staff respect the right of dying patients to have those unique needs addressed in the care process.

Standard PFR.3
The organization informs patients and families about its process to receive and to act on complaints, conflicts, and differences of opinion about patient care and the patient’s right to participate in these processes.

Intent of PFR.3
Patients have a right to voice complaints about their care and to have those complaints reviewed and, when possible, resolved. Also, decisions regarding care sometimes present questions, conflicts, or other dilemmas for the organization and the patient, family, or other decision makers. These dilemmas may arise from issues of access, treatment, or discharge. They can be especially difficult to resolve when the issues involve, for example, withholding resuscitative services or forgoing or withdrawing life-sustaining treatment.

The organization has established processes for seeking resolution of such dilemmas and complaints. The organization identifies in policies and procedures those who need to be involved in the processes and how the patient and family participate.
Measurable Elements of PFR.3
- 1. Patients are informed about the process for voicing complaints, conflicts, or differences of opinion.
- 2. Complaints, conflicts, and differences of opinion are investigated by the organization.
- 3. Complaints, conflicts, and differences of opinion that arise during the care process are resolved.
- 4. Patients and, when appropriate, families participate in the resolution process.
- 5. Policies and procedures support consistent practice.

Standard PFR.4
Staff members are educated about their role in identifying patients’ values and beliefs and protecting patients’ rights.

Intent of PFR.4
The organization educates all staff about patient and family rights. The education recognizes that staff members may hold values and beliefs that differ from those of the patients in their care. The education includes how each staff member participates in identifying patient values and beliefs and how he or she respects those values and beliefs in the care process.

Measurable Elements of PFR.4
- 1. Staff members understand their role in identifying patient and family values and beliefs and how such values and beliefs can be respected in the care process.
- 2. Staff members understand their role in protecting patient and family rights.

Standard PFR.5
All patients are informed about their rights and responsibilities in a manner and language they can understand.

Intent of PFR.5
Admission as an inpatient or registration as an outpatient to a health care organization can be frightening and confusing for patients, making it difficult for them to act on their rights and to understand their responsibilities in the care process. Thus, the organization prepares a written statement of patient and family rights and responsibilities that is given to patients when they are admitted as inpatients or registered as outpatients to the organization and is available each visit or throughout their stay. For example, the statement may be posted in the facility.

The statement is appropriate to the patient’s age, understanding, and language. When written communication is not effective or appropriate, the patient and family are informed of their rights and responsibilities in a language and manner they can understand. (Also see MCI.3, MEs 1 and 2)

Measurable Elements of PFR.5
- 1. Information about patient rights and responsibilities is provided in writing to each patient.
- 2. The statement of patient rights and responsibilities is posted or otherwise available from staff at all times.
- 3. The organization has a process to inform patients of their rights and responsibilities when written communication is not effective or appropriate.
**Informed Consent**

**Standard PFR.6**
Patient informed consent is obtained through a process defined by the organization and carried out by trained staff in a language the patient can understand.

**Intent of PFR.6**
One of the main ways that patients are involved in their care decisions is by granting informed consent. To consent, a patient must be informed of those factors related to the planned care required for an informed decision. Informed consent may be obtained at several points in the care process. For example, informed consent can be obtained when the patient is admitted for inpatient care in the organization and before certain procedures or treatments for which the risk is high. The consent process is clearly defined by the organization in policies and procedures. Relevant laws and regulations are incorporated into the policies and procedures.

Patients and families are informed as to what tests, procedures, and treatments require consent and how they can give consent (for example, given verbally, by signing a consent form, or through some other means). Patients and families understand who may, in addition to the patient, give consent. Designated staff members are trained to inform patients and to obtain and to document patient consent. *(Also see PFR.8, intent statement)*

**Measurable Elements of PFR.6**
- 1. The organization has a clearly defined informed consent process described in policies and procedures.
- 2. Designated staff are trained to implement the policies and procedures.
- 3. Patients give informed consent consistent with the policies and procedures.

**Standard PFR.6.1**
Patients and families receive adequate information about the illness, proposed treatment(s), and health care practitioners so that they can make care decisions.

**Intent of PFR.6.1**
Staff members clearly explain any proposed treatment(s) or procedures to the patient and, when appropriate, the family. The information provided includes
a) the patient’s condition;
b) the proposed treatment(s);
c) the name of the person providing the treatment;
d) potential benefits and drawbacks;
e) possible alternatives;
f) the likelihood of success;
g) possible problems related to recovery; and
h) possible results of nontreatment.

Staff members also inform the patient of the name of the physician or other practitioner who has primary responsibility for the patient’s care or who is authorized to perform procedures or treatment(s). Frequently, patients have questions about their primary care practitioners’ experience, length of time with the organization, and the like. The organization needs to have a process to respond when patients request additional information about their primary care practitioners.
**Measurable Elements of PFR.6.1**
- 1. Patients are informed of elements a) through h) as relevant to their condition and planned treatment.
- 2. Patients know the identities of the physicians or other practitioners responsible for their care. *(Also see ACC.2.1, ME 1)*
- 3. There is a process to respond to a patient’s request for additional information on the practitioner responsible for his or her care.

**Standard PFR.6.2**
The organization establishes a process, within the context of existing law and culture, for when others can grant consent.

**Intent of PFR.6.2**
Informed consent for care sometimes requires that people other than (or in addition to) the patient be involved in decisions about the patient's care. This is especially true when the patient does not have the mental or physical capacity to make care decisions, when culture or custom requires that others make care decisions, or when the patient is a child. When the patient cannot make decisions about his or her care, a surrogate decision maker is identified. When someone other than the patient gives consent, that individual is noted in the patient’s record.

**Measurable Elements of PFR.6.2**
- 1. The organization has a process for when others can grant informed consent.
- 2. The process respects law, culture, and custom.
- 3. Individuals, other than the patient, granting consent are noted in the patient’s record.

**Standard PFR6.3**
General consent for treatment, if obtained when a patient is admitted as an inpatient or is registered for the first time as an outpatient, is clear in its scope and limits.

**Intent of PFR.6.3**
Many organizations obtain a general consent (rather than rely on implied consent) for treatment when the patient is admitted as an inpatient to the organization or when the patient is registered for the first time as an outpatient. When a general consent is obtained, patients are given information on the scope of the general consent, such as which tests and treatments are included under the general consent. Patients are also given information about those tests and treatments for which a separate informed consent will be obtained. The general consent notes if it is likely that students and other trainees will participate in care processes. The organization defines how a general consent is documented in the patient’s record.

**Measurable Elements of PFR.6.3**
- 1. Patients and families are informed as to the scope of a general consent, when used by the organization.
- 2. The organization has defined how a general consent, when used, is documented in the patient's record.
Standard PFR.6.4

Informed consent is obtained before surgery, anesthesia, use of blood and blood products, and other high-risk treatments and procedures.

Intent of PFR.6.4

When the planned care includes surgical or invasive procedures, anesthesia (including moderate and deep sedation), use of blood and blood products, or other high-risk treatments or procedures, a separate consent is obtained. This consent process provides the information identified in PFR.6.1 and documents the identity of the individual providing the information.

Measurable Elements of PFR.6.4

- 1. Consent is obtained before surgical or invasive procedures. (Also see ASC.7.1, intent statement)
- 2. Consent is obtained before anesthesia (including moderate and deep sedation). (Also see ASC.5.1, intent statement and ME 1)
- 3. Consent is obtained before the use of blood and blood products.
- 4. Consent is obtained before other high-risk procedures and treatments.
- 5. The identity of the individual providing the information to the patient and family is noted in the patient’s record. (Also see PFR.8, ME 2)
- 6. Consent is documented in the patient’s record by signature or record of verbal consent. (Also see PFR.8, ME 2)

Standard PFR.6.4.1

The organization lists those categories or types of treatments and procedures that require specific informed consent.

Intent of PFR.6.4.1

Not all treatments and procedures require a specific, separate consent. Each organization identifies those high-risk, problem-prone, or other procedures and treatments for which consent must be obtained. The organization lists these procedures and treatments and educates staff to ensure the process to obtain consent is consistent. The list is developed collaboratively by those physicians and others who provide the treatments or perform the procedures. The list includes procedures and treatments provided on an outpatient basis and inpatient basis.

Measurable Elements of PFR.6.4.1

- 1. The organization has listed those procedures and treatments that require separate consent.
- 2. The list is developed collaboratively by those physicians and others who provide the treatments and perform the procedures.

Research

Standard PFR.7

The organization informs patients and families about how to gain access to clinical research, clinical investigation, or clinical trials involving human subjects.
**Intent of PFR.7**

An organization that conducts clinical research, clinical investigations, or clinical trials involving human subjects provides information to patients and families about how to gain access to those activities when relevant to the patients' treatment needs. When patients are asked to participate, they need information upon which to base their decisions. That information includes

- expected benefits;
- potential discomforts and risks;
- alternatives that might also help them; and
- procedures that must be followed.

Patients are informed that they can refuse to participate or withdraw participation and that their refusal or withdrawal will not compromise their access to the organization's services.

The organization has policies and procedures for providing patients and families with this information.

**Measurable Elements of PFR.7**

- 1. Appropriate patients and families are identified and informed about how to gain access to clinical research, clinical investigations, or clinical trials relevant to their treatment needs.
- 2. Patients asked to participate are informed about expected benefits.
- 3. Patients asked to participate are informed about potential discomforts and risks.
- 4. Patients asked to participate are informed about alternatives that might also help them.
- 5. Patients asked to participate are informed about the procedures that must be followed.
- 6. Patients are assured that their refusal to participate or withdraw from participation will not compromise their access to the organization's services.
- 7. Policies and procedures guide the information and decision process.

**Standard PFR.7.1**

The organization informs patients and families about how patients who choose to participate in clinical research, clinical investigation, or clinical trials are protected.

**Intent of PFR.7.1**

An organization that conducts clinical research, clinical investigations, or clinical trials involving human subjects knows that its first responsibility is to the patient's health and well-being.

The organization informs patients and families in advance about established processes to

- review research protocols;
- weigh the relative risks and benefits to the subjects;
- obtain subject consent; and
- withdraw from participation.

This information is communicated to patients and families to assist with decisions regarding participation.

**Measurable Elements of PFR.7.1**

- 1. Patients and families are informed about the organization's process for reviewing research protocols.
- 2. Patients and families are informed about the organization's process for weighing the benefits and risks to the subjects.
3. Patients and families are informed about the organization’s process for obtaining consent.

4. Patients and families are informed about the organization’s process for withdrawing from participation.

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**Standard PFR.8**

Informed consent is obtained before a patient participates in clinical research, clinical investigation, and clinical trials.

**Intent of PFR.8**

When patients and families decide to participate in clinical research, clinical investigations, or clinical trials, informed consent is granted. The information provided at the time the decision to participate was made serves as the basis for the informed consent (also see PFR.6, intent statement). The individual(s) providing the information and obtaining the consent is noted in the patient’s record.

**Measurable Elements of PFR.8**

1. Informed consent is obtained when a patient decides to participate in clinical research, clinical investigations, or clinical trials.

2. Consent decisions are documented, dated, and based on the information identified in PFR.6.4, MEs 5 and 6.

3. The identity of the individual(s) providing the information and obtaining the consent is noted in the patient’s record.

4. Consent is documented in the patient’s record by signature or record of verbal consent.

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**Standard PFR.9**

The organization has a committee or another way to oversee all research in the organization involving human subjects.

**Intent of PFR.9**

When the organization conducts clinical research, investigations, or trials that involve human subjects, a committee or other mechanism to provide oversight for all such activities in the organization is established. The organization develops a statement of purpose for the oversight activities. Oversight activities include the review process for all research protocols, a process to weigh the relative risks and benefits to the subjects, and processes related to the confidentiality and security of the research information.

**Measurable Elements of PFR.9**

1. The organization has a committee or other mechanism to oversee all research within the organization.

2. The organization develops a clear statement of purpose for the oversight activities.

3. Oversight activities include a review process.

4. Oversight activities include a process to weigh relative risks and benefits to subjects.

5. Oversight activities include processes to provide confidentiality and security of research information.
Organ Donation

**Standard PFR.10**
The organization informs patients and families about how to choose to donate organs and other tissues.

**Intent of PFR.10**
The organization supports the choice of patients and families to donate organs and other tissues for research or transplantation. Information is provided on the donation process and if the organization is a procurement site for a community, regional, or national organ procurement agency or network.

**Measurable Elements of PFR.10**
- 1. The organization supports patient and family choices to donate organs and other tissues.
- 2. The organization provides information to support the choice.

**Standard PFR.11**
The organization provides oversight of the harvesting and transplantation of organs and tissues.

**Intent of PFR.11**
The policies are consistent with laws and regulations* and respect the community’s religious and cultural values. Organization staff are trained in implementing the policies and procedures to support patient and family choices. Staff are also trained in the contemporary concerns and issues related to organ donation and availability of transplants (for example, information on organ and tissue shortages, the buying and selling of organs over black market trade, the harvesting of organs without consent from executed prisoners or dead patients). The organization has a responsibility to ensure that valid consent is received from live donors and adequate controls are in place to prevent patients from feeling pressured to donate. The organization cooperates with other organizations and agencies in the community responsible for all or a portion of the procurement, banking, transportation, or transplantation process.

**Measurable Elements of PFR.11**
- 1. Policies and procedures guide the procurement and donation process.
- 2. Policies and procedures guide the transplantation process.
- 3. Staff are trained in the policies and procedures.
- 4. Staff are trained in the issues and concerns related to organ donation and the availability of transplants.
- 5. The organization obtains informed consent from live donors.
- 6. The organization cooperates with relevant organizations and agencies in the community to respect and to implement choices to donate.

*In some countries, laws determine that everyone is a donor unless specified otherwise.*
Patient and Family Rights (PFR)
Overview

An effective patient-assessment process results in decisions about the patient’s immediate and continuing treatment needs for emergency, elective, or planned care, even when the patient’s condition changes. Patient assessment is an ongoing, dynamic process that takes place in many inpatient and outpatient settings and departments and clinics. Patient assessment consists of three primary processes:

- Collecting information and data on the patient’s physical, psychological, social status, and health history
- Analyzing the data and information, including the results of laboratory and imaging diagnostic tests, to identify the patient’s health care needs
- Developing a plan of care to meet the patient’s identified needs

Patient assessment is appropriate when it considers the patient’s condition, age, health needs, and his or her requests or preferences. These processes are most effectively carried out when the various health professionals responsible for the patient work together.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

**AOP.1** All patients cared for by the organization have their health care needs identified through an established assessment process.

- **AOP.1.1** The organization has determined the scope and content of assessments, based on applicable laws and regulations and professional standards.
- **AOP.1.2** Each patient’s initial assessment(s) includes an evaluation of physical, psychological, social, and economic factors, including a physical examination and health history.
- **AOP.1.3** The patient’s medical and nursing needs are identified from the initial assessments and recorded in the clinical record.
  - **AOP.1.3.1** The initial medical and nursing assessment of emergency patients is based on their needs and conditions.
AOP.1.4 Assessments are completed in the time frame prescribed by the organization.

AOP.1.4.1 The initial medical and nursing assessments are completed within the first 24 hours after the patient’s admission as an inpatient or earlier as indicated by the patient’s condition or hospital policy.

AOP.1.5 Assessment findings are documented in the patient’s record and readily available to those responsible for the patient’s care.

AOP.1.5.1 The initial medical assessment is documented before anesthesia or surgical treatment.

AOP.1.6 Patients are screened for nutritional status and functional needs and are referred for further assessment and treatment when necessary.

AOP.1.7 All inpatients and outpatients are screened for pain and assessed when pain is present.

AOP.1.8 The organization conducts individualized initial assessments for special populations cared for by the organization.

AOP.1.9 Dying patients and their families are assessed and reassessed according to their individualized needs.

AOP.1.10 The initial assessment includes determining the need for additional specialized assessments.

AOP.1.11 The initial assessment includes determining the need for discharge planning.

AOP.2 All patients are reassessed at intervals based on their condition and treatment to determine their response to treatment and to plan for continued treatment or discharge.

AOP.3 Qualified individuals conduct the assessments and reassessments.

AOP.4 Physicians, nurses, and other individuals and services responsible for patient care collaborate to analyze and to integrate patient assessments.

AOP.4.1 The most urgent or important care needs are identified.

Laboratory Services

AOP.5 Laboratory services are available to meet patient needs, and all such services meet applicable local and national standards, laws, and regulations.

AOP.5.1 A laboratory safety program is in place, followed, and documented.

AOP.5.2 Individuals with proper qualifications and experience administer the tests and interpret the results.

AOP.5.3 Laboratory results are available in a timely way as defined by the organization.

AOP.5.3.1 There is a process for reporting critical results of diagnostic tests.

AOP.5.4 All equipment used for laboratory testing is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.
AOP.5.5 Essential reagents and other supplies are regularly available and evaluated to ensure accuracy and precision of results.

AOP.5.6 Procedures for collecting, identifying, handling, safely transporting, and disposing of specimens are followed.

AOP.5.7 Established norms and ranges are used to interpret and to report clinical laboratory results.

AOP.5.8 A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service.

AOP.5.9 Quality control procedures are in place, followed, and documented.

AOP.5.9.1 There is a process for proficiency testing.

AOP.5.10 The organization regularly reviews quality control results for all outside sources of laboratory services.

AOP.5.11 The organization has access to experts in specialized diagnostic areas when necessary.

Radiology and Diagnostic Imaging Services

AOP.6 Radiology and diagnostic imaging services are available to meet patient needs, and all such services meet applicable local and national standards, laws, and regulations.

AOP.6.1 Radiology and diagnostic imaging services are provided by the organization or are readily available through arrangements with outside sources.

AOP.6.2 A radiation safety program is in place, followed, and documented.

AOP.6.3 Individuals with proper qualifications and experience perform diagnostic imaging studies, interpret the results, and report the results.

AOP.6.4 Radiology and diagnostic imaging study results are available in a timely way as defined by the organization.

AOP.6.5 All equipment used to conduct radiology and diagnostic imaging studies is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.

AOP.6.6 X-ray film and other supplies are regularly available.

AOP.6.7 A qualified individual(s) is responsible for managing the diagnostic radiology and imaging services.

AOP.6.8 Quality control procedures are in place, followed, and documented.

AOP.6.9 The organization regularly reviews quality control results for all outside sources of diagnostic services.

AOP.6.10 The organization has access to experts in specialized diagnostic areas when needed.
Standards, Intents, and Measurable Elements

**Standard AOP.1**
All patients cared for by the organization have their health care needs identified through an established assessment process.

**Intent of AOP.1**
When a patient has been registered or admitted to an organization for inpatient or outpatient care/treatment, a complete assessment needs to be performed related to the reason the patient has come for care. The specific information the organization requires at this stage, and the procedures for getting it, depend on the patient’s needs and the setting in which care is being provided (for example, inpatient or outpatient care). Organization policy and procedures define how this process functions and what information needs to be gathered and documented. (*Also see ACC.1, intent statement*)

**Measurable Elements of AOP.1**
1. Organization policy and procedure define the assessment information to be obtained for inpatients.
2. Organization policy and procedure define the assessment information to be obtained for outpatients.
3. Organization policy identifies the information to be documented for the assessments.

**Standard AOP.1.1**
The organization has determined the minimum content of assessments, based on applicable laws and regulations and professional standards.

**Intent of AOP.1.1**
To consistently assess patient needs, the organization defines, in policies, the minimum content of assessments to be performed by physicians, nurses, and other clinical disciplines. Assessments are performed by each discipline within its scope of practice, licensure, applicable laws and regulations, or certification. Only qualified individuals conduct the assessments. Any assessment forms used for assessments reflect this policy. The organization defines assessment activities in both inpatient and outpatient settings in which care is provided. The organization defines those elements common to all assessments and defines any differences, when permitted, in the scope of general medical and specialty services assessments. The assessment defined in policy may be completed by more than one qualified individual and at different points in time. All the content must be available when treatment is initiated.

**Measurable Elements of AOP.1.1**
1. The minimum content of assessments is defined for each clinical discipline that performs assessments and specifies the required elements of the history and physical examination. (*Also see ASC.3, ME 3, and ASC.4, ME 1*)
2. Only qualified individuals permitted by licensure, applicable laws and regulations, or certification perform the assessment.
3. The minimum content of assessments performed in inpatient settings is defined in policies. (*Also see AOP.1.2, ME 1*)
4. The minimum content of assessments performed in outpatient settings is defined in policies.
**Standard AOP.1.2**

Each patient’s initial assessment(s) includes an evaluation of physical, psychological, social, and economic factors, including a physical examination and health history.

**Intent of AOP.1.2**

The initial assessment(s) of a patient, outpatient or inpatient, is critical to identifying his or her needs and starting the care process. The initial assessment(s) provides information to

- understand the care the patient is seeking;
- select the best care setting for the patient;
- form an initial diagnosis; and
- understand the patient’s response to any previous care.

To provide this information, the initial assessment includes an evaluation of the patient’s medical status through a physical examination and health history. The psychological assessment determines the patient’s emotional status (for example, if he or she is depressed, fearful, or belligerent and may harm him- or herself or others). Gathering social information on a patient is not intended to “classify” patients. Rather, a patient’s social, cultural, family, and economic contexts are important factors that can influence his or her response to illness and treatment. Families can be very helpful in these areas of assessment and in understanding the patient’s wishes and preferences in the assessment process. Economic factors are assessed as part of the social assessment or assessed separately when the patient and his or her family will be responsible for the cost of all or a portion of the care while an inpatient or following discharge. Many different qualified individuals may be involved in the assessment of a patient. The most important factors are that the assessments are complete and available (*also see* MCI.7, ME 2) to those caring for the patient. (*Also see* AOP.1.7, ME 1, regarding pain assessments)

**Measurable Elements of AOP.1.2**

- **1.** All inpatients and outpatients have an initial assessment(s) that includes a health history and physical examination consistent with the requirements defined in hospital policy. (*Also see* AOP.1.1, ME 3)
- **2.** Each patient receives an initial psychological assessment as indicated by his or her needs.
- **3.** Each patient receives an initial social and economic assessment as indicated by his or her needs.
- **4.** The initial assessment(s) results in an initial diagnosis.

**Standard AOP.1.3**

The patient’s medical and nursing needs are identified from the initial assessments and recorded in the clinical record.

**Standard AOP.1.3.1**

The initial medical and nursing assessments of emergency patients are based on their needs and conditions.

**Intent of AOP.1.3 and AOP.1.3.1**

The primary outcome from the patient’s initial assessments is an understanding of the patient’s medical and nursing needs so care and treatment can begin. To accomplish this, the organization determines the minimum content of the initial medical and nursing and other assessments (*also see* AOP.1.1), the time frame for completion of assessments (*also see* AOP.1.4), and the documentation requirements for assessments (*also see* AOP.1.5). Although the medical and nursing assessments are primary to the initiation of care, there may be
additional assessments by other health care practitioners, including special assessments (also see AOP.1.8) and individualized assessments (also see AOP.1.7). These assessments must be integrated (also see AOP.4) and the most urgent care needs identified (also see AOP.4.1).

In an emergency, the initial medical and nursing assessments may be limited to the patient’s apparent needs and condition. Also, when there is no time to record the complete history and physical examination of an emergency patient requiring surgery, a brief note and the preoperative diagnosis are recorded before surgery.

**Measurable Elements of AOP.1.3**
- 1. The patient’s medical needs are identified by the initial assessment, documented health history, physical exam, and other assessments performed based on the patient’s identified needs.
- 2. The nursing care needs of the patient are identified by the nurse’s documented assessment, the medical assessment, and other assessments performed based on the patient’s needs.
- 3. The identified medical needs of the patient are documented in the patient’s clinical record.
- 4. The identified nursing needs of the patient are documented in the patient’s clinical record.
- 5. Policies and procedures support consistent practice in all areas.

**Measurable Elements of AOP.1.3.1**
- 1. For emergency patients, the medical assessment is based on their needs and condition.
- 2. For emergency patients, the nursing assessment is based on their needs and condition.
- 3. If surgery is performed, there is at least a brief note and preoperative diagnosis recorded before surgery.

**Standard AOP.1.4**
Assessments are completed in the time frame prescribed by the organization.

**Intent of AOP.1.4**
To begin correct treatment for the patient as quickly as possible, the initial assessments must be completed as rapidly as possible. The health care organization determines the time frame for completing assessments, in particular the medical and nursing assessments. The precise time frame depends on a variety of factors, including the types of patients cared for by the organization, the complexity and duration of their care, and the dynamics of conditions surrounding their care. With this in mind, an organization may establish different time frames for assessment in different areas or services.

When an assessment is partially or entirely completed outside the organization (for example, in a consultant surgeon’s office), the findings are reviewed and/or verified at admission as an inpatient, as appropriate to the time between the outside assessment and admission (also see AOP.1.4.1), the critical nature of the findings, the complexity of the patient, and the planned care and treatment (for example, the review confirms the clarity of the diagnosis and any planned procedures or treatments; the presence of radiographs needed in surgery; any change[s] in the patient’s condition, such as control of blood sugar; and identifies any critical lab tests that may need repeating).

**Measurable Elements of AOP.1.4**
- 1. Appropriate time frames for performing assessments are established for all settings and services.
- 2. Assessments are completed within the time frames established by the organization.
- 3. The findings of all assessments performed outside the organization are reviewed and/or verified at the time of admission to inpatient status. (Also see AOP.1.4.1 for the updating or repeating of portions of medical assessments older than 30 days; also see MCL.6, ME 1)
Standard AOP.1.4.1
The initial medical and nursing assessments are completed within the first 24 hours after the patient’s admission as an inpatient or earlier as indicated by the patient’s condition or hospital policy.

Intent of AOP.1.4.1
The initial medical and nursing assessments are completed within 24 hours of admission to the organization and available for use by all those caring for the patient. When the patient’s condition indicates, the initial medical and/or nursing assessment are conducted and available earlier. Thus, emergency patients are assessed immediately, and policy may define that certain other patient groups are assessed sooner than 24 hours.

When the initial medical assessment is conducted in a physician’s private office or other outpatient setting prior to care in the organization as an inpatient, it must be within the previous 30 days. If at the time of admission as an inpatient the medical assessment is more than 30 days old, the medical history must be updated and the physical examination repeated. For medical assessments conducted within 30 days prior to admission, any significant changes in the patient’s condition since the assessment are noted at admission. This updating and/or re-examination can be accomplished by any qualified individual. (Also see AOP.4, intent statement)

Measurable Elements of AOP.1.4.1
- 1. The initial medical assessment is conducted within the first 24 hours of admission as an inpatient or earlier as indicated by the patient’s condition or hospital policy.
- 2. The initial nursing assessment is conducted within the first 24 hours of admission as an inpatient or earlier as indicated by the patient’s condition or hospital policy.
- 3. Initial medical assessments conducted prior to admission to inpatient status, or prior to an outpatient procedure in the organization, are no older than 30 days, or the medical history has been updated and the physical exam repeated.
- 4. For any assessment less than 30 days old, any significant changes in the patient’s condition since the assessment are noted in the patient’s record at the time of admission to inpatient status.

Standard AOP.1.5
Assessment findings are documented in the patient’s record and readily available to those responsible for the patient’s care.

Intent of AOP.1.5
Assessment findings are used throughout the care process to evaluate patient progress and to understand the need for reassessment. It is therefore essential that the medical, nursing, and other meaningful assessments be documented well and can be quickly and easily retrieved from the patient’s record or other standardized location and used by those caring for the patient. In particular, the patient’s medical and nursing assessments are documented in the record within the first 24 hours of admission as an inpatient. This does not preclude the placement of additional, more detailed assessments in separate locations from the patient’s record as long as they remain accessible to those caring for the patient.

Measurable Elements of AOP.1.5
- 1. Assessment findings are documented in the patient’s record. (Also see MCI.19.1, ME 1)
- 2. Those caring for the patient can find and retrieve assessments as needed from the patient’s record or other standardized accessible location. (Also see MCI.7, ME 2)
3. Medical assessments are documented in the patient’s record within 24 hours of admission.

4. Nursing assessments are documented in the patient’s record within 24 hours of admission.

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**Standard AOP.1.5.1**

The initial medical assessment is documented before anesthesia or surgical treatment.

**Intent of AOP.1.5.1**

Results of the medical assessment and any diagnostic tests are recorded in the patient’s record before anesthesia or surgery.

**Measurable Elements of AOP.1.5.1**

- 1. Patients for which surgery is planned have a medical assessment performed before the surgery. *(Also see ASC.7, MEs 1 and 2)*
- 2. The medical assessment of surgical patients is documented before surgery.

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**Standard AOP.1.6**

Patients are screened for nutritional status and functional needs and are referred for further assessment and treatment when necessary.

**Intent of AOP.1.6**

The information gathered at the initial medical and/or nursing assessment, through the application of screening criteria, may indicate that the patient needs further or more in-depth assessment of nutritional status or functional status, including a fall-risk assessment. The more in-depth assessment may be necessary to identify those patients in need of nutritional interventions and patients in need of rehabilitation services or other services related to their ability to function independently or at their greatest potential.

The most effective way to identify patients with nutritional or functional needs is through screening criteria. For example, the nursing initial assessment form may contain the criteria. In each case, the screening criteria are developed by qualified individuals able to further assess and, if necessary, to provide any required patient treatment. For example, screening criteria for nutritional risk may be developed by nurses who will apply the criteria, dietitians who will supply the recommended dietary intervention, and nutritionists able to integrate nutritional needs with the other needs of the patient. *(Also see COP.5)*

**Measurable Elements of AOP.1.6**

- 1. Qualified individuals develop criteria to identify patients who require further nutritional assessment.
- 2. Patients are screened for nutritional risk as part of the initial assessment.
- 3. Patients at risk for nutritional problems according to the criteria receive a nutritional assessment.
- 4. Qualified individuals develop criteria to identify patients who require further functional assessment. *(Also see IPSG.6, ME 1, related to fall-risk assessment)*
- 5. Patients are screened for their need for further functional assessment as part of the initial assessment. *(Also see IPSG.6, ME 2)*
- 6. Patients in need of a functional assessment according to the criteria are referred for such an assessment.
**Standard AOP.1.7**

All inpatients and outpatients are screened for pain and assessed when pain is present.

**Intent of AOP.1.7**

During the initial assessment and during any reassessments, a screening procedure is used to identify patients with pain. When pain is identified, the patient can be treated in the organization or referred for treatment. The scope of treatment is based on the care setting and services provided.

When the patient is treated in the organization, a more comprehensive assessment is performed. This assessment is appropriate to the patient's age and measures pain intensity and quality, such as pain character, frequency, location, and duration. This assessment is recorded in a way that facilitates regular reassessment and follow-up according to criteria developed by the organization and the patient's needs.

**Measurable Elements of AOP.1.7**

- 1. Patients are screened for pain. *(Also see COP.6, ME 1)*
- 2. When pain is identified from the initial screening exam, the patient is referred or the organization performs a comprehensive assessment, appropriate to the patient's age and measuring pain intensity and quality, such as pain character, frequency, location, and duration.
- 3. The assessment is recorded in a way that facilitates regular reassessment and follow-up according to criteria developed by the organization and the patient's needs.

**Standard AOP.1.8**

The organization conducts individualized initial assessments for special populations cared for by the organization.

**Intent of AOP.1.8**

The initial assessment of certain types of patients or certain patient populations requires that the assessment process be modified. Such modification is based on the unique characteristics or needs of each patient population. Each organization identifies those special patient groups and populations and modifies the assessment process to meet their special needs. In particular, when the organization serves one or more of the special-needs patients or populations listed below, the organization conducts individualized assessments of the following:

- Children
- Adolescents
- Frail elderly
- Terminally ill
- Patients with intense or chronic pain
- Women in labor
- Women experiencing terminations in pregnancy
- Patients with emotional or psychiatric disorders
- Patients suspected of drug and/or alcohol dependency
- Victims of abuse and neglect
- Patients with infectious or communicable diseases
- Patients receiving chemo or radiation therapy
- Patients whose immune systems are compromised

The assessment of patients suspected of drug and/or alcohol dependency and the assessment of victims of abuse and neglect are shaped by the culture of the patient population. These assessments are not intended to
be proactive case-finding processes. Rather, the assessment of these patients responds to their needs and condition in a culturally acceptable and confidential manner.

The assessment process is modified to be consistent with local laws and regulations and professional standards related to such populations and situations and involve the family when appropriate or necessary.

**Measurable Elements of AOP.1.8**

1. The organization defines criteria, in writing, that identify when additional, specialized, or more in-depth special-needs assessments are performed.

2. The assessment process for special-needs patient populations is appropriately modified to reflect their needs.

**Standard AOP.1.9**

Dying patients and their families are assessed and reassessed according to their individualized needs.

**Intent of AOP.1.9**

Assessments and reassessments need to be individualized to meet patients’ and families’ needs when patients are at the end of life. Assessments and reassessments should evaluate, as indicated by the patient’s condition,

- such symptoms as nausea and respiratory distress;
- factors that alleviate or exacerbate physical symptoms;
- current symptom management and the patient’s response;
- patient and family spiritual orientation and, as appropriate, any involvement in a religious group;
- patient and family psychosocial status, such as family relationships, the adequacy of the home environment if care is provided there, coping mechanisms, and the patient’s and family’s reactions to illness;
- the need for support or respite services for the patient, family, or other caregivers;
- the need for an alternative setting or level of care; and
- survivor risk factors, such as family coping mechanisms and the potential for pathological grief reactions.

**Measurable Elements of AOP.1.9**

1. Dying patients and their families are assessed and reassessed for those elements in a) through i) of the intent statement, according to their identified needs.

2. Assessment findings guide the care and services provided. (*Also see AOP.2, ME 2)*

3. Assessment findings are documented in the patient’s record.

**Standard AOP.1.10**

The initial assessment includes determining the need for additional specialized assessments.

**Intent of AOP.1.10**

The initial assessment process may identify a need for other assessments, such as dental, hearing, eye, and so on. The organization refers the patient for such assessments when available within the organization or the community.
**Measurable Elements of AOP.1.10**

- 1. When the need for additional specialized assessments is identified, patients are referred within the organization or outside the organization. (*Also see ACC.3, ME 1)*
- 2. Specialized assessments conducted within the organization are completed and documented in the patient’s record.

**Standard AOP.1.11**

The initial assessment includes determining the need for discharge planning.

**Intent of AOP.1.11**

Continuity of care requires special preparation and considerations for some patients, such as for discharge planning. The organization develops a mechanism, such as a list of criteria, to identify those patients for whom discharge planning is critical due to age, lack of mobility, continuing medical and nursing needs, or assistance with activities of daily living, among others. As arrangements for discharge may take some time, the assessment process and planning process are initiated as soon as possible after admission as an inpatient.

**Measurable Elements of AOP.1.11**

- 1. There is a process to identify those patients for whom discharge planning is critical. (*Also see ACC.3, ME 2)*
- 2. Planning for discharge for these patients begins soon after admission as inpatients. (*Also see ACC.3, ME 4)*

**Standard AOP.2**

All patients are reassessed at intervals based on their condition and treatment to determine their response to treatment and to plan for continued treatment or discharge.

**Intent of AOP.2**

Reassessment by all the patient’s health care practitioners is key to understanding whether care decisions are appropriate and effective. Patients are reassessed throughout the care process at intervals based on their needs and plan of care or as defined in organization policies and procedures. The results of these reassessments are noted in the patient’s record for the information and use of all those caring for the patient. (*Also see MCI.19.1, ME 5)*

Reassessment by a physician is integral to ongoing patient care. A physician assesses an acute care patient at least daily, including weekends, and when there has been a significant change in the patient’s condition.

Reassessments are conducted and results are entered in the patient’s record:

- at regular intervals during care (for example, nursing staff periodically record vital signs as needed based on the patient’s condition);
- daily by a physician for acute care patients or less frequently, as described in organization policy;
- in response to a significant change in the patient’s condition;
- if the patient’s diagnosis has changed and the care needs require revised planning; and
- to determine if medications and other treatments have been successful and the patient can be transferred or discharged.
**Measurable Elements of AOP.2**

1. Patients are reassessed to determine their response to treatment. (*Also see* ASC.5.3, MEs 1 and 2; ASC.7.3, MEs 1 and 2; MMU.7, ME 1; and COP.5, ME 3)

2. Patients are reassessed to plan for continued treatment or discharge. (*Also see* ACC.3, MEs 2 and 3; COP.7.1, ME 2; ASC.5.3, MEs 1 and 2; and AOP.1.9, ME 2)

3. Patients are reassessed at intervals based on their condition and when there has been a significant change in their condition, plan of care, and individual needs or according to organization policies and procedures. (*Also see* ASC.3, ME 1, and ASC.5.3, ME 1)

4. A physician reassesses patients at least daily, including weekends, during the acute phase of their care and treatment.

5. For nonacute patients, the organization policy defines the circumstances in which, and the types of patients or patient populations for which, a physician’s assessment may be less than daily and identifies the minimum reassessment interval for these patients.

6. Reassessments are documented in the patient’s record.

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**Standard AOP.3**

Qualified individuals conduct the assessments and reassessments.

**Intent of AOP.3**

The assessment and reassessment of patients are critical processes that require special education, training, knowledge, and skills. Thus, for each type of assessment, those individuals qualified to perform the assessment are identified and their responsibilities defined in writing. In particular, those individuals qualified to conduct emergency assessments or assessments of nursing needs are clearly identified. Assessments are performed by each discipline within its scope of practice, licensure, applicable laws and regulations, or certification.

**Measurable Elements of AOP.3**

1. Individuals qualified to conduct patient assessments and reassessments are identified by the organization.

2. Only those individuals permitted by licensure, applicable laws and regulations, or certification perform patient assessments.

3. Emergency assessments are conducted by individuals qualified to do so.

4. Nursing assessments are conducted by individuals qualified to do so.

5. Those qualified to conduct patient assessments and reassessments have their responsibilities defined in writing. (*Also see* SQE.1.1, MEs 1 and 2, and SQE.10, ME 1)

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**Standard AOP.4**

Medical, nursing, and other individuals and services responsible for patient care collaborate to analyze and to integrate patient assessments.

**Standard AOP.4.1**

The most urgent or important care needs are identified.
Intent of AOP.4 and AOP.4.1
A patient may undergo many kinds of assessments outside and inside the organization by many different departments and services. As a result, there may be a variety of information, test results, and other data in the patient’s record (also see AOP.1.4.1, intent statement). A patient benefits most when the staff responsible for the patient work together to analyze the assessment findings and combine this information into a comprehensive picture of the patient’s condition. From this collaboration, the patient’s needs are identified, the order of their importance is established, and care decisions are made. Integration of finding at this point will facilitate the coordination of care provision. (Also see COP.2)

The process for working together is simple and informal when the patient’s needs are not complex. Formal treatment team meetings, patient conferences, and clinical rounds may be needed for patients with complex or unclear needs. The patient, his or her family, and others who make decisions on the patient’s behalf are included in the decision process when it is needed.

Measurable Elements of AOP.4
- 1. Patient assessment data and information are analyzed and integrated. (Also see COP.1, ME 1)
- 2. Those responsible for the patient’s care participate in the process.

Measurable Elements of AOP.4.1
- 1. Patient needs are prioritized based on assessment results.
- 2. The patient and his or her family are informed of the outcomes of the assessment process and any confirmed diagnosis when appropriate. (Also see PFR.2.1, ME 1)
- 3. The patient and his or her family are informed of the planned care and treatment and participate in the decisions about the priority needs to be met. (Also see PFR.2.1, MEs 2 and 4, and ACC.1.2, ME 5)

Laboratory Services

Standard AOP.5
Laboratory services are available to meet patient needs, and all such services meet applicable local and national standards, laws, and regulations.

Intent of AOP.5
The organization has a system for providing laboratory services, including clinical pathology services, required by its patient population, clinical services offered, and health care practitioner needs. The laboratory services are organized and provided in a manner that meets applicable local and national standards, laws, and regulations.

Laboratory services, including those required for emergencies, may be provided within the organization, by agreement with another organization, or both. Laboratory services are available after normal hours for emergencies.

Outside sources are convenient for the patient to access. The organization selects outside sources based on the recommendation of the director or other individual responsible for laboratory services. Outside sources of laboratory services meet applicable laws and regulations and have an acceptable record of accurate, timely services. Patients are informed when an outside source of laboratory services is owned by the referring physician.

Measurable Elements of AOP.5
- 1. Laboratory services meet applicable local and national standards, laws, and regulations.
- 2. Adequate, regular, and convenient laboratory services are available to meet needs.
3. Emergency laboratory services are available, including after normal hours.

4. Outside sources are selected based on an acceptable record and compliance with laws and regulations.

5. Patients are informed about any relationships between the referring physician and outside sources of laboratory services. *(Also see GLD.6.1, ME 1)*

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**Standard AOP.5.1**

A laboratory safety program is in place, followed, and documented.

**Intent of AOP.5.1**

The laboratory has an active safety program to the degree required by the risks and hazards encountered in the laboratory. The program addresses safety practices and prevention measures (for example, eye-wash stations, spill kits, and the like) for laboratory staff, other staff, and patients when present. The laboratory program is coordinated with the organization's safety management program.

The laboratory safety management program includes

- written policies and procedures that support compliance with applicable standards and regulations;
- written policies and procedures for the handling and disposal of infectious and hazardous materials *(also see FMS.5, ME 2, and PCI.7.2, MEs 1 and 2)*;
- availability of safety devices appropriate to the laboratory's practices and hazards encountered;
- the orientation of all laboratory staff to safety procedures and practices; and
- in-service education for new procedures and newly acquired or recognized hazardous materials.

**Measurable Elements of AOP.5.1**

1. A laboratory safety program addresses potential safety risks in the laboratory and other areas outside the laboratory where laboratory services are provided. *(Also see FMS.4 and FMS.5)*

2. The program is part of the organization's safety management program and reports to the organization safety structure at least annually and when any safety events occur. *(Also see FMS.4, ME 2)*

3. Written policies and procedures address the handling and disposal of infectious and hazardous materials. *(Also see FMS.5, ME 2)*

4. Identified safety risks are addressed by specific processes and/or devices to reduce the safety risks. *(Also see FMS.5, ME 5)*

5. Laboratory staff are oriented to safety procedures and practices. *(Also see FMS.11, ME 1; GLD.5.4, MEs 1 and 2; and GLD.6.1, ME 1)*

6. Laboratory staff receive education for new procedures and newly acquired or recognized hazardous materials. *(Also see SQE.8, MEs 3 and 4)*

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**Standard AOP.5.2**

Individuals with proper qualifications and experience administer the tests and interpret the results.

**Intent of AOP.5.2**

The organization identifies which laboratory staff members perform testing, those who are approved to perform point-of-care screening tests at the bedside, and those who direct or supervise staff who perform testing. Supervisory staff and technical staff have appropriate and adequate training, experience, and skills and are oriented to their work. Technical staff are given work assignments consistent with their training and experience.
In addition, there is a sufficient number of staff to perform tests promptly and to provide necessary laboratory staffing during all hours of operation and for emergencies.

**Measurable Elements of AOP.5.2**
- 1. Those individuals who perform testing and those who direct or supervise testing are identified.
- 2. Staff with proper qualifications and experience administer tests. *(Also see SQE.4, ME 1)*
- 3. Staff with proper qualifications and experience interpret tests. *(Also see SQE.4, ME 1)*
- 4. There is an adequate number of staff to meet patient needs.
- 5. Supervisory staff have proper qualifications and experience.

**Standard AOP.5.3**
Laboratory results are available in a timely way as defined by the organization.

**Intent of AOP.5.3**
The organization defines the time period for reporting laboratory test results. Results are reported within a time frame based on patient needs, services offered, and clinical staff needs. Emergency tests and after-hours and weekend testing needs are included. Results from urgent tests, such as those from the emergency department, operating theatres, and intensive care units, are given special attention in the quality measurement process. In addition, when laboratory services are by contract with an outside organization, the reports are also timely, as set forth by organization policy or the contract. *(Also see AOP.5.3.1)*

**Measurable Elements of AOP.5.3**
- 1. The organization has established the expected report time for results.
- 2. The timeliness of reporting of urgent/emergency tests is measured.
- 3. Laboratory results are reported within a time frame to meet patient needs. *(Also see ASC.7, ME 1)*

**Standard AOP.5.3.1**
There is a process for reporting critical results of diagnostic tests.

**Intent of AOP.5.3.1**
The reporting of critical results of diagnostic tests is a significant patient safety issue. Results that are significantly outside the normal range may indicate a high risk or life-threatening condition. It is important for the organization to develop a formal reporting system that clearly identifies how health care practitioners are made aware of critical results of diagnostic tests and how staff document that communication. *(Also see IPSG.2, MEs 2 and 4, and AOP.5.3)*

The process developed by the organization for managing the critical results of diagnostic tests provides guidelines to practitioners for requesting and receiving test results on an emergency or STAT basis. The process also includes a definition of critical tests and critical values for each type of test, by whom and to whom critical test results are reported, and an established method for monitoring compliance.

**Measurable Elements of AOP.5.3.1**
- 1. A collaborative method is used to develop processes for reporting critical results of diagnostic tests.
- 2. The process defines critical test values for each type of test.
3. The process identifies by whom and to whom critical results of diagnostic tests are reported.

4. The process identifies what is documented in the patient record.

5. The process is monitored for compliance and modified based on results of monitoring.

Standard AOP.5.4

All equipment used for laboratory testing is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.

Intent of AOP.5.4

Laboratory staff work to ensure that all equipment, including equipment used for point-of-care testing, functions at acceptable levels and in a manner that is safe to the operator(s). A laboratory equipment management program provides for

- selecting and acquiring equipment;
- identifying and taking inventory of equipment;
- assessing equipment use through inspection, testing, calibration, and maintenance;
- monitoring and acting on equipment hazard notices, recalls, reportable incidents, problems, and failures; and
- documenting the management program.

Testing, maintenance, and calibration frequency are related to the laboratory's use of the equipment and its documented history of service.

Measurable Elements of AOP.5.4

1. There is a laboratory equipment management program and it is implemented. *(Also see FMS.8, ME 1)*

2. The program includes selecting and acquiring equipment.

3. The program includes inventorying equipment. *(Also see FMS.8, ME 2)*

4. The program includes inspecting and testing equipment. *(Also see FMS.8, ME 3)*

5. The program includes calibrating and maintaining equipment. *(Also see FMS.8, ME 4)*

6. The program includes monitoring and follow-up. *(Also see FMS.8, ME 5)*

7. All testing, maintenance, and calibration of equipment are adequately documented. *(Also see FMS.8.1, ME 1)*

Standard AOP.5.5

Essential reagents and other supplies are regularly available and evaluated to ensure accuracy and precision of results.

Intent of AOP.5.5

The organization has identified those reagents and supplies necessary to regularly provide laboratory services to its patients. A process to order or to secure those essential reagents and other supplies is effective. All reagents are stored and dispensed according to defined procedures. The evaluation of all reagents ensures accuracy and precision of results. Written guidelines ensure the complete and accurate labeling of reagents and solutions and the accuracy and precision of all results.
Measurable Elements of AOP.5.5

1. Essential reagents and supplies are identified. (Also see FMS.5, ME 1)

2. Essential reagents and supplies are available, and there is a process to address when reagents are not available.

3. All reagents are stored and dispensed according to manufacturer’s directives or packaging instructions. (Also see FMS.5, ME 2)

4. The laboratory has and follows written guidelines for evaluation of all reagents to provide for accuracy and precision of results.

5. All reagents and solutions are completely and accurately labeled. (Also see FMS.5, ME 7)

Standard AOP.5.6

Procedures for collecting, identifying, handling, safely transporting, and disposing of specimens are followed.

Intent of AOP.5.6

Procedures are developed and implemented for

- ordering tests;
- collecting and identifying specimens;
- transporting, storing, and preserving specimens; and
- receiving, logging in, and tracking specimens.

These procedures are observed for specimens sent to outside sources for testing.

Measurable Elements of AOP.5.6

1. Procedures guide the ordering of tests.

2. Procedures guide the collection and identification of specimens. (Also see IPSG.1, ME 3)

3. Procedures guide the transport, storage, and preservation of specimens.

4. Procedures guide the receipt and tracking of specimens.

5. The procedures are implemented.

6. The procedures are observed when outside sources or services are used.

Standard AOP.5.7

Established norms and ranges are used to interpret and to report clinical laboratory results.

Intent of AOP.5.7

The laboratory establishes reference intervals or “normal” ranges for each test performed. The range is included in the clinical record, either as part of the report or by including a current listing of such values approved by the laboratory director. Ranges are furnished when an outside source performs the test. The reference ranges are appropriate to the organization’s geography and demographics and are reviewed and updated when methods change.

Measurable Elements of AOP.5.7

1. The laboratory has established reference ranges for each test performed.

2. The range is included in the clinical record at the time test results are reported.
3.Ranges are furnished when tests are performed by outside sources.
4. Ranges are appropriate to the organization's geography and demographics.
5. Ranges are reviewed and updated as needed.

Standard AOP.5.8
A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service.

Intent of AOP.5.8
Clinical laboratory services are under the direction of an individual who is qualified by virtue of documented training, expertise, and experience, consistent with applicable laws and regulations. This individual assumes professional responsibility for the laboratory facility and the services provided in the laboratory as well as tests performed outside the laboratory, such as the testing performed at bedside (point-of-care testing). The oversight of services outside the laboratory include ensuring consistent organizationwide policies and practices, such as training and supply management, among others, and not daily supervision of those activities. Daily supervision remains the responsibility of the leaders of the department or unit in which the testing is conducted.

When this individual provides clinical consultation or medical opinion, he or she is a physician, preferably a pathologist. Specialty and subspecialty laboratory services are under the direction of appropriately qualified individuals. Responsibilities of the laboratory director include
- developing, implementing, and maintaining policies and procedures;
- administrative oversight;
- maintaining any necessary quality control program;
- recommending outside sources of laboratory services; and
- monitoring and reviewing all laboratory services.

Measurable Elements of AOP.5.8
1. The clinical laboratory, and other laboratory services throughout the organization, are under the direction and oversight of one or more qualified individuals. (Also see GLD.5, ME 1)
2. Responsibilities for developing, implementing, and maintaining policies and procedures are defined and carried out.
3. Responsibilities for administrative oversight are defined and carried out.
4. Responsibilities for maintaining quality control programs are defined and carried out.
5. Responsibilities for recommending outside sources of laboratory services are defined and carried out. (Also see GLD.3.3, ME 4, and GLD.3.3.1, ME 2)
6. Responsibilities for monitoring and reviewing all laboratory services within and outside the laboratory are defined and carried out. (Also see GLD.3.3, MEs 1 and 3, and GLD.3.3.1, ME 1)

Standard AOP.5.9
Quality control procedures are in place, followed, and documented.

Standard AOP.5.9.1
There is a process for proficiency testing.
**Intent of AOP.5.9 and AOP.5.9.1**

Sound quality control systems are essential to providing excellent pathology and clinical laboratory services. Quality control procedures include

- a) validation of the test methods used for accuracy, precision, and reportable range;
- b) daily surveillance of results by qualified laboratory staff;
- c) rapid corrective action when a deficiency is identified;
- d) testing of reagents *(also see AOP.5.5)*; and
- e) documentation of results and corrective actions.

Proficiency testing determines how well an individual laboratory’s results compare with other laboratories that use the same methodologies. Such testing can identify performance problems not recognized by internal mechanisms. Thus, the laboratory participates in an approved proficiency-testing program when available. Alternatively, when approved programs are not available, the laboratory exchanges samples with a laboratory in another organization for purposes of peer comparison testing. The laboratory maintains a cumulative record of participation in a proficiency-testing process. Proficiency testing, or an alternative, is carried out for all specialty laboratory programs when available.

**Measurable Elements of AOP.5.9**

- 1. There is a quality control program for the clinical laboratory.
- 2. The program includes the validation of test methods.
- 3. The program includes the daily surveillance of test results.
- 4. The program includes rapid correction of deficiencies.
- 5. The program includes the documentation of results and corrective actions.
- 6. Program elements a) through e) identified in the intent statement are implemented.

**Measurable Elements of AOP.5.9.1**

- 1. The laboratory participates in a proficiency-testing program, or an alternative, for all specialty laboratory services and tests.
- 2. A cumulative record of participation is maintained.

**Standard AOP.5.10**

The organization regularly reviews quality control results for all outside sources of laboratory services.

**Intent of AOP.5.10**

When the organization uses outside sources of laboratory services, it regularly receives and reviews the quality control results of that outside source. Qualified individuals review the quality control results.

**Measurable Elements of AOP.5.10**

- 1. The frequency and type of quality control data from outside sources are determined by the organization.
- 2. The qualified individual responsible for the laboratory quality control or a qualified designee reviews the quality control results from the outside source.
- 3. The responsible individual or qualified designee takes action based on the quality control results.
- 4. An annual report of the quality control data from the outside source is provided to leadership to facilitate management of contracts and contract renewals.
Standard AOP.5.11
The organization has access to experts in specialized diagnostic areas when necessary.

Intent of AOP.5.11
The organization is able to identify and to contact experts in specialized diagnostic areas, such as parasitology, virology, or toxicology, when needed. The organization maintains a roster of such experts.

Measurable Elements of AOP.5.11
- 1. A roster of experts for specialized diagnostic areas is maintained.
- 2. Experts in specialized diagnostic areas are contacted when needed.

Radiology and Diagnostic Imaging Services

Standard AOP.6
Radiology and diagnostic imaging services are available to meet patient needs, and all such services meet applicable local and national standards, laws, and regulations.

Standard AOP.6.1
Radiology and diagnostic imaging services are provided by the organization or are readily available through arrangements with outside sources.

Intent of AOP.6 and AOP.6.1
The organization has a system for providing radiology and diagnostic imaging services required by its patient population, clinical services offered, and health care practitioner needs. Radiology and diagnostic imaging services meet all applicable local and national standards, laws, and regulations.

Radiology and diagnostic imaging services, including those required for emergencies, may be provided within the organization, by agreement with another organization, or both. Radiology and diagnostic imaging services are available after normal hours for emergencies.

Outside sources are convenient for the patient to access, and reports are received in a timely way that supports continuity of care. The organization selects outside sources based on the recommendation of the director or other individual responsible for radiology and diagnostic imaging services. Outside sources of radiology and diagnostic imaging services meet applicable laws and regulations and have an acceptable record of accurate, timely services. Patients are informed when an outside source of services is owned by the referring physician.

Measurable Elements of AOP.6
- 1. Radiology and diagnostic imaging services meet applicable local and national standards, laws, and regulations.
- 2. Adequate, regular, and convenient radiology and diagnostic imaging services are available to meet patient needs.
- 3. Radiology and diagnostic imaging services are available for emergencies after normal hours of operation.
**Measurable Elements of AOP.6.1**

- 1. Outside sources are selected based on recommendations of the director and an acceptable record of timely performance and compliance with applicable laws and regulations.
- 2. Patients are informed about any relationships between the referring physician and outside sources of radiology and/or diagnostic imaging services. (*Also see* GLD.6.1, ME 1)

**Standard AOP.6.2**

A radiation safety program is in place, followed, and documented.

**Intent of AOP.6.2**

The organization has an active radiation safety program that includes all components of the organization’s radiology and diagnostic imaging services, including radiation oncology and the cardiac catheterization laboratory. The radiation safety program reflects the risks and hazards encountered. The program addresses safety practices and prevention measures for radiology and diagnostic imaging staff, other staff, and patients. The program is coordinated with the organization’s safety management program.

The radiation safety management program includes:

- written policies and procedures that support compliance with applicable standards, laws, and regulations;
- written policies and procedures for handling and disposal of infectious and hazardous materials;
- availability of safety protective devices appropriate to the practices and hazards encountered;
- the orientation of all radiology and diagnostic imaging staff to safety procedures and practices; and
- in-service education for new procedures and newly acquired or recognized hazardous materials.

**Measurable Elements of AOP.6.2**

- 1. A radiation safety program is in place that addresses potential safety risks and hazards encountered within or outside the department. (*Also see* FMS.4 and FMS.5)
- 2. The safety program is part of the organization’s safety management program and reports to the organization safety structure at least annually and when any safety events occur. (*Also see* FMS.4, ME 2)
- 3. Written policies and procedures address compliance with applicable standards, laws, and regulations.
- 4. Written policies and procedures address handling and disposal of infectious and hazardous materials. (*Also see* FMS.5, MEs 2 and 4)
- 5. Identified radiation safety risks are addressed by specific processes or devices that reduce safety risks (such as lead aprons, radiation badges, and the like). (*Also see* FMS.5, ME 5)
- 6. Radiology and diagnostic imaging staff are oriented to safety procedures and practices. (*Also see* FMS.11, ME 1, and GLD.5.4, MEs 1 and 2)
- 7. Radiology and diagnostic imaging staff receive education for new procedures and hazardous materials. (*Also see* SQE.8, MEs 3 and 4)
Standard AOP.6.3

Individuals with proper qualifications and experience perform diagnostic imaging studies, interpret the results, and report the results.

Intent of AOP.6.3

The organization identifies which radiology and diagnostic imaging staff members perform diagnostic and imaging studies, those who are approved to perform point-of-care tests at the bedside, those who are qualified to interpret the results or to verify and report results, and those who direct or supervise the processes. Supervisory staff and technical staff have appropriate and adequate training, experience, and skills and are oriented to their work. Technical staff members are given work assignments consistent with their training and experience. In addition, there is a sufficient number of staff to perform, to interpret, and to report studies promptly and to provide necessary staffing during all hours of operation and for emergencies.

Measurable Elements of AOP.6.3

- 1. Those individuals who perform diagnostic and imaging studies or direct or supervise the studies are identified.
- 2. Staff with proper qualifications and experience perform diagnostic and imaging studies. (Also see SQE.4, ME 1)
- 3. Staff with proper qualifications and experience interpret study results. (Also see SQE.4, ME 1)
- 4. Properly qualified staff verify and report the results of studies.
- 5. There is an adequate number of staff to meet patient needs. (Also see GLD.5.2, ME 3, and SQE.6, ME 3)
- 6. Supervisory staff have proper qualifications and experience.

Standard AOP.6.4

Radiology and diagnostic imaging study results are available in a timely way as defined by the organization.

Intent of AOP.6.4

The organization defines the time period for reporting diagnostic radiology and diagnostic imaging study results. Results are reported within a time frame based on patient needs, services offered, and the clinical staff’s needs. Emergency tests and after-hours and weekend testing needs are included. Results from urgent radiology and diagnostic imaging studies, such as those from the emergency department, operating theatres, and intensive care units, are given special attention in the quality measurement process. Radiology and diagnostic imaging studies performed by outside contractors of services are reported according to organization policy or contract requirement.

Measurable Elements of AOP.6.4

- 1. The organization has established the expected report time for results.
- 2. The timeliness of reporting of urgent/emergency studies is measured.
- 3. Radiology and diagnostic imaging study results are reported within a time frame to meet patient needs. (Also see ASC.7, ME 1)
Standard AOP.6.5

All equipment used to conduct radiology and diagnostic imaging studies is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.

Intent of AOP.6.5

Radiology and diagnostic imaging staff work to ensure that all equipment functions at acceptable levels and in a manner that is safe to the operator(s). A radiology and diagnostic imaging equipment management program provides for

- selecting and acquiring equipment;
- identifying and inventorying equipment;
- assessing equipment use through inspection, testing, calibration, and maintenance;
- monitoring and acting on equipment hazard notices, recalls, reportable incidents, problems, and failures; and
- documenting the management program.

Testing, maintenance, and calibration frequency are related to the use of the equipment and its documented history of service. (Also see FMS.8, intent statement)

Measurable Elements of AOP.6.5

1. There is a radiology and diagnostic imaging equipment management program, and it is implemented. (Also see FMS.8, ME 1)
2. The program includes selecting and acquiring equipment.
3. The program includes inventorying equipment. (Also see FMS.8, ME 2)
4. The program includes inspecting and testing equipment. (Also see FMS.8, ME 3)
5. The program includes calibrating and maintaining equipment. (Also see FMS.8, ME 4)
6. The program includes monitoring and follow-up. (Also see FMS.8, ME 5)
7. There is adequate documentation of all testing, maintenance, and calibration of equipment. (Also see FME.8.1, ME 1)

Standard AOP.6.6

X-ray film and other supplies are regularly available.

Intent of AOP.6.6

The organization has identified the film, reagents, and supplies necessary to regularly provide radiology and diagnostic imaging services to its patients. A process to order or to secure essential film, reagents, and other supplies is effective. All supplies are stored and dispensed according to defined procedures that incorporate the manufacturers’ recommendations. The periodic evaluation of reagents according to manufacturers’ recommendations ensures accuracy and precision of results. (Also see AOP.6.8, intent statement)

Measurable Elements of AOP.6.6

1. Essential x-ray film, reagents, and supplies are identified. (Also see FMS.5, ME 1)
2. Essential x-ray film, reagents, and supplies are available.
3. All supplies are stored and dispensed according to guidelines. (Also see FMS.5, ME 2)
4. All supplies are periodically evaluated for accuracy and results.
5. All supplies are completely and accurately labeled. (Also see FMS.5, ME 7)
**Standard AOP.6.7**

A qualified individual(s) is responsible for managing the radiology and diagnostic imaging services.

**Intent of AOP.6.7**

Radiology and diagnostic imaging services, provided at any location in the organization, are under the direction of an individual who is qualified by documented training, expertise, and experience, consistent with applicable laws and regulations. This individual assumes professional responsibility for the radiology and diagnostic imaging facility and the services provided. When this individual provides clinical consultation or medical opinion, he or she is a physician, preferably a radiologist. When radiation therapy or other special services are provided, they are under the direction of appropriately qualified individuals.

The radiology and diagnostic imaging director’s responsibilities include
- developing, implementing, and maintaining policies and procedures;
- administrative oversight;
- maintaining any necessary quality control program;
- recommending outside sources of radiology and diagnostic imaging services; and
- monitoring and reviewing all radiology and diagnostic imaging services.

**Measurable Elements of AOP.6.7**

1. Radiology and diagnostic imaging services are under the direction of one or more qualified individuals. (Also see GLD.5, ME 1)
2. Responsibilities for developing, implementing, and maintaining policies and procedures are defined and carried out.
3. Responsibilities for administrative oversight are defined and carried out.
4. Responsibilities for maintaining quality control programs are defined and carried out.
5. Responsibilities for recommending outside sources of radiology and diagnostic imaging services are defined and carried out. (Also see GLD.3.3, ME 4)
6. Responsibilities for monitoring and reviewing all radiology and diagnostic imaging services are defined and carried out. (Also see GLD.3.3, ME 1)

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**Standard AOP.6.8**

Quality control procedures are in place, followed, and documented.

**Intent of AOP.6.8**

Sound quality control systems are essential to providing excellent radiology and diagnostic imaging services.

Quality control procedures include
- validation of the test methods used for accuracy and precision;
- daily surveillance of imaging results by qualified radiology staff;
- rapid corrective action when a deficiency is identified;
- testing of reagents and solutions (also see AOP.6.6); and
- documentation of results and corrective actions.
Measurable Elements of AOP.6.8
1. There is a quality control program for the radiology and diagnostic imaging services, and it is implemented.
2. Quality control includes validating test methods.
3. Quality control includes daily surveillance of imaging results.
4. Quality control includes rapid correction when a deficiency is identified.
5. Quality control includes testing reagents and solutions.
6. Quality control includes documenting results and corrective actions.

Standard AOP.6.9
The organization regularly reviews quality control results for all outside sources of diagnostic services.

Intent of AOP.6.9
When the organization uses outside sources of radiology and diagnostic imaging services, it regularly receives and reviews the quality control results of those outside sources. Qualified individuals review the quality control results. When diagnostic imaging quality control of outside sources is difficult to obtain, the director develops an alternative approach for quality oversight.

Measurable Elements of AOP.6.9
1. The frequency and type of quality control data from outside sources are determined by the organization.
2. The qualified individual responsible for the radiology quality control or qualified designee reviews the quality control results from the outside source.
3. The responsible individual or qualified designee takes action based on the quality control results.
4. An annual report of the quality control data from the outside source is provided to leadership to facilitate management of contracts and contract renewal.

Standard AOP.6.10
The organization has access to experts in specialized diagnostic areas when needed.

Intent of AOP.6.10
The organization can identify and contact experts in specialized diagnostic areas, such as radiation physics, radiation oncology, or nuclear medicine, when necessary. The organization maintains a roster of such experts.

Measurable Elements of AOP.6.10
1. The organization maintains a roster of experts for specialized diagnostic areas.
2. The organization contacts experts in specialized diagnostic areas when needed.
Overview

A health care organization’s main purpose is patient care. Providing the most appropriate care in a setting that supports and responds to each patient’s unique needs requires a high level of planning and coordination. Certain activities are basic to patient care. For all disciplines that care for patients, these activities include

- planning and delivering care to each patient;
- monitoring the patient to understand the results of the care;
- modifying care when necessary;
- completing the care; and
- planning the follow-up.

Many physicians, nurses, pharmacists, rehabilitation therapists, and other types of health care practitioners may carry out these activities. Each practitioner has a clear role in patient care. That role is determined by licensure; credentials; certification; laws and regulations; an individual’s particular skills, knowledge, and experience; and organization policies or job descriptions. Some care may be carried out by the patient, his or her family, or other trained caregivers.

The Assessment of Patients (AOP) standards (also see pages 75–100) describe the basis for care delivery—a plan for each patient based on an assessment of his or her needs. That care may be preventive, palliative, curative, or rehabilitative and may include anesthesia, surgery, medication, supportive therapies, or a combination of these. A plan of care is not sufficient to achieve optimal outcomes. The delivery of the services must be coordinated and integrated by all individuals caring for the patient.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

Care Delivery for All Patients

COP.1 Policies and procedures and applicable laws and regulations guide the uniform care of all patients.

COP.2 There is a process to integrate and to coordinate the care provided to each patient.
COP.2.1 The care provided to each patient is planned and written in the patient’s record.

COP.2.2 Those permitted to write patient orders write the order in the patient record in a uniform location.

COP.2.3 Procedures performed are written into the patient’s record.

COP.2.4 Patients and families are informed about the outcomes of care and treatment, including unanticipated outcomes.

Care of High-Risk Patients and Provision of High-Risk Services

COP.3 Policies and procedures guide the care of high-risk patients and the provision of high-risk services.

COP.3.1 Policies and procedures guide the care of emergency patients.

COP.3.2 Policies and procedures guide the use of resuscitation services throughout the organization.

COP.3.3 Policies and procedures guide the handling, use, and administration of blood and blood products.

COP.3.4 Policies and procedures guide the care of patients on life support or who are comatose. *(Also see PFR.1.5)*

COP.3.5 Policies and procedures guide the care of patients with communicable diseases and immune-suppressed patients.

COP.3.6 Policies and procedures guide the care of patients on dialysis.

COP.3.7 Policies and procedures guide use of restraint and the care of patients in restraint.

COP.3.8 Policies and procedures guide the care of elderly patients, disabled individuals, children, and populations at risk for abuse.

COP.3.9 Policies and procedures guide the care of patients receiving chemotherapy or other high-risk medications.

Food and Nutrition Therapy

COP.4 A variety of food choices, appropriate for the patient’s nutritional status and consistent with his or her clinical care, is regularly available.

COP.4.1 Food preparation, handling, storage, and distribution are safe and comply with laws, regulations, and current acceptable practices.

COP.5 Patients at nutrition risk receive nutrition therapy.

Pain Management

COP.6 Patients are supported in managing pain effectively.

End-of-Life Care

COP.7 The organization addresses end-of-life care.

COP.7.1 Care of the dying patient optimizes his or her comfort and dignity.
Standards, Intents, and Measurable Elements

Care Delivery for All Patients

Standard COP.1
Policies and procedures and applicable laws and regulations guide the uniform care of all patients.

Intent of COP.1
Patients with the same health problems and care needs have a right to receive the same quality of care throughout the organization. To carry out the principle of “one level of quality of care” requires that the leaders plan and coordinate patient care. In particular, services provided to similar patient populations in multiple departments or settings are guided by policies and procedures that result in their uniform delivery. In addition, the leaders ensure that the same level of care is available each day of the week, and all work shifts each day. Those policies and procedures respect applicable laws and regulations that shape the care process and are best developed collaboratively. Uniform patient care is reflected in the following:

a) Access to and appropriateness of care and treatment do not depend on the patient’s ability to pay or the source of payment.

b) Access to appropriate care and treatment by qualified practitioners does not depend on the day of the week or time of day.

c) Acuity of the patient’s condition determines the resources allocated to meet the patient’s needs.

d) The level of care provided to patients (for example, anesthesia care) is the same throughout the organization.

e) Patients with the same nursing care needs receive comparable levels of nursing care throughout the organization.

Uniform patient care results in the efficient use of resources and permits the evaluation of outcomes of similar care throughout the organization.

Measurable Elements of COP.1

1. The organization’s leaders collaborate to provide uniform care processes. (Also see ACC.1.1; AOP.4, ME 1; and ASC.2, ME 1)

2. Policies and procedures guide uniform care and reflect relevant laws and regulations.

3. Uniform care is provided that meets requirements a) through e) in the intent statement. (Also see ASC.3, ME 1)

Standard COP.2
There is a process to integrate and to coordinate the care provided to each patient.

Intent of COP.2
The patient care process is dynamic and involves many health care practitioners and can involve multiple care settings and departments and services. The integration and coordination of patient care activities are goals that result in efficient care processes, more effective use of human and other resources, and the likelihood of better patient outcomes. Thus, leaders use tools and techniques to better integrate and to coordinate care for their patients (for example, team-delivered care, multidisciplinary patient rounds, combined care planning forms, integrated patient record, case managers). (Also see AOP.4, intent statement)
The patient’s record facilitates and reflects the integration and coordination of care. In particular, each practitioner records observations and treatments in the patient’s record. Also, any results or conclusions from collaborative patient care team meetings or similar patient discussions are written in the patient’s record. (Also see COP.5, ME 2)

**Measurable Elements of COP.2**

- 1. Care planning is integrated and coordinated among settings, departments, and services. (Also see ACC.2, ME 3)
- 2. Care delivery is integrated and coordinated among settings, departments, and services.
- 3. The results or conclusions of any patient care team meetings or other collaborative discussions are written in the patient’s record.

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**Standard COP.2.1**

The care provided to each patient is planned and written in the patient’s record.

**Intent of COP.2.1**

Patient care processes are carefully planned to achieve optimal outcomes. The planning process uses the data from the initial assessment and from periodic reassessments to identify and to prioritize the treatments, procedures, nursing care, and other care to meet the patient’s needs. The patient and family are involved in the planning process. The plan is recorded in the patient’s record. The plan of care is developed within 24 hours of admission as an inpatient. Based on the reassessment of the patient performed by the patient’s health care practitioners, the plan is updated as appropriate to reflect the evolving condition of the patient.

The care planned for a patient must be related to his or her identified needs. Those needs may change as the result of clinical improvement or new information from a routine reassessment (for example, abnormal laboratory or radiography results), or they may be evident from a sudden change in the patient’s condition (for example, loss of consciousness). As needs change, the plan for the patient’s care also changes. Changes are written in the record as notes to the initial plan or as revised or new care goals, or they may result in a new plan.

**Note:** A single, integrated care plan that identifies measurable progress (goals) expected by each discipline is preferable to the entry of a separate care plan by each practitioner. The plan of care for each patient should reflect individualized, objective, and realistic care goals to facilitate reassessment and revision of the care plan.

**Measurable Elements of COP.2.1**

- 1. The care for each patient is planned by the responsible physician, nurse, and other health professionals within 24 hours of admission as an inpatient.
- 2. The planned care is individualized and based on the patient’s initial assessment data.
- 3. The planned care is documented in the record in the form of measurable progress (goals).
- 4. The anticipated progress (goals) is updated or revised, as appropriate, based on the reassessment of the patient by the health care practitioners.
- 5. The care planned for each patient is reviewed and verified by the responsible physician with a notation in the progress notes. (Also see ACC.2.1, ME 1)
- 6. The planned care is provided. (Also see COP.2.3, intent statement)
- 7. The care provided for each patient is written in the patient’s record by the health professional providing the care. (Also see ASC.5.2, ME 1; ASC.7.2, intent statement; and COP.2.3, ME 1)
Standard COP.2.2
Those permitted to write patient orders write the order in the patient record in a uniform location.

Intent of COP.2.2
Patient care activities include orders (for example, for laboratory testing, administration of medications, nursing care, and nutrition therapy). Diagnostic, surgical, and other procedures are ordered by individuals qualified to do so. Such orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the carrying out of orders. Written orders help staff understand the specifics of an order, when the order is to be carried out, and who is to carry out the order. Orders can be written on an order sheet that is transferred to the patient’s record periodically or at discharge.

Each organization decides
- which orders must be written rather than verbal;
- which diagnostic imaging and clinical laboratory test orders must provide a clinical indication/rationale;
- any exceptions in specialized settings, such as emergency departments and intensive care units;
- who is permitted to write orders; and
- where orders are to be located in the patient record.

Measurable Elements of COP.2.2
- 1. Orders are written when required and follow organization policy. (Also see MMU.4, ME 1)
- 2. Diagnostic imaging and clinical laboratory test orders include a clinical indication/rationale when required for interpretation.
- 3. Only those permitted to write orders do so.
- 4. Orders are found in a uniform location in patient records.

Standard COP.2.3
Procedures performed are written into the patient’s record.

Intent of COP.2.3
Diagnostic and other procedures performed and the results are written in the patient’s record. Such procedures include endoscopies, cardiac catheterization, and other invasive and noninvasive diagnostic and treatment procedures. (For surgical procedures, see ASC.7.2, ME 2, and COP.2.1, ME 6)

Measurable Elements of COP.2.3
- 1. Procedures performed are written into the patient’s record. (Also see COP.2.1, ME 7)
- 2. The results of procedures performed are written into the patient’s record.

Standard COP.2.4
Patients and families are informed about the outcomes of care and treatment, including unanticipated outcomes.

Intent of COP.2.4
The care and treatment process is an ongoing cycle of assessments and reassessments, planning and delivering care, and assessing outcomes. Patients and their families are informed of the results of the assessment process, are informed of the planned care and treatment, and participate in care decisions. Thus, to complete the cycle
of information with patients, they need to be informed of the outcome(s) of care and treatment. This includes being informed of any unanticipated outcomes of care.

**Measurable Elements of COP.2.4**

- 1. Patients and families are informed about the outcomes of their care and treatment. (*Also see PFR.2.1.1, ME 1*)
- 2. Patients and families are informed about any unanticipated outcomes of their care and treatment. (*Also see PFR.2.1.1, ME 2*)

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**Care of High-Risk Patients and Provision of High-Risk Services**

**Standard COP.3**

Policies and procedures guide the care of high-risk patients and the provision of high-risk services.

**Intent of COP.3**

Health care organizations care for a variety of patients with a variety of health care needs. Some patients are considered high risk because of their age, condition, or critical nature of their needs. Children and the elderly are commonly placed in this group, as they frequently cannot speak for themselves, do not understand the care process, and cannot participate in decisions regarding their care. Similarly, the frightened, confused, or comatose emergency patient is unable to understand the care process when care needs to be provided efficiently and rapidly.

Health care organizations also provide a variety of services, some of which are considered high risk because of the complex equipment needed to treat a life-threatening condition (dialysis patients), the nature of the treatment (use of blood and blood products), the potential for harm to the patient (restraint), or toxic effects of certain high-risk medications (for example, chemotherapy).

Policies and procedures are important tools for staff to understand these patients and services and to respond in a thorough, competent, and uniform manner. The leaders are responsible for

- identifying the patients and services considered high risk in the organization;
- using a collaborative process to develop relevant policies and procedures; and
- training staff in implementing the policies and procedures.

The patients and services identified in COP.3.1 through COP.3.9, when present in the organization, are included in the process. Additional patients and services are included when represented in the organization’s patient population and services.

Organizations may also wish to identify collateral risk as the result of any procedures or plan of care (for example, the need to prevent deep vein thrombosis, decubitus ulcers, and falls). Such risks, when present, may be prevented by educating staff and developing appropriate policies and procedures. (*Also see PFR.1.5, MEs 1 and 2*)

**Measurable Elements of COP.3**

- 1. The organization’s leaders have identified the high-risk patients and services.
- 2. The leaders develop applicable policies and procedures.
- 3. Staff have been trained and use the policies and procedures to guide care.
Standard COP.3.1
Policies and procedures guide the care of emergency patients.

Standard COP.3.2
Policies and procedures guide the use of resuscitation services throughout the organization.

Standard COP.3.3
Policies and procedures guide the handling, use, and administration of blood and blood products.

Standard COP.3.4
Policies and procedures guide the care of patients on life support or who are comatose.

Standard COP.3.5
Policies and procedures guide the care of patients with communicable diseases and immune-suppressed patients.

Standard COP.3.6
Policies and procedures guide the care of patients on dialysis.

Standard COP.3.7
Policies and procedures guide use of restraint and the care of patients in restraint.

Standard COP.3.8
Policies and procedures guide the care of elderly patients, disabled individuals, children, and populations at risk for abuse.

Standard COP.3.9
Policies and procedures guide the care of patients receiving chemotherapy or other high-risk medications.

Intent of COP.3.1 through COP.3.9
Policies and procedures must be tailored to the particular at-risk patient population or high-risk service to be appropriate and effective in reducing the related risk. It is particularly important that the policy or procedure identify

a) how planning will occur, including the identification of differences between adult and pediatric populations, or other special considerations;
b) the documentation required for the care team to work and to communicate effectively;
c) special consent considerations, if appropriate;
d) patient-monitoring requirements;
e) special qualifications or skills of staff involved in the care process; and
f) the availability and use of specialized equipment.

Clinical guidelines and clinical pathways are frequently helpful in developing the policies and procedures and may be incorporated into them. (Also see PFR.1.4, ME 2; PFR.1.5, MEs 1 and 2; and AOP.1.7)

Note: For standards COP.3.1 through COP.3.9, elements a) through f) of the intent statement must be reflected in the required policies and procedures.
Measurable Elements of COP.3.1
1. The care of emergency patients is guided by appropriate policies and procedures.
2. Patients receive care consistent with the policies and procedures.

Measurable Elements of COP.3.2
1. The uniform use of resuscitation services throughout the organization is guided by appropriate policies and procedures.
2. Resuscitation is provided according to policies and procedures.

Measurable Elements of COP.3.3
1. The handling, use, and administration of blood and blood products is guided by appropriate policies and procedures.
2. Blood and blood products are administered according to policies and procedures.

Measurable Elements of COP.3.4
1. The care of comatose patients is guided by appropriate policies and procedures.
2. The care of patients who are on life support is guided by policies and procedures.
3. Comatose patients and patients on life support receive care according to the policies and procedures.

Measurable Elements of COP.3.5
1. The care of patients with communicable diseases is guided by appropriate policies and procedures.
2. The care of immune-suppressed patients is guided by appropriate policies and procedures.
3. Immune-suppressed patients and patients with communicable diseases receive care according to the policies and procedures.

Measurable Elements of COP.3.6
1. The care of patients on dialysis is guided by appropriate policies and procedures.
2. Dialysis patients receive care according to the policies and procedures.

Measurable Elements of COP.3.7
1. The use of restraint is guided by appropriate policies and procedures.
2. Patients in restraint receive care according to the policies and procedures.

Measurable Elements of COP.3.8
1. The care of frail, dependent elderly patients is guided by appropriate policies and procedures.
2. Frail, dependent elderly patients receive care according to the policies and procedures.
3. The care of young, dependent children is guided by appropriate policies and procedures.
4. Young, dependent children receive care according to the policies and procedures.
5. Patient populations at risk for abuse are identified, and their care is guided by appropriate policies and procedures.
6. Identified populations at risk for abuse receive care according to the policies and procedures.

Measurable Elements of COP.3.9
1. The care of patients receiving chemotherapy or other high-risk medications is guided by appropriate policies and procedures.
2. Patients receiving chemotherapy or other high-risk medications receive care according to the policies and procedures.
Food and Nutrition Therapy

Standard COP.4
A variety of food choices, appropriate for the patient’s nutritional status and consistent with his or her clinical care, is regularly available.

Intent of COP.4
Appropriate food and nutrition are important to patients’ well-being and recovery. Food appropriate for the patient’s age, cultural and dietary preferences, and planned care is available on a regular basis. The patient participates in planning and selecting foods, and the patient’s family may, when appropriate, participate in providing food, consistent with cultural, religious, and other traditions and practices. Based on the patient’s assessed needs and plan of care, the patient’s physician or other qualified caregiver orders appropriate food or other nutrients for the patient. When the patient’s family or others provide food to the patient, they are educated about foods that are contraindicated according to the patient’s care needs and plans, including information about any medications associated with food interactions. When possible, patients are offered a variety of food choices consistent with their nutritional status.

Measurable Elements of COP.4
- 1. Food or nutrition, appropriate to the patient, is regularly available.
- 2. Prior to feeding patients, all inpatients have orders for food in their records.
- 3. The order is based on the patient’s nutritional status and needs.
- 4. Patients have a variety of food choices consistent with their condition and care.
- 5. When families provide food, they are educated about the patients’ diet limitations.

Standard COP.4.1
Food preparation, handling, storage, and distribution are safe and comply with laws, regulations, and current acceptable practices.

Intent of COP.4.1
Food preparation, storage, and distribution are monitored to ensure safety and compliance with laws, regulations, and current acceptable practices. Food preparation and storage practices reduce the risk of contamination and spoilage. Food is distributed to patients at specified times. Food and nutritional products, including enteral nutrition products, are available to meet special patient needs.

Measurable Elements of COP.4.1
- 1. Food is prepared in a manner that reduces risk of contamination and spoilage.
- 2. Food is stored in a manner that reduces risk of contamination and spoilage.
- 3. Enteral nutrition products are stored according to manufacturer recommendations.
- 4. The distribution of food is timely, and special requests are met.
- 5. Practices meet applicable laws, regulations, and acceptable practices.
Standard COP.5
Patients at nutrition risk receive nutrition therapy.

Intent of COP.5
On initial assessment, patients are screened to identify those at nutritional risk. These patients are referred to a nutritionist for further assessment. When it is determined that a patient is at nutrition risk, a plan for nutrition therapy is carried out. The patient’s progress is monitored and recorded in his or her record. Physicians, nurses, the dietetics service, and, when appropriate, the patient’s family, collaborate to plan and to provide nutrition therapy. (Also see AOP.1.6, intent statement)

Measurable Elements of COP.5
- 1. Patients assessed at nutrition risk receive nutrition therapy.
- 2. A collaborative process is used to plan, to deliver, and to monitor nutrition therapy. (Also see COP.2, intent statement)
- 3. The patient’s response to nutrition therapy is monitored. (Also see AOP.2, ME 1)
- 4. The patient’s response to nutrition therapy is recorded in his or her record. (Also see MCI.19.1, ME 5)

Pain Management

Standard COP.6
Patients are supported in managing pain effectively.

Intent of COP.6
Pain can be a common part of the patient experience; unrelieved pain has adverse physical and psychological effects. The patient’s right to appropriate assessment and management of pain is respected and supported (also see PFR.2.5, intent statement). Based on the scope of services provided, the organization has processes to assess and to manage pain appropriately, including
   a) identifying patients with pain during initial assessment and reassessments;
   b) providing management of pain according to guidelines or protocols;
   c) communicating with and educating patients and families about pain and symptom management in the context of their personal, cultural, and religious beliefs (also see PFR.1.1, ME 1); and
   d) educating health care practitioners about pain assessment and management. (Also see PFR.2.4)

Measurable Elements of COP.6
- 1. Based on the scope of services provided, the organization has processes to identify patients in pain. (Also see AOP.1.7, ME 1)
- 2. Patients in pain receive care according to pain management guidelines.
- 3. Based on the scope of services provided, the organization has processes to communicate with and to educate patients and families about pain. (Also see PFE.4, ME 4)
- 4. Based on the scope of services provided, the organization has processes to educate staff about pain. (Also see SQE.3, ME 1)
**End-of-Life Care**

Patients who are approaching the end of life and their families require care focused on their unique needs. Dying patients may experience symptoms related to the disease process or curative treatments or may need help in dealing with psychosocial, spiritual, and cultural issues associated with death and dying. Families and caregivers may require respite from caring for a terminally ill family member or help in coping with grief and loss.

The organization's goal for providing care at the end of life considers the settings in which care or service is provided (such as a hospice or palliative care unit), the type of services provided, and the patient population served. The organization develops processes to manage end-of-life care. These processes

- ensure that symptoms will be assessed and appropriately managed;
- ensure that terminally ill patients will be treated with dignity and respect;
- assess patients as frequently as necessary to identify symptoms;
- plan preventive and therapeutic approaches to manage symptoms; and
- educate patients and staff about managing symptoms.

**Standard COP.7**

The organization addresses end-of-life care.

**Intent of COP.7**

Patients who are dying have unique needs for respectful, compassionate care. To accomplish this, all staff are made aware of the unique needs of patients at the end of life. Concern for the patient's comfort and dignity should guide all aspects of care during the final stages of life. End-of-life care provided by the organization includes

- providing appropriate treatment for any symptoms according to the wishes of the patient and family;
- sensitively addressing such issues as autopsy and organ donation;
- respecting the patient's values, religion, and cultural preferences;
- involving the patient and family in all aspects of care; and
- responding to the psychological, emotional, spiritual, and cultural concerns of the patient and family.

To accomplish these goals, all staff are made aware of patients’ unique needs at the end of life. *(Also see PFR.2.5, intent statement)*. The organization evaluates the quality of the end-of-life care provided by evaluating family and staff perceptions of the care provided.

**Measurable Elements of COP.7**

- 1. Staff are made aware of patients’ unique needs at the end of life. *(Also see PFR.1.1, ME 1)*
- 2. End-of-life care provided by the organization addresses dying patients’ needs, at least including evaluation of elements a) through e) in the intent statement.
- 3. The quality of the end-of-life care is evaluated by family and staff.
Standard COP.7.1
Care of the dying patient optimizes his or her comfort and dignity.

Intent of COP.7.1
The organization ensures appropriate care of those in pain or dying by
- taking interventions to manage pain and primary or secondary symptoms;
- preventing symptoms and complications to the extent reasonably possible;
- taking interventions that address patient and family psychosocial, emotional, and spiritual needs regarding dying and grieving;
- taking interventions that address patient and family religious and cultural concerns; and
- involving the patient and family in care decisions.

Measurable Elements of COP.7.1
- 1. Interventions are taken to manage pain and primary or secondary symptoms. *(Also see PFR.2.4, ME 1)*
- 2. Symptoms and complications are prevented to the extent reasonably possible. *(Also see AOP.2, ME 2)*
- 3. Interventions address patient and family psychosocial, emotional, and spiritual needs regarding dying and grieving.
- 4. Interventions address patient and family religious and cultural concerns.
- 5. The patient and family are involved in care decisions. *(Also see PFR.2, ME 1, and PFR.2.1, ME 4)*
Overview

The use of anesthesia, sedation, and surgical interventions are common and complex processes in a health care organization. They require complete and comprehensive patient assessment, integrated care planning, continued patient monitoring, and criteria-determined transfer for continuing care, rehabilitation, and eventual transfer and discharge.

Anesthesia and sedation are commonly viewed as a continuum from minimal sedation to full anesthesia. As patient response may move along that continuum, anesthesia and sedation use are organized in an integrated manner. Thus, this chapter includes anesthesia and moderate and deep sedation, during which the patient's protective reflexes needed for ventilatory functions are at risk. This chapter does not address the use of minimal sedation (anxiolysis). Thus, the use of the term “anesthesia” includes moderate and deep sedation.

Note: The anesthesia and surgery standards are applicable in whatever setting anesthesia and/or moderate or deep sedation are used and surgical and other invasive procedures that require consent (also see PFR.6.4) are performed. Such settings include hospital operating theatres, day surgery or day hospital units, dental and other outpatient clinics, emergency services, intensive care areas, or elsewhere.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

Organization and Management

ASC.1 Anesthesia services (including moderate and deep sedation) are available to meet patient needs, and all such services meet applicable local and national standards, laws, and regulations and professional standards.

ASC.2 A qualified individual(s) is responsible for managing the anesthesia services (including moderate and deep sedation).

Sedation Care

ASC.3 Policies and procedures guide the care of patients undergoing moderate and deep sedation.
Anesthesia Care

**ASC.4** A qualified individual conducts a preanesthesia assessment and preinduction assessment.

**ASC.5** Each patient’s anesthesia care is planned and documented in the patient’s record.

- **ASC.5.1** The risks, benefits, and alternatives are discussed with the patient, his or her family, or those who make decisions for the patient.

- **ASC.5.2** The anesthesia used and anesthetic technique are written in the patient record.

- **ASC.5.3** Each patient’s physiological status during anesthesia is continuously monitored and written in the patient’s record.

**ASC.6** Each patient’s postanesthesia status is monitored and documented, and the patient is discharged from the recovery area by a qualified individual or by using established criteria.

Surgical Care

**ASC.7** Each patient’s surgical care is planned and documented based on the results of the assessment.

- **ASC.7.1** The risks, benefits, and alternatives are discussed with the patient and his or her family or those who make decisions for the patient.

- **ASC.7.2** There is a surgical report or a brief operative note in the patient’s record to facilitate continuing care.

- **ASC.7.3** Each patient’s physiological status is continuously monitored during and immediately after surgery and written in the patient’s record.

- **ASC.7.4** Patient care after surgery is planned and documented.
Standards, Intents, and Measurable Elements

**Anesthesia and Surgical Care (ASC)**

**Organization and Management**

**Standard ASC.1**

Anesthesia services (including moderate and deep sedation) are available to meet patient needs, and all such services meet applicable local and national standards, laws, and regulations and professional standards.

**Intent of ASC.1**

The organization has a system for providing anesthesia services (including moderate and deep sedation) required by its patient population, clinical services offered, and health care practitioners’ needs. Anesthesia services (including moderate and deep sedation) meet all applicable local and national standards, laws, and regulations.

Anesthesia services (including moderate and deep sedation and services required for emergencies) may be provided within the organization, by agreement with another organization, or both. Anesthesia services (including moderate and deep sedation) are available after normal hours for emergencies.

Any use of outside anesthesia sources is based on the recommendation of the director and other individuals responsible for anesthesia/sedation services. Outside sources meet applicable laws and regulations and have acceptable quality and patient safety records.

**Measurable Elements of ASC.1**

- 1. Anesthesia services (including moderate and deep sedation) meet applicable local and national standards, laws, and regulations.
- 2. Adequate, regular, and convenient anesthesia services (including moderate and deep sedation) are available to meet patient needs.
- 3. Anesthesia services (including moderate and deep sedation) are available for emergencies after normal hours of operation.
- 4. Outside sources are selected based on recommendations of the director, acceptable records of performance, and compliance with applicable laws and regulations.

**Standard ASC.2**

A qualified individual(s) is responsible for managing the anesthesia services (including moderate and deep sedation).

**Intent of ASC.2**

Anesthesia services (including moderate and deep sedation) are under the direction of one or more individuals who are qualified by documented training, expertise, and experience, consistent with applicable laws and regulations. This individual(s) assumes professional responsibility for the anesthesia services provided. Responsibilities include:

- developing, implementing, and maintaining policies and procedures;
- administrative oversight;
- maintaining any necessary quality control program;
- recommending outside sources of anesthesia services (including moderate and deep sedation); and
- monitoring and reviewing all anesthesia services (including moderate and deep sedation).
Measurable Elements of ASC.2

- 1. Anesthesia services (including moderate and deep sedation) are uniform throughout the organization. *(Also see COP.1, ME 1)*
- 2. Anesthesia services (including moderate and deep sedation) are under the direction of one or more qualified individuals. *(Also see GLD.5)*
- 3. Responsibilities for developing, implementing, and maintaining policies and procedures are defined and carried out.
- 4. Responsibilities for maintaining quality control programs are defined and carried out.
- 5. Responsibilities for recommending outside sources of anesthesia services (including moderate and deep sedation) are defined and carried out. *(Also see GLD.3.3, ME 1)*
- 6. Responsibilities for monitoring and reviewing all anesthesia services (including moderate and deep sedation) are defined and carried out.

**Sedation Care**

**Standard ASC.3**

Policies and procedures guide the care of patients undergoing moderate and deep sedation.

**Intent of ASC.3**

Sedation—in particular, moderate and deep sedation—poses risks to patients and thus needs to be provided using clear definitions, policies, and procedures. The degrees of sedation occur on a continuum, and a patient may progress from one degree to another, based on the medications administered, route, and dosages.

Important considerations include the patient’s ability to maintain protective reflexes; an independent, continuous patent airway; and the capability to respond to physical stimulation or verbal commands.

Sedation policies and procedures identify

- a) how planning will occur, including the identification of differences between adult and pediatric populations or other special considerations;
- b) documentation required for the care team to work and to communicate effectively;
- c) special consent considerations, if appropriate;
- d) frequency and type of patient-monitoring requirements;
- e) special qualifications or skills of staff involved in sedation process; and
- f) availability and use of specialized equipment.

The qualifications of the physician, dentist, or other qualified individual responsible for the patient receiving moderate and deep sedation are also important. The individual should be competent in

- g) techniques of various modes of sedation;
- h) appropriate monitoring;
- i) response to complications;
- j) use of reversal agents; and
- k) at least basic life support.

The responsible qualified individual conducts a presedation assessment of the patient to ensure the planned sedation and level of sedation is appropriate for the patient. Organization policy defines the scope and content of this assessment.
In addition to the physician or dentist, a qualified individual is responsible for providing uninterrupted monitor-
ing of the patient’s physiological parameters and assistance in supportive or resuscitation measures. The qual-
ifications of the individual providing the monitoring and the monitoring equipment and supplies are the same as for sedation provided in other settings within the organization (for example, in the operating theatre and the
ambulatory dental clinic). Thus, one level of care is maintained. (Also see COP.1, ME 3, and GLD.3.2.1, ME 3)
Definitions of the levels of sedation can be found in the Glossary of this manual on page 245.

Measurable Elements of ASC.3

- 1. Appropriate policies and procedures, addressing at least elements a) through f) found in the intent
   statement, guide the care of patients undergoing moderate and deep sedation. (Also see AOP.2, ME 3;
   COP.1, ME 3; and MMU.4, ME 1)

- 2. The qualified individual(s) identified in ASC.2 participates in the development of the policies and
   procedures.

- 3. There is a presedation assessment performed that is consistent with organization policy to evaluate
   risk and appropriateness of the sedation for the patient. (Also see AOP.1.1, ME 1)

- 4. The qualified practitioner responsible for the sedation is qualified in at least elements g) through k)
   in the intent statement.

- 5. A qualified individual monitors the patient during the period of sedation and documents the
   monitoring.

- 6. Established criteria are developed and documented for the recovery and discharge from sedation.

- 7. Moderate and deep sedation are administered according to hospital policy.

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Anesthesia Care

Standard ASC.4

A qualified individual conducts a preanesthesia assessment and preinduction assessment.

Intent of ASC.4

Because anesthesia carries a high level of risk, administration is carefully planned. The patient’s preanesthesia
assessment is the basis for that plan and for the use of postoperative analgesia. The preanesthesia assessment
provides information needed to

- select the anesthesia and to plan anesthesia care;
- safely administer an appropriate anesthetic; and
- interpret findings of patient monitoring.

An anesthesiologist or another qualified individual conducts the preanesthesia assessment.

The preanesthesia assessment may be carried out some time prior to admission or prior to the surgical proce-
dure or shortly before the surgical procedure, as in emergency and obstetrical patients.

The preinduction assessment is separate from the preanesthesia assessment, as it focuses on the physiologic sta-
bility and readiness of the patient for anesthesia and occurs immediately prior to the induction of anesthesia.

When anesthesia must be provided emergently, the preanesthesia assessment and preinduction assessment may
be performed immediately following one another, or simultaneously, but are documented independently.
Measurable Elements of ASC.4
- 1. A preanesthesia assessment is performed for each patient. *(Also see AOP.1.1, ME 1)*
- 2. A separate preinduction assessment is performed to reevaluate patients immediately before the induction of anesthesia.
- 3. The two assessments are performed by an individual(s) qualified to do so.
- 4. The two assessments are documented in the clinical record.

Standard ASC.5
Each patient’s anesthesia care is planned and documented in the patient’s record.

Intent of ASC.5
Anesthesia care is carefully planned and documented in the anesthesia record. The plan includes information from other patient assessments and identifies the anesthesia to be used, the method of administration, other medications and fluids, monitoring procedures, and anticipated postanesthesia care.

Measurable Elements of ASC.5
- 1. The anesthesia care of each patient is planned.
- 2. The plan is documented.

Standard ASC.5.1
The risks, benefits, and alternatives are discussed with the patient, his or her family, or those who make decisions for the patient.

Intent of ASC.5.1
The anesthesia planning process includes educating the patient, his or her family, or decision maker on the risks, benefits, and alternatives related to the planned anesthesia and postoperative analgesia. This discussion occurs as part of the process to obtain consent for anesthesia (including moderate and deep sedation) as required in PFR.6.4, ME 2. An anesthesiologist or a qualified individual provides this education.

Measurable Elements of ASC.5.1
- 1. The patient, family, and decision makers are educated on the risks, benefits, and alternatives of anesthesia. *(Also see PFR.6.4, ME 2)*
- 2. The anesthesiologist or another qualified individual provides the education.

Standard ASC.5.2
The anesthesia used and anesthetic technique are written in the patient record.

Intent of ASC.5.2
The anesthesia used and the anesthetic technique are written in the patient’s anesthesia record.

Measurable Elements of ASC.5.2
- 1. The anesthesia used is written into the patient’s anesthesia record. *(Also see COP.2.1, ME 7, and MCI.19.1, ME 4)*
- 2. The anesthetic technique used is written into the patient’s anesthesia record.
3. The anesthesiologist and/or nurse anesthetist and anesthesia assistants are identified in the patient’s anesthesia record.

**Standard ASC.5.3**

Each patient’s physiological status during anesthesia is continuously monitored and written in the patient’s record.

**Intent of ASC.5.3**

Physiological monitoring provides reliable information about the patient’s status during anesthesia (general, spinal, and regional) and the recovery period. Monitoring methods depend on the patient’s preanesthesia status, anesthesia choice, and complexity of the surgical or other procedure performed during anesthesia. In all cases, however, the overall monitoring during anesthesia is a continuous process, and the results are written into the patient’s record.

**Measurable Elements of ASC.5.3**

1. Policy and procedure address the minimum frequency and type of monitoring during anesthesia and is uniform for similar patients receiving similar anesthesia wherever anesthesia is provided. (Also see AOP.2, MEs 1–3)
2. Physiological status is monitored according to policy and procedure during anesthesia administration. (Also see AOP.2, MEs 1 and 2)
3. The results of monitoring are written into the patient’s anesthesia record. (Also see MCI.19.1, ME 4)

**Standard ASC.6**

Each patient’s postanesthesia status is monitored and documented, and the patient is discharged from the recovery area by a qualified individual or by using established criteria.

**Intent of ASC.6**

Monitoring during anesthesia is the basis for monitoring during the postanesthesia recovery period. The ongoing, systematic collection and analysis of data on the patient’s status in recovery support decisions about moving the patient to other settings and less-intensive services. Recording of monitoring data provides the documentation to support discharge decisions.

Discharge from the postanesthesia recovery areas or discontinuation of recovery monitoring is by one of the following alternative ways:

a) The patient is discharged (or recovery monitoring is discontinued) by a fully qualified anesthesiologist or other individual authorized by the individual(s) responsible for managing the anesthesia services.

b) The patient is discharged (or recovery monitoring is discontinued) by a nurse or similarly qualified individual in accordance with postanesthesia criteria developed by the hospital’s leaders, and the patient’s record contains evidence that criteria are met.

c) The patient is discharged to a unit which is capable of providing postanesthesia or postsedation care of selected patients, such as a cardiovascular intensive care unit or neurosurgical intensive care unit, among others.

The time of arrival and discharge from the recovery area (or discontinuation of recovery monitoring) is recorded.
Measurable Elements of ASC.6

- 1. Patients are monitored according to policy during the postanesthesia recovery period. *(Also see AOP.2, ME 3)*
- 2. Monitoring findings are entered into the patient’s clinical record by written or electronic entry. *(Also see MCI.19.1, ME 4)*
- 3. Patients are discharged from the postanesthesia unit (or recovery monitoring is discontinued) in accordance with the alternatives described in a) through c) found in the intent statement.
- 4. Time recovery is started and time recovery is ended are recorded in the patient’s record.

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**Surgical Care**

**Standard ASC.7**

Each patient’s surgical care is planned and documented based on the results of the assessment.

**Intent of ASC.7**

Because surgery carries a high level of risk, its use is carefully planned. The patient’s assessment(s) is the basis for selecting the appropriate surgical procedure. Assessment(s) provide information necessary to

- select the appropriate procedure and the optimal time;
- perform procedures safely; and
- interpret findings of patient monitoring.

Procedure selection depends on the patient’s history, physical status, and diagnostic data as well as the risks and benefits of the procedure for the patient. Procedure selection considers the information from the admitting assessment, diagnostic test, and other available sources. The assessment process is carried out in a shortened time frame when an emergency patient needs surgery.

The surgical care planned for the patient is documented in the patient’s record, including a preoperative diagnosis. The name of the surgical procedure alone does not constitute a diagnosis.

**Measurable Elements of ASC.7**

- 1. The assessment information used to develop and to support the planned invasive procedure is documented in the patient’s record by the responsible physician before the procedure is performed. *(Also see AOP.1.5.1, ME 1; AOP.5.3, ME 3; and AOP.6.4, ME 3)*
- 2. Each patient’s surgical care is planned based on the assessment information. *(Also see AOP.1.5.1, ME 1)*
- 3. A preoperative diagnosis and the planned procedure are documented in the patient record by the responsible physician prior to the procedure. *(Also see AOP.1.5.1, ME 1, and MCI.19.1, ME 3)*

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**Standard ASC.7.1**

The risks, benefits, and alternatives are discussed with the patient and his or her family or those who make decisions for the patient.

**Intent of ASC.7.1**

Patients and their families or decision makers receive adequate information to participate in care decisions and to provide the informed consent required in PFR.6.4. The information includes
• the risks of the planned procedure;
• the benefits of the planned procedure;
• the potential complications; and
• the surgical and nonsurgical options (alternatives) available to treat the patient.

In addition, when blood or blood products may be needed, information on the risks and alternatives is discussed. The patient’s surgeon or other qualified individual provides this information.

**Measurable Elements of ASC.7.1**

1. The patient, family, and decision makers are educated on the risks, benefits, potential complications, and alternatives related to the planned surgical procedure. *(Also see PFR.6.4, ME 1)*

2. The education includes the need for, risk and benefits of, and alternatives to blood and blood-product use.

3. The patient’s surgeon or other qualified individual provides the education. *(Also see PFR.6.1, ME 2)*

**Standard ASC.7.2**

There is a surgical report or a brief operative note in the patient’s record to facilitate continuing care.

**Intent of ASC.7.2**

A patient’s postsurgical care depends on the events and findings of the surgical procedure. Thus, the patient’s record includes a postoperative diagnosis, a description of the surgical procedure and findings (including surgical specimens sent for examination), and the names of the surgeon and surgical assistants. To support a continuum of postsurgical supportive care, the written surgical report is available prior to the patient leaving the postanesthesia recovery area. *(Also see COP.2.1, ME 7, and AOP.5.3, ME 3)*

Prior to the patient leaving the postanesthesia recovery area, a brief operative note may be used in lieu of the written surgical report. The minimum content for the written surgical report or brief operative note includes:

a) postoperative diagnosis;
b) name of operative surgeon and assistants;
c) name of the procedure;
d) surgical specimens sent for examination;
e) specific mention of complications or the absence of complications during the procedure, including amount of blood loss; and
f) date, time, and signature of responsible physician.

**Measurable Elements of ASC.7.2**

1. Written surgical reports and brief operative notes include at least a) through f) in the intent statement.

2. The written surgical report, or a brief operative note in the patient’s record, is available before the patient leaves the postanesthesia recovery area. *(Also see COP.2.3, intent statement)*

**Standard ASC.7.3**

Each patient’s physiological status is continuously monitored during and immediately after surgery and written in the patient’s record.

**Note:** This requirement will be scored here only if the procedure was performed under a local anesthetic with no general or regional anesthesia or sedation.
Intent of ASC.7.3
The patient’s physiological status is monitored during surgery and immediately after. The monitoring is appropriate to the patient’s condition and the procedure performed.

Results of monitoring trigger key intraoperative decisions as well as postoperative decisions, such as return to surgery, transfer to another level of care, or discharge. Monitoring information guides medical and nursing care and identifies the need for diagnostic and other services. Monitoring findings are entered into the patient’s record. This requirement is related to the same requirement for physiological monitoring during anesthesia. (Also see ASC.5.3)

Measurable Elements of ASC.7.3
1. The patient’s physiological status is monitored continuously during surgery. (Also see AOP.2, ME 1)
2. Findings are entered into the patient’s record. (Also see AOP.2, ME 1, and MCI.19.1, ME 4)

Standard ASC.7.4
Patient care after surgery is planned and documented.

Intent of ASC.7.4
Each patient’s postsurgical medical and nursing care needs differ. Therefore, it is necessary to plan for that care, including the level of care, care setting, follow-up monitoring or treatment, and need for medication. Postsurgical care planning can begin before surgery based on the patient’s assessed needs and condition. The planned care is documented in the patient’s record to ensure continuity of services during the recovery or rehabilitative period.

Measurable Elements of ASC.7.4
1. Each patient’s immediate postsurgical care is planned and includes medical, nursing, and others as indicated by the patient’s defined needs.
2. The postsurgical plan(s) is documented in the patient’s record by the responsible surgeon or verified by the responsible surgeon by co-signature on the documented plan entered by the surgeon’s delegate.
3. The nursing postsurgical plan of care is documented in the patient’s record.
4. When indicated by the patient’s needs, the postsurgical plan of care provided by others is documented in the patient’s record.
5. The plans of care are documented in the patient’s record within 24 hours of the surgery.
6. The planned care is provided.
Overview

Medication management is an important component in symptomatic, preventive, curative, and palliative treatment and management of diseases and conditions. Medication management encompasses the system and processes an organization uses to provide pharmacotherapies to its patients. This is usually a multidisciplinary, coordinated effort of staff of a health care organization, applying the principles of effective process design, implementation, and improvement to the selecting, procuring, storing, ordering/prescribing, transcribing, distributing, preparing, dispensing, administering, documenting, and monitoring of medication therapies. Although health care practitioners’ roles in medication management vary greatly from one country to another, sound medication management processes for patient safety are universal.

Note: Medication is defined as any prescription medications; sample medications; herbal remedies; vitamins; nutriceuticals; over-the-counter drugs; vaccines; or diagnostic and contrast agents used on or administered to persons to diagnose, to treat, or to prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood derivatives; and intravenous solutions (plain, with electrolytes and/or drugs).

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

Organization and Management

MMU.1 Medication use in the organization complies with applicable laws and regulations and is organized to meet patient needs.

   MMU.1.1 An appropriately licensed pharmacist, technician, or other trained professional supervises the pharmacy or pharmaceutical service.

Selection and Procurement

MMU.2 An appropriate selection of medications for prescribing or ordering is stocked or readily available.

   MMU.2.1 There is a method for overseeing the organization's medication list and medication use.
MMU.2.2 The organization can readily obtain medications not stocked or normally available to the organization or for times when the pharmacy is closed.

Storage
MMU.3 Medications are properly and safely stored.

MMU.3.1 Organization policy supports appropriate storage of medications and applicable nutrition products.

MMU.3.2 Emergency medications are available, monitored, and safe when stored out of the pharmacy.

MMU.3.3 The organization has a medication recall system.

Ordering and Transcribing
MMU.4 Prescribing, ordering, and transcribing are guided by policies and procedures.

MMU.4.1 The organization defines the elements of a complete order or prescription and the types of orders that are acceptable for use.

MMU.4.2 The organization identifies those qualified individuals permitted to prescribe or to order medications.

MMU.4.3 Medications prescribed and administered are written in the patient’s record.

Preparing and Dispensing
MMU.5 Medications are prepared and dispensed in a safe and clean environment.

MMU.5.1 Medication prescriptions or orders are reviewed for appropriateness.

MMU.5.2 A system is used to dispense medications in the right dose to the right patient at the right time.

Administration
MMU.6 The organization identifies those qualified individuals permitted to administer medications.

MMU.6.1 Medication administration includes a process to verify the medication is correct based on the medication order.

MMU.6.2 Policies and procedures govern medications brought into the organization for patient self-administration or as samples.

Monitoring
MMU.7 Medication effects on patients are monitored.

MMU.7.1 Medication errors, including near misses, are reported through a process and time frame defined by the organization.
Standards, Intents, and Measurable Elements

**Organization and Management**

**Standard MMU.1**
Medication use in the organization complies with applicable laws and regulations and is organized to meet patient needs.

**Intent of MMU.1**
Medications, as an important resource in patient care, must be organized effectively and efficiently. Medication management is not only the responsibility of the pharmaceutical service but also of managers and health care practitioners. How this responsibility is shared depends on the organization's structure and staffing. In those cases where a pharmacy is not present, medications may be managed on each clinical unit according to organization policy. In other cases, where a large central pharmacy is present, the pharmacy may organize and control medications throughout the organization. Effective medication management includes all parts of the organization, inpatient, outpatient, and specialized units. Applicable laws and regulations are incorporated into the organizational structure and the operations of the medication management system used in the organization.

To ensure efficient and effective medication management and use, the organization conducts a systems review at least once a year. The annual review pulls together all information and experience related to medication management. That information and experience includes, for example, the following:

- How well the system is working related to
  - the selection and procurement of medications;
  - storage;
  - ordering and transcribing;
  - preparing and dispensing; and
  - administration and monitoring;
- Monitoring resulting from any changes in the formulary, such as addition of drugs
- Monitoring of medication errors and near misses
- Any education needs identified
- Consideration of new evidence-based practices

The review allows organizations to understand the need and priority of continued system improvements in quality and safety of medication use.

**Measurable Elements of MMU.1**

1. There is a plan or policy or other document that identifies how medication use is organized and managed throughout the organization.

2. All settings, services, and individuals who manage medication processes are included in the organizational structure.

3. Policies guide all phases of medication management and medication use in the organization.

4. There is at least one documented review of the medication management system within the previous 12 months.

5. The pharmacy or pharmaceutical service and medication use comply with applicable laws and regulations.
6. Appropriate sources of drug information are readily available to those involved in medication use.

**Standard MMU.1.1**
An appropriately licensed pharmacist, technician, or other trained professional supervises the pharmacy or pharmaceutical service.

**Intent of MMU.1.1**
A qualified individual directly supervises the activities of the pharmacy or pharmaceutical service. The individual is appropriately licensed, certified, and trained. Supervision includes all the processes described in MMU.2 through MMU.5, and participation in MMU.7 through MMU.7.1.

**Measurable Elements of MMU.1.1**
- 1. An appropriately licensed, certified, and trained individual supervises all activities. *(Also see GLD.5, ME 1)*
- 2. The individual provides supervision for the processes described in MMU.2 through MMU.5.

**Selection and Procurement**

**Standard MMU.2**
An appropriate selection of medications for prescribing or ordering is stocked or readily available.

**Intent of MMU.2**
Every organization must decide which medications to make available for prescribing and ordering by the health care practitioners. This decision is based on the organization’s mission, patient needs, and types of services provided. The organization develops a list (often referred to as a formulary) of all the medications it stocks or that are readily available from outside sources. In some cases, laws and regulations may determine the medications on the list or the source of those medications. Medication selection is a collaborative process that includes patient need and safety as well as economics. Medications are occasionally out of stock due to delayed delivery, national shortages, or other reasons not anticipated through normal inventory control. There is a process to notify prescribers of the shortage and suggested substitutes.

**Measurable Elements of MMU.2**
- 1. There is a list of medications stocked in the organization or readily available from outside sources.
- 2. A collaborative process was used to develop the list (unless determined by regulation or an authority outside the organization).
- 3. There is a process established for when medications are not available that includes a notification to prescribers and suggested substitutions.

**Standard MMU.2.1**
There is a method for overseeing the organization’s medication list and medication use.

**Intent of MMU.2.1**
The organization has a method, such as designating a committee, to maintain and to monitor the medication list and to monitor the use of medications in the organization. Those involved in the oversight of the list
include health care practitioners involved in the ordering, dispensing, administering, and monitoring process for medications. Decisions to add or to remove medications from the list are guided by criteria that include the indication for use, effectiveness, risks, and costs. There is a process or mechanism to monitor patient response to newly added medications. For example, when the decision is made to add a new type of medication or a new class of drugs to the list, there is a process to monitor appropriateness of indication, how the drug is prescribed (dosage or route, for example), and any unanticipated adverse events or conditions associated with the new drug during the introductory period.

The list is reviewed at least annually based on emerging safety and efficacy information and information on usage and adverse events. Associated with the overall management of medications is the need to ensure that medications are protected from loss or theft from the pharmacy or any other location where medications are stored or dispensed.

**Measurable Elements of MMU.2.1**

- 1. There is a method for overseeing medication use in the organization.
- 2. Medications are protected from loss or theft throughout the organization.
- 3. Health care practitioners involved in ordering, dispensing, administering, and patient-monitoring processes are involved in evaluating and maintaining the medication list.
- 4. Decisions to add or to remove medications from the list are guided by criteria.
- 5. When medications are newly added to the list, there is a process or mechanism to monitor how the drug is used and any unanticipated adverse events.
- 6. The list is reviewed at least annually based on safety and efficacy information.

**Standard MMU.2.2**

The organization can readily obtain medications not stocked or normally available to the organization or for times when the pharmacy is closed.

**Intent of MMU.2.2**

On occasion, medications not stocked or readily available to the organization are needed. There is a process to approve and procure such medications. Also, there are occasions when medications are needed during the night or when the pharmacy is closed or medication supply locked. Each organization needs to plan for these occurrences and educate staff on procedures to follow in the event they occur. *(Also see GLD.3.2.1, ME 2)*

**Measurable Elements of MMU.2.2**

- 1. There is a process to approve and to procure required medications not stocked or normally available to the organization. *(Also see GLD.3.2.1, ME 1)*
- 2. There is a process to obtain medications at times the pharmacy is closed or medication supply locked. *(Also see GLD.3.2.1, ME 2)*
- 3. Staff understand the processes.
Storage

Standard MMU.3
Medications are properly and safely stored.

Intent of MMU.3
Medications may be stored within a storage area, in a pharmacy or pharmaceutical service, or on the patient care units in unit pharmacies or the nursing station in the clinical unit. Standard MMU.1 provides the oversight mechanism for all locations that medications are stored. In all locations that medications are stored, the following is evident:

a) Medications are stored under conditions suitable for product stability.

b) Controlled substances are accurately accounted for according to applicable laws and regulations.

c) Medications and chemicals used to prepare medications are accurately labeled with contents, expiration dates, and warnings.

d) Concentrated electrolytes are not stored in care units unless clinically necessary, and when stored in care units there are safeguards in place to prevent inadvertent administration (scored at IPSG.3, MEs 1 and 2).

e) All medication storage areas are periodically inspected according to hospital policy to ensure medications are stored properly.

f) Organization policy defines how medications brought in by the patient are identified and stored.

Measurable Elements of MMU.3
Each element a) through f) found in the intent statement is scored separately, as they represent critical or high-risk areas.

- 1. Medications are stored under conditions suitable for product stability.
- 2. Controlled substances are accurately accounted for according to applicable laws and regulations.
- 3. Medications and chemicals used to prepare medications are accurately labeled with contents, expiration dates, and warnings.
- 4. All medication storage areas are periodically inspected according to hospital policy to ensure medications are stored properly.
- 5. Organization policy defines how medications brought in by the patient are identified and stored.

Standard MMU.3.1
Organization policy supports appropriate storage of medications and applicable nutrition products.

Intent of MMU.3.1
There are some types of medications that because of their high risk (radioactive medications), unusual circumstances (brought in by the patient), opportunity for abuse or misuse (sample medications and emergency medications), or their special nature (applicable nutritional products) are best supported by policies that guide storage and control of use. The policies address the receipt process, the identification of the medication, if necessary, the storage, and any distribution.
Measurable Elements of MMU.3.1
- 1. Organization policy defines how appropriate nutrition products are stored.
- 2. Organization policy defines how radioactive, investigational, and similar medications are stored.
- 3. Organization policy defines how sample medications are stored and controlled.
- 4. All storage is according to organization policy.

Standard MMU.3.2
Emergency medications are available, monitored, and safe when stored out of the pharmacy.

Intent of MMU.3.2
When patient emergencies occur, quick access to appropriate emergency medications is critical. Each organization plans the location of emergency medications and the medications to be supplied in these locations. For example, agents to reverse anesthesia are found in the operating theatres. Emergency cabinets, carts, bags, or boxes can be used for this purpose. To ensure access to emergency medications when needed, the organization establishes a procedure or process to prevent abuse, theft, or loss of the medications. The process ensures that medications are replaced when used, damaged, or out of date. Thus, the organization understands the balance between ready access and security for locations where emergency medications are stored.

Measurable Elements of MMU.3.2
- 1. Emergency medications are available in the units they will be needed or readily accessible within the organization to meet emergency needs. (Also see GLD.3.2.1, ME 1, and MMU.2.2, ME 1)
- 2. Organization policy defines how emergency medications are stored, maintained, and protected from loss or theft.
- 3. Emergency medications are monitored and replaced in a timely manner in accordance with organization policy after use or when expired or damaged.

Standard MMU.3.3
The organization has a medication recall system.

Intent of MMU.3.3
The organization has a process for identifying, retrieving, and returning or safely and properly destroying medications recalled by the manufacturer or supplier. There is a policy or procedure that addresses any use of or the destruction of medications known to be expired or outdated.

Measurable Elements of MMU.3.3
- 1. There is a medication recall system in place.
- 2. Policies and procedures address any use of medications known to be expired or outdated.
- 3. Policies and procedures address the destruction of medications known to be expired or outdated.
- 4. Policies and procedures are implemented.
Ordering and Transcribing

Standard MMU.4
Prescribing, ordering, and transcribing are guided by policies and procedures.

Intent of MMU.4
Safe prescribing, ordering, and transcribing are guided by organization policies and procedures. Medical, nursing, pharmacy, and administrative staff collaborate to develop and to monitor the policies and procedures. Relevant staff are trained in correct prescribing, ordering, and transcribing practices. As illegible medication prescriptions or orders jeopardize patient safety and may delay treatment, organization policy addresses actions to reduce illegibility. A listing of all current medications is recorded in the patient’s record and is available to the pharmacy, nurses, and physicians. The organization establishes a process to compare the patient’s list of medications taken prior to admission against the initial orders.

Measurable Elements of MMU.4
- 1. Policies and procedures guide the safe prescribing, ordering, and transcribing of medications in the organization. (Also see COP.2.2, ME 1; AOP.3, ME 1; and IPSG.2, ME 1)
- 2. Policies and procedures address actions related to illegible prescriptions and orders.
- 3. There is a collaborative process to develop the policies and procedures.
- 4. Relevant staff are trained in correct prescribing, ordering, and transcribing practices.
- 5. Patient records contain a list of current medications taken prior to admission, and this information is made available to the pharmacy and the patient’s health care practitioners.
- 6. Initial medication orders are compared to the list of medications taken prior to admission, according to the organization’s established process.

Standard MMU.4.1
The organization defines the elements of a complete order or prescription and the types of orders that are acceptable for use.

Intent of MMU.4.1
To reduce the variation and improve patient safety, the organization defines in policy the acceptable elements of a complete order or prescription. The elements addressed in the policy include at least the following:
- a) The data necessary to accurately identify the patient
- b) The elements of the order or prescription
- c) When generic or brand names are acceptable or required
- d) Whether or when indications for use are required on a PRN (pro re nata, or “as needed”) or other medication order
- e) Special precautions or procedures for ordering drugs with look-alike/sound-alike names
- f) Actions to be taken when medication orders are incomplete, illegible, or unclear
- g) The permitted additional types of orders, such as emergency, standing, or automatic stop, and any elements required in such orders
- h) The use of verbal and telephone medication orders and the process to verify such orders (also see IPSG.2, ME 1)
- i) The types of orders that are weight based, such as for pediatric populations
Thus, this standard sets organizationwide expectations for medication orders. The implemented policy will be reflected in complete orders entered in the patient record, the pharmacy or dispensing unit receiving the information needed for dispensing, and the administration of the medication based on a complete order.

**Measurable Elements of MMU.4.1**

Elements a) through i) found in the intent statement are scored together, as they represent aspects of the organization's policy on complete orders.

- 1. Acceptable medication orders or prescriptions are defined in policy, and at least elements a) through i) are addressed in the policy.
- 2. Medication orders or prescriptions are complete per organization policy.

**Standard MMU.4.2**

The organization identifies those qualified individuals permitted to prescribe or to order medications.

**Intent of MMU.4.2**

Selecting a medication to treat a patient requires specific knowledge and experience. Each organization is responsible for identifying those individuals with the requisite knowledge and experience and who are also permitted by licensure, certification, laws, or regulations to prescribe or to order medications. An organization may place limits on prescribing or ordering by an individual, such as for controlled substances, chemotherapy agents, or radioactive and investigational medications. Individuals permitted to prescribe and to order medications are known to the pharmaceutical service or others who dispense medications. In emergency situations, the organization identifies any additional individuals permitted to prescribe or to order medications.

**Measurable Elements of MMU.4.2**

- 1. Only those permitted by the organization and by relevant licensure, laws, and regulations prescribe or order medications.
- 2. There is a process to place limits, when appropriate, on the prescribing or ordering practices of individuals. (Also see SQE.10, ME 1)
- 3. Individuals permitted to prescribe and to order medications are known to the pharmaceutical service or others who dispense medications.

**Standard MMU.4.3**

Medications prescribed and administered are written in the patient’s record.

**Intent of MMU.4.3**

The record of each patient who receives medication contains a list of the medications prescribed or ordered for the patient and the dosage and times the medication was administered. Included are medications administered “as needed.” If this information is recorded on a separate medication form, the form is inserted in the patient’s record at discharge or transfer.

**Measurable Elements of MMU.4.3**

- 1. Medications prescribed or ordered are recorded for each patient.
- 2. Medication administration is recorded for each dose.
- 3. Medication information is kept in the patient’s record or inserted into his or her record at discharge or transfer.
Preparing and Dispensing

**Standard MMU.5**
Medications are prepared and dispensed in a safe and clean environment.

**Intent of MMU.5**
The pharmacy or pharmaceutical service prepares and dispenses medications in a clean and safe environment that complies with law, regulation, and professional practice standards. The organization identifies the standards of practice for a safe and clean preparation and dispensing environment. Medications stored and dispensed from areas outside the pharmacy (for example, patient care units comply with the same safety and cleanliness measures). Staff preparing compounded sterile products (such as IVs and epidurals) are trained in the principles of aseptic technique. Similarly, hooded vents are available and used when indicated by professional practices (for example, cytotoxic medications).

**Measurable Elements of MMU.5**

- 1. Medications are prepared and dispensed in clean and safe areas with appropriate equipment and supplies. *(Also see PCI.7, MEs 1 and 2)*
- 2. Medications preparation and dispensing adhere to law, regulation, and professional standards of practice.
- 3. Staff preparing sterile products are trained in aseptic techniques.

**Standard MMU.5.1**
Medication prescriptions or orders are reviewed for appropriateness.

**Intent of MMU.5.1**
The licensed pharmacist, technician, or trained professional reviews each prescription or order, newly prescribed or ordered, for appropriateness or when the dosage or other appropriateness factors change. The organization defines what patient-specific information is required for the effective review of the order or prescription. This occurs prior to dispensing or prior to administration when medications are dispensed from locations other than the pharmacy. When questions arise, the individual who prescribed or ordered the medication is contacted.

The process to review an order or prescription prior to dispensing includes evaluation by a trained professional of

- a) the appropriateness of the drug, dose, frequency, and route of administration;
- b) therapeutic duplication;
- c) real or potential allergies or sensitivities;
- d) real or potential interactions between the medication and other medications or food;
- e) variation from organization criteria for use;
- f) patient’s weight and other physiological information; and
- g) other contraindications.

Those who review medication orders or prescriptions are competent to do so by virtue of education and training, as specified by privileging, or have demonstrated competency in the review process. In addition, the review for appropriateness may not be necessary or appropriate in an emergency or when the ordering physician is present for ordering, administering, and monitoring of the patient (for example, the operating room or...
the emergency department), or in interventional radiology or diagnostic imaging where the medication is part of the procedure.

To facilitate review, there is a record (profile) for all medication administered to a patient except emergency medications and those administered as part of a procedure.

When computer software programs are used to cross-check drug/drug interactions and drug allergies, the software is updated on an appropriate schedule.

**Measurable Elements of MMU.5.1**

- 1. The organization defines the patient-specific information required for an effective review process. *(Also see MCI.4, MEs 1 and 3)*
- 2. Apart from exceptions identified in the intent, each prescription or order is reviewed for appropriateness prior to dispensing and administration and includes elements a) through g) in the intent. Thus, each prescription or order is evaluated for appropriateness review.
- 3. There is a process to contact the individual who prescribed or ordered the medication when questions arise.
- 4. Individuals permitted to review orders or prescriptions are judged competent to do so.
- 5. Review is facilitated by a record (profile) for all patients receiving medications.
- 6. Computer software, when used to cross-check drugs for drug/drug interactions and allergies, is periodically updated.

**Standard MMU.5.2**

**A system is used to dispense medications in the right dose to the right patient at the right time.**

**Intent of MMU.5.2**

The organization dispenses medications in the most ready-to-administer form possible to minimize opportunities for error during distribution and administration. When a medication is removed from its original packaging or prepared and dispensed in a different form/container—and not immediately administered—the medication must be labeled with the name of the medication, the dosage/concentration of the medication, the date of preparation, and the date of expiration. The central pharmacy and other medication-distribution points throughout the organization use the same system. The system supports accurate dispensing of medications in a timely manner.

**Measurable Elements of MMU.5.2**

- 1. There is a uniform medication dispensing and distribution system in the organization.
- 2. After preparation, medications are labeled with the name of the medication, the dosage/concentration, the date prepared, the expiration date, and the patient’s name.
- 3. Medications are dispensed in the most ready-to-administer form.
- 4. The system supports accurate dispensing.
- 5. The system supports timely dispensing.
Administration

Standard MMU.6
The organization identifies those qualified individuals permitted to administer medications.

Intent of MMU.6
Administering a medication to treat a patient requires specific knowledge and experience. Each organization is responsible for identifying those individuals with the requisite knowledge and experience and who are also permitted by licensure, certification, laws, or regulations to administer medications. An organization may place limits on medication administration by an individual, such as for controlled substances or radioactive and investigational medications. In emergency situations, the organization identifies any additional individuals permitted to administer medications.

Measurable Elements of MMU.6
- 1. The organization identifies those individuals, by job description or the privileging process, authorized to administer medications.
- 2. Only those permitted by the organization and by relevant licensure, laws, and regulations administer medications.
- 3. There is a process to place limits, when appropriate, on the medication administration of individuals. (Also see SQE.13, MEs 1 and 2)

Standard MMU.6.1
Medication administration includes a process to verify the medication is correct based on the medication order.

Intent of MMU.6.1
The safe administration of medications includes verifying the
  a) medication with the prescription or order;
  b) time and frequency of administration with the prescription or order;
  c) dosage amount with the prescription or order;
  d) route of administration with the prescription or order; and
  e) identity of the patient. (Scored at IPSG.1, ME 3)

The organization defines the verification process to be used in administering medications.

When the medication is prepared and dispensed on the patient care unit, then the process of appropriateness review described in MMU.5.1 must also be carried out by a qualified individual.

Measurable Elements of MMU.6.1
- 1. Medications are verified with the prescription or order.
- 2. The dosage amount of the medication is verified with the prescription or order.
- 3. The route of administration is verified with the prescription or order.
- 4. Medications are administered on a timely basis.
- 5. Medications are administered as prescribed and noted in the patient’s record.
**Standard MMU.6.2**

Policies and procedures govern medications brought into the organization for patient self-administration or as samples.

**Intent of MMU.6.2**

Overseeing medication use in an organization requires an understanding of the sources and uses of medications that are not prescribed or ordered in the organization. Medications brought into the organization by the patient or his or her family are known to the patient’s physician and noted in the patient’s record. The self-administration of medications—either those brought into the organization or those prescribed or ordered within the organization—is known to the patient’s physician and noted in the patient’s record. The organization controls the availability and use of medication samples.

**Measurable Elements of MMU.6.2**

- 1. Policies and procedures are implemented to govern patient self-administration of medications.
- 2. Policies and procedures are implemented to govern the documentation and management of any medications brought into the organization for or by the patient.
- 3. Policies and procedures are implemented to govern the availability and use of medication samples.

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**Monitoring**

**Standard MMU.7**

Medication effects on patients are monitored.

**Intent of MMU.7**

Patients, their physicians, nurses, and other health care practitioners work together to monitor patients on medications. The purposes of monitoring are to evaluate the medication’s effect on the patient’s symptoms or illness, as well as blood count, renal function, liver function, and other monitoring with select medications, and to evaluate the patient for adverse effects. Based on monitoring, the dosage or type of medication can be adjusted when needed. It is appropriate to closely monitor the patient’s response to the first dose(s) of a medication new to the patient. Such monitoring is intended to identify the anticipated therapeutic response as well as allergic responses, unanticipated drug/drug interactions, or a change in the patient’s equilibrium raising the risk of falls, among others.

Monitoring medication effects includes observing and documenting any adverse effects. The organization has a policy that identifies all adverse effects that are to be recorded and those that must be reported. The organization establishes a mechanism for reporting adverse events when required and the time frame for reporting.

**Measurable Elements of MMU.7**

- 1. Medication effects on patients are monitored, including adverse effects. (*Also see AOP.2, ME 1*)
- 2. The monitoring process is collaborative.
- 3. The organization has a policy that identifies those adverse effects that are to be recorded in the patient’s record and those that must be reported to the organization. (*Also see QPS.6, ME 3*)
- 4. Adverse effects are documented in the patient’s record as required by policy.
- 5. Adverse effects are reported in the time frame required by policy.
Standard MMU.7.1
Medication errors, including near misses, are reported through a process and time frame defined by the organization.

Intent of MMU.7.1
The organization has a process to identify and to report medication errors and near misses. The process includes defining a medication error and near miss, using a standardized format for reporting, and educating staff on the process and importance of reporting. Definitions and processes are developed through a collaborative process that includes all those involved in the different steps in medication management. The reporting process is part of the organization’s quality and patient safety program. The reports are directed to one or more individuals who are accountable for taking action (also see QPS.7). The program focuses on preventing medication errors through understanding the types of errors that occur in the organization and in other organizations and why near misses occur. Improvements in medication processes and staff training are used to prevent errors in the future. The pharmacy participates in such staff training.

Measurable Elements of MMU.7.1
- 1. A medication error and near miss are defined through a collaborative process. (Also see QPS.6, ME 4, and QPS.7, ME 1)
- 2. Medication errors and near misses are reported in a timely manner using an established process. (Also see QPS.7, ME 2)
- 3. Those accountable for taking action on the reports are identified.
- 4. The organization uses medication errors and near misses reporting information to improve medication use processes. (Also see QPS.7, ME 3)
Patient and Family Education (PFE)

Overview

Patient and family education helps patients better participate in their care and make informed care decisions. Many different staff in the organization educate patients and families. Education takes place when the patient interacts with his or her physician(s) or the nurse(s). Others provide education as they provide specific services, such as rehabilitation or nutrition therapy, or prepare the patient for discharge and continuing care. Because many staff help educate patients and families, it is important that staff members coordinate their activities and focus on what patients need to learn.

Effective education thus begins with an assessment of the patient's and family's learning needs. This assessment determines not only what needs to be learned but how the learning can best occur. Learning is most effective when it suits an individual's learning preferences, religious and cultural values, and reading and language skills. Learning is also affected by when it occurs in the care process.

Education includes the knowledge needed during the care process and the knowledge needed after the patient is discharged to another care site or home. Thus, education can include information on community resources for additional care and required follow-up care and how to access emergency services if necessary. Effective education in an organization employs available electronic and visual formats and a variety of distance learning and other techniques.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

**PFE.1** The organization provides education that supports patient and family participation in care decisions and care processes.

**PFE.2** Each patient's educational needs are assessed and recorded in his or her record.

**PFE.2.1** The patient's and family's ability to learn and willingness to learn are assessed.

**PFE.3** Education and training help meet patients' ongoing health needs.
PFE.4 Patient and family education includes the following topics, related to the patient's care: the safe use of medications, the safe use of medical equipment, potential interactions between medications and food, nutritional guidance, pain management, and rehabilitation techniques.

PFE.5 Education methods include the patient's and family's values and preferences and allow sufficient interaction among the patient, family, and staff for learning to occur.

PFE.6 Health professionals caring for the patient collaborate to provide education.
Standards, Intents, and Measurable Elements

**Standard PFE.1**
The organization provides education that supports patient and family participation in care decisions and care processes.

**Intent of PFE.1**
Health care organizations educate patients and families so that they have the knowledge and skills to participate in the patient care processes and care decisions. Each organization builds education into care processes based upon its mission, services provided, and patient population. Education is planned to ensure that every patient is offered the education he or she requires. The organization chooses how it organizes its educational resources in an efficient and effective manner. Thus, organizations may choose to appoint an education coordinator or education committee, create an education service, or simply work with all staff to provide education in a coordinated manner.

**Measurable Elements of PFE.1**
- 1. The organization plans education consistent with its mission, services, and patient population.
- 2. There is an established structure or mechanism for education throughout the organization.
- 3. The education structure and resources are organized in an effective manner.

**Standard PFE.2**
Each patient's educational needs are assessed and recorded in his or her record.

**Intent of PFE.2**
Education focuses on the specific knowledge and skills the patient and family will need to make care decisions, participate in their care, and continue care at home. This is in contrast to the general flow of information between staff and the patient that is informative but not of an educational nature.

To understand the educational needs of each patient and his or her family, there is an assessment process that identifies the types of surgeries, other invasive procedures and treatments planned, the accompanying nursing needs, and the continuing care needs following discharge. This assessment permits the patient’s care givers to plan and to deliver the needed education.

Education by organization staff is provided to patients and families to support decisions in the care process. Education provided as part of the process of obtaining informed consent for treatment (for example, for surgery and anesthesia) is documented in the patient’s record. In addition, when a patient or family directly participates in providing care (for example, changing dressings, feeding the patient, administering medications and treatments), they need to be educated.

Once the educational needs are identified, they are recorded in the patient’s record. This helps all the patient's caregivers participate in the education process. Each organization decides the location and format for educational assessment, planning, and delivery of information in the patient’s record.

**Measurable Elements of PFE.2**
- 1. The educational needs of the patient and family are assessed.
- 2. Educational needs assessment findings are recorded in the patient's record.
3. There is uniform recording of patient education by all staff.

4. When informed consent is required, patients and families learn about the process for granting informed consent. *(Also see PFR.2.1, ME 3, and MCI.3, MEs 1 and 2)*

5. Patients and families learn about how to participate in care decisions. *(Also see PFR.2, ME 1)*

6. Patients and families learn about their conditions and any confirmed diagnoses. *(Also see PFR.2.1, ME 1)*

7. Patients and families learn about their rights to participate in the care process. *(Also see PFR.2.1, ME 4)*

**Standard PFE.2.1**
The patient’s and family’s ability to learn and willingness to learn are assessed.

**Intent of PFE.2.1**
Knowledge and skill strengths and deficits are identified and used to plan the education. There are many patient variables that determine if the patient and family are willing and capable to learn. Thus, to plan the education, the organization must assess

a) the patient's and family's beliefs and values;

b) their literacy, educational level, and language;

c) emotional barriers and motivations;

d) physical and cognitive limitations; and

e) the patient's willingness to receive information.

*(Also see PFR.5, ME 3)*

**Measurable Elements of PFE.2.1**

1. The patient and family are assessed on elements a) through e) of the intent. *(Also see PFR.1.1, ME 1)*

2. The assessment findings are used to plan the education.

3. The assessment findings are documented in the patient’s record.

**Standard PFE.3**
Education and training help meet patients’ ongoing health needs.

**Intent of PFE.3**
Patients frequently require follow-up care to meet ongoing health needs or to achieve their health goals.

General health information provided by the organization or from community resources may include when to resume daily activities postdischarge, preventive practices relevant to the patient’s condition or health goals, and information on coping with disease or disability if relevant to the patient’s condition.

The organization identifies educational and training resources available in the community. In particular, community organizations that support health promotion and disease prevention are identified, and, when possible, ongoing relationships are established.

**Measurable Elements of PFE.3**

1. Patients and families receive education and training to meet their ongoing health needs or to achieve their health goals. *(Also see MCI.3, MEs 1 and 2)*
2. The organization identifies and establishes relationships with community resources that support continuing health promotion and disease prevention education. (*Also see ACC.3.1, ME 2, and GLD.3.1, ME 2*)

3. When indicated by the patient’s condition, patients are referred to resources available within the community. (*Also see GLD.3.1, ME 2*)

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### Standard PFE.4

Patient and family education includes the following topics, related to the patient’s care: the safe use of medications, the safe use of medical equipment, potential interactions between medications and food, nutritional guidance, pain management, and rehabilitation techniques.

**Intent of PFE.4**

The organization routinely provides education in areas that carry high risk to patients. Education supports the return to previous functional levels and maintenance of optimal health.

The organization uses standardized materials and processes in educating patients on at least the following topics:

- Safe and effective use of all medications taken by the patient (not just discharge medications), including potential medication side effects
- Safe and effective use of medical equipment
- Potential interactions between prescribed medications and other medications (including over-the-counter preparations) and food
- Diet and nutrition
- Pain management
- Rehabilitation techniques

**Measurable Elements of PFE.4**

1. As related to the care provided, patients and families are educated about the safe and effective use of all medications, potential side effects of medications, and prevention of potential interactions with over-the-counter medications and/or food.

2. As related to the care provided, patients and families are educated about safely and effectively using medical equipment.

3. As related to the care provided, patients and families are educated about proper diet and nutrition.

4. As related to the care provided, patients and families are educated about pain management. (*Also see COP.6, ME 3*)

5. As related to the care provided, patients and families are educated about rehabilitation techniques.

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### Standard PFE.5

Education methods include the patient’s and family’s values and preferences and allow sufficient interaction among the patient, family, and staff for learning to occur.

**Intent of PFE.5**

Learning occurs when attention is paid to the methods used to educate patients and families. Understanding patients and families helps the organization select educators and educational methods consistent with the patients’ and families’ values and preferences and to identify the families’ roles and the instruction method.
Patients and their families are encouraged to participate in the care process by speaking up and asking staff questions to ensure correct understanding and anticipated participation. Staff recognize the important role patients play in the provision of safe, high-quality care.

The opportunity for interaction among staff, the patient, and his or her family permits feedback to ensure that the information is understood, useful, and usable (also see MCI.3, MEs 1 and 2). The organization decides when and how verbal education is reinforced with written materials to enhance understanding and to provide a future educational reference.

**Measurable Elements of PFE.5**

- 1. There is a process to verify that patients and families received and understood the education provided. *(Also see MCI.3, MEs 1 and 2)*
- 2. Those who provide education encourage patients and their families to ask questions and to speak up as active participants. *(Also see PFR.2, ME 1)*
- 3. Verbal information is reinforced with written material that is related to the patient’s needs and consistent with the patient’s and family’s learning preferences. *(Also see PFR.2.1, intent statement, and MCI.3)*

**Standard PFE.6**

Health professionals caring for the patient collaborate to provide education.

**Intent of PFE.6**

When health care professionals understand one another’s contributions to patient education, they can collaborate more effectively. Collaboration, in turn, helps ensure that the information patients and families receive is comprehensive, consistent, and as effective as possible. Collaboration is based on the patient’s needs and therefore may not always be necessary.

Knowledge of the subject matter, available adequate time, and ability to communicate effectively are important considerations in effective education.

**Measurable Elements of PFE.6**

- 1. Patient and family education is provided collaboratively when indicated.
- 2. Those who provide education have the subject knowledge to do so.
- 3. Those who provide education have adequate time to do so.
- 4. Those who provide education have the communication skills to do so. *(Also see ASC.5.1, ME 2)*
Section II:
Health Care Organization Management Standards
Overview

This chapter describes a comprehensive approach to quality improvement and patient safety. Integral to overall improvement in quality is the ongoing reduction in risks to patients and staff. Such risks may be found in clinical processes as well as in the physical environment. This approach includes

- leading and planning the quality improvement and patient safety program;
- designing new clinical and managerial processes well;
- measuring how well processes work through data collection;
- analyzing the data; and
- implementing and sustaining changes that result in improvement.

Both quality improvement and patient safety programs

- are leadership driven;
- seek to change the culture of an organization;
- proactively identify and reduce risk and variation;
- use data to focus on priority issues; and
- seek to demonstrate sustainable improvements.

Quality and safety are rooted in the daily work of individual health care professionals and other staff. As physicians and nurses assess patient needs and provide care, this chapter can help them understand how to make real improvements that help patients and reduce risks. Similarly, managers, support staff, and others can apply the standards to their daily work to understand how processes can be more efficient, resources can be used more wisely, and physical risks can be reduced.

This chapter emphasizes that continuously planning, designing, measuring, analyzing, and improving clinical and managerial processes must be well organized and requires clear leadership to achieve maximum benefit. This approach takes into account that most clinical care processes involve more than one department or unit and may involve many individual jobs. This approach also takes into account that most clinical and managerial quality issues are interrelated. Thus, efforts to improve those processes must be guided by an overall framework for quality management and improvement activities in the organization, overseen by a quality improvement and patient safety oversight group or committee.

These international accreditation standards address the full spectrum of clinical and managerial activities of a health care organization, including the framework for improving those activities and reducing the risks associated with variation in processes.
Thus, the framework presented in these standards is suitable for a wide variety of structured programs and less-formal approaches to quality improvement and patient safety. This framework can also incorporate traditional measurement programs, such as those related to unanticipated events (risk management) and resource use (utilization management).

Over time, organizations that follow this framework will

- develop greater leadership support for an organizationwide program;
- train and involve more staff;
- set clearer priorities for what to measure;
- base decisions on measurement data; and
- make improvements based on comparison to other organizations, nationally and internationally.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

**QPS.1** Those responsible for governing and managing the organization participate in planning and measuring a quality improvement and patient safety program.

**QPS.1.1** The organization's leaders collaborate to carry out the quality improvement and patient safety program.

**QPS.1.2** The leaders prioritize which processes should be measured and which improvement and patient safety activities should be carried out.

**QPS.1.3** The leaders provide technological and other support to the quality improvement and patient safety program.

**QPS.1.4** Quality improvement and patient safety information is communicated to staff.

**QPS.1.5** Staff are trained to participate in the program.

**Design of Clinical and Managerial Processes**

**QPS.2** The organization designs new and modified systems and processes according to quality improvement principles.

**QPS.2.1** Clinical practice guidelines, clinical pathways, and/or clinical protocols are used to guide clinical care.

**Data Collection for Quality Measurement**

**QPS.3** The organization’s leaders identify key measures in the organization's structures, processes, and outcomes to be used in the organizationwide quality improvement and patient safety plan.

**QPS.3.1** The organization's leaders identify key measures for each of the organization's clinical structures, processes, and outcomes.

**QPS.3.2** The organization's leaders identify key measures for each of the organizations managerial structures, processes, and outcomes.
QPS.3.3 The organization's leaders identify key measures for each of the International Patient Safety Goals.

**Analysis of Measurement Data**

QPS.4 Individuals with appropriate experience, knowledge, and skills systematically aggregate and analyze data in the organization.

QPS.4.1 The frequency of data analysis is appropriate to the process being studied and meets organization requirements.

QPS.4.2 The analysis process includes comparisons internally, with other organizations when available, and with scientific standards and desirable practices.

QPS.5 The organization uses an internal process to validate data.

QPS.5.1 When the organization publishes data or posts data on a public Web site, the leaders of the organization ensure the reliability of the data.

QPS.6 The organization uses a defined process for identifying and managing sentinel events.

QPS.7 Data are analyzed when undesirable trends and variation are evident from the data.

QPS.8 The organization uses a defined process for the identification and analysis of near-miss events.

**Improvement**

QPS.9 Improvement in quality and safety is achieved and sustained.

QPS.10 Improvement and safety activities are undertaken for the priority areas identified by the organization's leaders.

QPS.11 An ongoing program of risk management is used to identify and to reduce unanticipated adverse events and other safety risks to patients and staff.
Standards, Intents, and Measurable Elements

Leadership and Planning

Standard QPS.1
Those responsible for governing and managing the organization participate in planning and measuring a quality improvement and patient safety program.

Intent of QPS.1
If an organization is to initiate and to maintain improvement and to reduce risks to patients and staff, leadership and planning are essential. This leadership and planning come from the governing body of the organization along with those who manage the clinical and managerial activities of the organization on a daily basis. Collectively they represent the leadership of the organization. The leadership is responsible for establishing the organization’s commitment, approach to improvement and safety, and program management and oversight. The leadership develops the quality and patient safety plan and, through its vision and support, shapes the quality culture of the organization.

The governing body holds ultimate accountability for quality and patient safety in the organization, and, thus, it approves the quality and patient safety plan (also see GLD.1.6); on a regular basis, it receives and acts on reports related to the organization’s program to improve quality and patient safety (also see GLD.1.6).

Measurable Elements of QPS.1
- 1. The organization’s leadership participates in developing the plan for the quality improvement and patient safety program.
- 2. The organization’s leadership participates in measuring the quality improvement and patient safety program.
- 3. The organization’s leadership establishes the oversight process or mechanism for the organization’s quality improvement and patient safety program.
- 4. The organization’s leadership reports on the quality and patient safety program to governance.

Standard QPS.1.1
The organization’s leaders collaborate to carry out the quality improvement and patient safety program.

Intent of QPS.1.1
The organization’s leaders have key roles in ensuring that the quality and patient safety plan shapes the organization’s culture and makes an impact on every aspect of operations. This plan takes collaboration and commitment through a multidisciplinary approach. Leaders ensure the program addresses
- the role of system design and redesign in the improvement process;
- a multidisciplinary approach with all departments and services in the organization included in the program;
- coordination among the multiple organizational units concerned with quality and safety, such as the clinical laboratory quality control program, a risk management program, a facility risk management program, a patient safety office, or other types of offices or programs. An inclusive program is necessary to improving patient outcomes, because patients receive care from many different departments and services and/or types of clinical staff; and

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• a systematic approach in that it employs similar or uniform quality processes and knowledge to carry out all improvement and patient safety activities.

**Measurable Elements of QPS.1.1**

1. The organization’s leaders collaborate to carry out the quality improvement and patient safety program. *(Also see GLD.3.4, ME 2; SQE.11, ME 1; SQE.14, ME 1; and SQE.17, ME 1)*
2. The quality improvement and patient safety program is organizationwide.
3. The program addresses the systems of the organization and the role of system design and redesign in quality and safety improvement.
4. The program addresses coordination among all components of the organization’s quality measurement and control activities. *(Also see GLD.3.4, ME 2, and PCI.10, ME 1)*
5. The program employs a systematic approach to quality improvement and patient safety.

**Standard QPS.1.2**

The leaders prioritize which processes should be measured and which improvement and patient safety activities should be carried out.

**Intent of QPS.1.2**

A primary responsibility of leaders is to set priorities. Organizations typically find more opportunities for quality measurement and improvement than they have human and other resources to accomplish. Therefore, the leaders provide focus for the organization’s quality measurement and improvement activities. The leaders prioritize those critical, high-risk, problem-prone, primary processes that most directly relate to quality of care and safety of the environment. The leaders include the International Patient Safety Goals *(also see pages 35–40)*. The leaders use available data and information to identify priority areas.

**Measurable Elements of QPS.1.2**

1. The leaders set organizational priorities for measurement activities.
2. The leaders set organizational priorities for improvement and patient safety activities.
3. The priorities include the implementation of the International Patient Safety Goals.

**Standard QPS.1.3**

The leaders provide technological and other support to the quality improvement and patient safety program.

**Intent of QPS.1.3**

Measuring clinical and management functions in a health care organization results in the accumulation of data and information. Understanding how well the organization is doing depends on the analysis of the data and information over time and comparison with other organizations. For large or complex organizations, this tracking and comparison may require technology and/or staff members with data management experience. An organization’s leaders understand the measurement and improvement priorities in terms of this necessary support. They provide the support consistent with the organization’s resources and quality improvement.

**Measurable Elements of QPS.1.3**

1. The leaders understand the technology and other support requirements for tracking and comparing measurement results.
2. The leaders provide technology and support, consistent with the organization’s resources, for tracking and comparing measurement results.
**Standard QPS.1.4**
Quality improvement and patient safety information is communicated to staff.

**Intent of QPS.1.4**
The regular communication of information about the quality improvement and patient safety program to staff is essential. The communication is on a regular basis through effective channels, such as newsletters, storyboards, staff meetings, and human resource processes. The information can be about new or recently completed improvement projects, progress in meeting the International Patient Safety Goals, the results of the analysis of sentinel and other adverse events, or recent research or benchmark programs, among others.

**Measurable Elements of QPS.1.4**
- 1. Information on the quality improvement and patient safety program is communicated to staff.
- 2. The communications are on a regular basis through effective channels. *(Also see GLD.1.6, ME 2)*
- 3. The communications include progress on compliance with the International Patient Safety Goals.

**Standard QPS.1.5**
Staff are trained to participate in the program.

**Intent of QPS.1.5**
Participating in data collection and analysis and planning and implementing quality improvements require knowledge and skill that most staff do not have or do not use regularly. Thus, when asked to participate in the program, staff members receive training consistent with their roles in the planned activity. Staff schedules may need to be adjusted to accommodate sufficient time to fully participate in training and improvement activities as part of regular work assignments. The organization identifies or provides a knowledgeable trainer for this education.

**Measurable Elements of QPS.1.5**
- 1. There is a training program for staff that is consistent with their roles in the quality improvement and patient safety program.
- 2. A knowledgeable individual provides the training.
- 3. Staff members participate in the training as part of their regular work assignments.

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### Design of Clinical and Managerial Processes

**Standard QPS.2**
The organization designs new and modified systems and processes according to quality improvement principles.

**Intent of QPS.2**
Organizations frequently have the opportunity to design new processes or need to modify existing processes. The new or modified process uses design elements from authoritative sources, including laws and regulations as applicable. Such authoritative sources include clinical practice guidelines *(also see standard QPS.2.1)* when available for clinical processes, national standards and norms, and other sources of information.
The design of new or modified processes may also be informed by the experiences of others considered to be best/better/good practices. Such practices are evaluated by the organization, and relevant practices may be used and tested.

When processes or services are designed well, they draw on a variety of information sources. Good process design:
- is consistent with the organization's mission and plans;
- meets the needs of patients, families, staff, and others;
- uses current practice guidelines, clinical standards, scientific literature, and other relevant evidence-based information on clinical practice design;
- is consistent with sound business practices;
- considers relevant risk management information;
- builds on available knowledge and skills in the organization;
- builds on the best/better/good practices of other organizations;
- uses information from related improvement activities; and
- integrates and connects processes and systems.

When an organization designs new processes, it selects suitable measures for the process. Once an organization implements a new process, it collects data to see if the process is actually operating as expected.

**Measurable Elements of QPS.2**
1. Quality improvement principles and tools are applied to the design of new or modified processes.
2. Design elements identified in the intent statement are included when relevant to the process being designed or modified.
3. Measures are selected to evaluate how well the newly designed or redesigned process operates.
4. Measurement data are used to evaluate the ongoing operation of the process.

**Standard QPS.2.1**
Clinical practice guidelines, clinical pathways, and/or clinical protocols are used to guide clinical care.

**Intent of QPS.2.1**
The goals of health care organizations include
- standardizing clinical care processes;
- reducing risks within care processes, particularly those associated with critical decision steps;
- providing clinical care in a timely, effective manner using available resources efficiently; and
- consistently delivering high-quality care using evidence-based practice.

Organizations use a variety of tools to reach these and other goals. For example, health care practitioners seek to develop clinical care processes and make clinical care decisions based on the best available scientific evidence. Clinical practice guidelines are useful tools in this effort to understand and to apply the best science to a particular diagnosis or condition.

In addition, health care practitioners seek to standardize care processes. Clinical care pathways and clinical protocols are useful tools in this effort to ensure effective integration and coordination of care and efficient use of available resources. Clinical practice guidelines, clinical care pathways, and clinical protocols relevant to the organization's patient population and mission are
- selected from among those applicable to the services and patients of the organization (mandatory national guidelines are included in this process, if present);
b) evaluated for their relevance to identified patient populations;
c) adapted when needed to the technology, drugs, and other resources of the organization or to accepted national professional norms;
d) assessed for their scientific evidence;
e) formally approved or adopted by the organization;
f) implemented and measured for consistent use and effectiveness;
g) supported by staff trained to apply the guidelines or pathways; and
h) periodically updated based on changes in the evidence and evaluation of processes and outcomes.

Organizations are expected to accomplish the following on an annual basis:

- Clinical leaders select at least five priority areas on which to focus, such as patient diagnosis, procedures, populations, or diseases, among others, for which guidelines, pathways, and protocols would impact the quality and safety of patient care and reduce unwanted variation in outcomes.
- Complete the process described in a) through h) for the identified priority focus areas.

**Measurable Elements of QPS.2.1**

- On an annual basis, clinical leaders determine at least five priority areas on which to focus the use of guidelines, clinical pathways, and/or clinical protocols.
- The organization follows the process described in a) through h) of the intent in implementing clinical practice guidelines, clinical pathways, and/or clinical protocols.
- The organization implements clinical guidelines and a clinical pathway or clinical protocol for each identified priority area.
- Clinical leaders can demonstrate how the use of clinical practice guidelines, clinical pathways, and/or clinical protocols has reduced variation in processes and outcomes.

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**Measure Selection and Data Collection**

**Standard QPS.3**

The organization's leaders identify key measures in the organization's structures, processes, and outcomes to be used in the organizationwide quality improvement and patient safety plan.

**Standard QPS.3.1**

The organization's leaders identify key measures for each of the organization's clinical structures, processes, and outcomes.

**Standard QPS.3.2**

The organization's leaders identify key measures for each of the organization's managerial structures, processes, and outcomes.

**Standard QPS.3.3**

The organization's leaders identify key measures for each of the International Patient Safety Goals.
### Intent of QPS.3 through QPS.3.3

Quality improvement and patient safety are data driven. Effective use of the data is best accomplished in the broader context of evidence-based clinical practices and evidence-based management practices.

Because most organizations have limited resources, they cannot collect data to measure everything they want. Thus, each organization must choose which clinical and managerial processes and outcomes are most important to measure based on its mission, patient needs, and services. Measurement often focuses on those processes that are high risk to patients, provided in high volume, or are problem prone. An organization’s leaders are responsible for making the final selection of key measures to be included in the organization’s quality activities.

The measures selected related to the important clinical areas include

1. patient assessments;
2. laboratory services;
3. radiology and diagnostic imaging services;
4. surgical procedures;
5. antibiotic and other medication use;
6. medication errors and near misses;
7. anesthesia and sedation use;
8. use of blood and blood products;
9. availability, content, and use of patient records;
10. infection prevention and control, surveillance, and reporting; and
11. clinical research.

At least five of the clinical measures must be selected from the Joint Commission International Library of Measures. These 11 clinical measures were formerly the same measures identified in the third edition of the hospital standards as QPS.3.1 through QPS.3.11.

The measures selected related to the important managerial areas include

a. the procurement of routinely required supplies and medication essential to meet patient needs;
b. reporting of activities as required by laws and regulations;
c. risk management;
d. utilization management;
e. patient and family expectations and satisfaction;
f. staff expectations and satisfaction;
g. patient demographics and clinical diagnoses;
h. financial management; and
i. prevention and control of events that jeopardize the safety of patients, families, and staff.

These nine managerial measures were formerly the same measures identified in the third edition of the hospital standards as QPS.3.12 through QPS.3.20. Managerial measures will be added to the Joint Commission International Library of Measures at a future date.

An organization’s leaders are responsible for making the final selection of targeted measurement activities. For each of these areas, leaders decide

- the process, procedure, or outcome to be measured;
- the availability of “science” or “evidence” supporting the measure;
- how measurement will be accomplished;
- how the measures fit into the organization’s overall plan for quality measurement and patient safety; and
- the frequency of measurement.
Identifying the process, procedure, or outcome to be measured is clearly the most important step. The measure needs to focus on, for example, risk points in processes, procedures that frequently present problems or are performed in high volume, and outcomes that can be clearly defined and are under the organization’s control. For example, an organization may choose to measure a particular surgical procedure (for example, repair of a cleft lip) or a class of surgical procedures (for example, orthopedic procedures). In addition, the organization may wish to measure the process used to select the surgical procedure for the cleft lip repair and may wish to measure the process of prosthesis alignment in hip replacement surgery. Frequency of data collection is associated with how often the particular process is used or procedure performed. Sufficient data from all cases or a sample of cases are needed to support conclusions and recommendations. New measures are selected when a current measure no longer provides data useful for analyzing the process, procedure, or outcome. Thus, an organization must have a track record of continuous measurement in the area identified; however, the actual measures may change.

To measure processes, the organization needs to determine how to organize the measurement activities, how often to collect data, and how to incorporate data collection into daily work processes. The measures are also helpful in better understanding or more intensively assessing the areas under study. Likewise, the analysis of the measurement data (also see QPS.4 through QPS.4.2) may result in strategies for improvement in the area being measured. The measure then is helpful in understanding the effectiveness of the improvement strategy.

For the five clinical measures selected by the organization from the Joint Commission International Library of Measures, data collection, analysis, and use will begin in 2011. Submission of data to JCI for these five measures is voluntary in 2011. Mandatory submission may begin in 2012 or later.

**Measurable Elements of QPS.3**

- 1. The organization’s leaders identify targeted areas for measurement and improvement.
- 2. The measurement is part of the quality improvement and patient safety program.
- 3. The results of measurement are communicated to the oversight mechanism and periodically to the organizational leaders and the governance structure of the organization.

**Measurable Elements of QPS.3.1**

- 1. The clinical leaders identify key measures for each clinical area identified in 1) through 11) in the intent statement.
- 2. At least 5 of the 11 required clinical measures are selected from the Joint Commission International Library of Measures.
- 3. The leaders look at the “science” or “evidence” supporting each of the selected measures.
- 4. Measurement includes structure, processes, and outcomes.
- 5. The scope, method, and frequency are identified for each measure.
- 6. Clinical measurement data are collected and used to evaluate the effectiveness of improvements.

**Measurable Elements of QPS.3.2**

- 1. The managerial leaders identify key measures for each managerial area identified in a) through i) in the intent statement.
- 2. The leaders look at the “science” or “evidence” supporting each of the selected measures.
- 4. The scope, method, and frequency are identified for each measure.
- 5. Managerial measurement data are collected and used to evaluate the effectiveness of improvements.
Measurable Elements of QPS.3.3
- 1. The clinical and managerial leaders identify key measures for each International Patient Safety Goal.
- 2. International Patient Safety Goal measurement includes the areas identified in IPSG.1 through IPSG.6.
- 3. Measurement data are used to evaluate the effectiveness of improvements.

Validation and Analysis of Measurement Data

Standard QPS.4
Individuals with appropriate experience, knowledge, and skills systematically aggregate and analyze data in the organization.

Intent of QPS.4
To reach conclusions and to make decisions, data must be aggregated, analyzed, and transformed into useful information. Data analysis involves individuals who understand information management, have skills in data aggregation methods, and know how to use various statistical tools. Results of data analysis need to be reported to those individuals responsible for the process or outcome being measured and who can take action on the results. These individuals may be clinical, managerial, or a combination. Thus, data analysis provides continuous feedback of quality management information to help those individuals make decisions and continuously improve clinical and managerial processes.

Understanding statistical techniques is helpful in data analysis, especially in interpreting variation and deciding where improvement needs to occur. Run charts, control charts, histograms, and Pareto charts are examples of statistical tools useful in understanding trends and variation in health care.

Measurable Elements of QPS.4
- 1. Data are aggregated, analyzed, and transformed into useful information.
- 2. Individuals with appropriate clinical or managerial experience, knowledge, and skills participate in the process.
- 3. Statistical tools and techniques are used in the analysis process when suitable.
- 4. Results of analysis are reported to those accountable for taking action. (Also see GLD.3.4, ME 2)

Standard QPS.4.1
The frequency of data analysis is appropriate to the process being studied and meets organization requirements.

Intent of QPS.4.1
The organization determines how often data are aggregated and analyzed. The frequency depends on the activity or area being measured, the frequency of measurement (also see QPS.3), and the organization’s priorities. For example, clinical laboratory quality control data may be analyzed weekly to meet local regulations, and patient fall data may be analyzed monthly if falls are infrequent. Thus, aggregation of data at points in time enables the organization to judge a particular process's stability or a particular outcome's predictability in relation to expectations.
Measurable Elements of QPS.4.1
- 1. The frequency of data analysis is appropriate to the process under study.
- 2. The frequency of data analysis meets organization requirements.

Standard QPS.4.2
The analysis process includes comparisons internally, with other organizations when available, and with scientific standards and desirable practices.

Intent of QPS.4.2
The goal of data analysis is to be able to compare an organization in four ways:
1. With itself over time, such as month to month, or one year to the next
2. With other similar organizations, such as through reference databases (also see MCI.20.2, ME 3)
3. With standards, such as those set by accrediting and professional bodies or those set by laws or regulations
4. With recognized desirable practices identified in the literature as best or better practices or practice guidelines

These comparisons help the organization understand the source and nature of undesirable change and help focus improvement efforts.

Measurable Elements of QPS.4.2
- 1. Comparisons are made over time within the organization.
- 2. Comparisons are made with similar organizations when possible.
- 3. Comparisons are made with standards when appropriate.
- 4. Comparisons are made with known desirable practices.

Standard QPS.5
The organization uses an internal process to validate data.

Intent of QPS.5
A quality improvement program is only as valid as the data that are collected. Reliable measurements are thus at the core of all improvements. To ensure that good, useful data have been collected, an internal data validation process needs to be in place. Data validation is most important when
- a new measure is implemented (in particular, those clinical measures that are intended to help an organization evaluate and improve an important clinical process or outcome);
- data will be made public on the organization's Web site or in other ways;
- a change has been made to an existing measure, such as the data collection tools have changed or the data abstraction process or abstractor has changed;
- the data resulting from an existing measure have changed in an unexplainable way;
- the data source has changed, such as when part of the patient record has been turned into an electronic format and thus the data source is now both electronic and paper; or
- the subject of the data collection has changed, such as changes in average age of patients, comorbidities, research protocol alterations, new practice guidelines implemented, or new technologies and treatment methodologies introduced.
Data validation is an important tool for understanding the quality of the quality data and for establishing the level of confidence decision makers can have in the data. Data validation becomes one of the steps in the process of setting priorities for measurement, selecting what is to be measured, selecting and testing the measure, collecting the data, validating the data, and using the data for improvement.

The essential elements of a credible data validation process include the following:

a) Re-collecting the data by a second person not involved in the original data collection
b) Using a statistically valid sample of records, cases, and other data. A 100% sample would only be needed when the number of records, cases, or other data is very small.
c) Comparing the original data with the re-collected data
d) Calculating the accuracy by dividing the number of data elements found to be the same by the total number of data elements and multiplying that total by 100. A 90% accuracy level is a good benchmark.
e) When data elements are found not to be the same, noting the reasons (for example, unclear data definitions) and taking corrective actions
f) Collecting a new sample after all corrective actions have been implemented to ensure the actions resulted in the desired accuracy level (Also see SQE.11, ME 4)

Measurable Elements of QPS.5

1. The organization integrates data validation into its quality management and improvement processes.
2. The organization has an internal data validation process that includes a) through f) in the intent statement.
3. The data validation process includes at least the measures selected as required in QPS.3.1.

Standard QPS.5.1

When the organization publishes data or posts data on a public Web site, the leaders of the organization ensure the reliability of the data.

Intent of QPS.5.1

When an organization publishes data on clinical outcomes, patient safety, or other areas, or in other ways makes the data public, such as on the organization's Web site, the organization has an ethical obligation to provide the public with the most accurate and reliable information. The leaders of an organization are accountable for ensuring that the data are accurate and reliable. This reliability can be established through the organization's internal process for data validity evaluation or, alternatively, can be judged by an independent third party.

Measurable Elements of QPS.5.1

1. The leaders of the organization assume accountability for the reliability of the quality and outcome data made public.
2. Data made public have been evaluated as to their reliability and validity.

Standard QPS.6

The organization uses a defined process for identifying and managing sentinel events.

Intent of QPS.6

Each organization establishes an operational definition of a sentinel event that includes at least

a) unanticipated death unrelated to the natural course of the patient’s illness or underlying condition (for example, suicide);
b) major permanent loss of function unrelated to the patient’s natural course illness or underlying condition;
c) wrong-site, wrong-procedure, wrong-patient surgery; and
d) infant abduction or infant who was sent home with the wrong parents.

The organization’s definition of a sentinel event includes a) through d) above and may include other events as may be required by laws or regulations or viewed by the organization as appropriate to add to its list of sentinel events. All events that meet the definition are assessed by performing a credible root cause analysis. When the root cause analysis reveals that systems improvements or other actions can prevent or reduce the risk of such sentinel events recurring, the organization redesigns the processes and takes whatever other actions are appropriate to do so.

It is important to note that the term “sentinel event” (also see “JCI Sentinel Event Policy” on page 27) does not always refer to an error or mistake or suggest any particular legal liability. (Also see SQE.11, ME 4)

Measurable Elements of QPS.6

1. The hospital leaders have established a definition of a sentinel event that at least includes a) through d) found in the intent statement.
2. The organization conducts a root cause analysis on all sentinel events in a time period specified by the hospital’s leaders.
3. Events are analyzed when they occur.
4. Hospital leaders take action on the results of the root cause analysis.

Standard QPS.7

Data are analyzed when undesirable trends and variation are evident from the data.

Intent of QPS.7

When the organization detects or suspects undesirable change from what is expected, it initiates intense analysis to determine where best to focus improvement (also see MMU.7.1, intent statement). In particular, intense analysis is initiated when levels, patterns, or trends vary significantly and undesirably from

- what was expected;
- that of other organizations; or
- recognized standards.

An analysis is conducted for the following:

a) All confirmed transfusion reactions, if applicable to the organization
b) All serious adverse drug events, if applicable and as defined by the organization
c) All significant medication errors, if applicable and as defined by the organization
d) All major discrepancies between preoperative and postoperative diagnoses
e) Adverse events or patterns of adverse events during moderate or deep sedation and anesthesia use
f) Other events, such as infectious disease outbreaks
Measurable Elements of QPS.7
- 1. Intense analysis of data takes place when adverse levels, patterns, or trends occur.
- 2. All confirmed transfusion reactions, if applicable to the organization, are analyzed.
- 3. All serious adverse drug events, if applicable and as defined by the organization, are analyzed. (Also see MMU.7, ME 3)
- 4. All significant medication errors, if applicable and as defined by the organization, are analyzed. (Also see MMU.7.1, ME 1)
- 5. All major discrepancies between preoperative and postoperative diagnoses are analyzed.
- 6. Adverse events or patterns of adverse events during moderate or deep sedation and anesthesia use are analyzed.
- 7. Other events defined by the organization are analyzed.

Standard QPS.8
The organization uses a defined process for the identification and analysis of near-miss events.

Intent of QPS.8
In an attempt to proactively learn where systems may be vulnerable to actual adverse event occurrence, the organization collects data and information on those events identified as a “near miss” and evaluates those events in an effort to prevent their actual occurrence. First, the organization establishes a definition of a near miss and what type of events are to be reported. Second, a reporting mechanism is put into place, and finally there is a process to aggregate and to analyze the data to learn where proactive process changes will reduce or eliminate the related event or near miss.

Measurable Elements of QPS.8
- 1. The organization establishes a definition of a near miss.
- 2. The organization defines the type of events to be reported. (Also see MMU.7.1 for medication near misses)
- 3. The organization establishes the process for the reporting of near misses. (Also see MMU.7.1 for medication near misses)
- 4. The data are analyzed and actions taken to reduce near-miss events. (Also see MMU.7.1, ME 3)

Gaining and Sustaining Improvement

Standard QPS.9
Improvement in quality and safety is achieved and sustained.

Intent of QPS.9
The organization uses the information from data analysis to identify potential improvements or to reduce (or prevent) adverse events. Routine measurement data, as well as data from intensive assessments, contribute to this understanding of where improvement should be planned and what priority should be given to the improvement. In particular, improvements are planned for the priority data collection areas identified by leaders.
Measurable Elements of QPS.9

1. The organization plans and implements improvements in quality and safety.
2. The organization uses a consistent process for identifying priority improvements that are selected by the leaders.
3. The organization documents the improvements achieved and sustained.

Standard QPS.10

Improvement and safety activities are undertaken for the priority areas identified by the organization’s leaders.

Intent of QPS.10

The organization uses appropriate resources and involves those individuals, disciplines, and departments closest to the processes or activities to be improved. Responsibility for planning and carrying an improvement is assigned to individuals or a team, any needed training is provided, and information management or other resources are made available.

Once planned, data are collected during a test period to demonstrate that the planned change was actually an improvement. To ensure that the improvement is sustained, measurement data are then collected for ongoing analysis. Effective changes are incorporated into standard operating procedure, and any necessary staff education is carried out. The organization documents those improvements achieved and sustained as part of its quality management and improvement program.

Measurable Elements of QPS.10

1. The priority areas identified by the organization’s leaders are included in improvement activities. (Also see QPS.3, ME 1)
2. Human and other resources needed to carry out an improvement are assigned or allocated.
3. Changes are planned and tested.
4. Changes that resulted in improvements are implemented.
5. Data are available to demonstrate that improvements are effective and sustained.
6. Policy changes necessary to plan, to carry out, and to sustain the improvement are made.
7. Successful improvements are documented.

Standard QPS.11

An ongoing program of risk management is used to identify and to reduce unanticipated adverse events and other safety risks to patients and staff.

Intent of QPS.11

Organizations need to adopt a proactive approach to risk management. One such way is a formalized risk management program whose essential components include

a) risk identification;
b) risk prioritization;
c) risk reporting;
d) risk management;
e) investigation of adverse events; and
f) management of related claims.
An important element of risk management is risk analysis, such as a process to evaluate near misses and other high-risk processes for which a failure would result in a sentinel event. One tool that provides such a proactive analysis of the consequences of an event that could occur in a critical, high-risk process is failure mode and effects analysis. The organization can also identify and use similar tools to identify and to reduce risks, such as a hazard vulnerability analysis.

To use this or similar tools effectively, the organization's leaders need to adopt and to learn the approach, to agree on a list of high-risk processes in terms of patient and staff safety, and then to use the tool on a priority risk process. Following analysis of the results, the organization's leaders take action to redesign the process or similar actions to reduce the risk in the process. This risk-reduction process is carried out at least once per year and documented.

### Measurable Elements of QPS

1. The organization's leaders adopt a risk management framework to include a) through f) in the intent.
2. The organization conducts and documents use of a proactive risk-reduction tool at least annually on one of the priority risk processes.
3. The organization's leaders take action to redesign high-risk processes based on the analysis.
Overview

The goal of an organization's infection prevention and control program is to identify and to reduce the risks of acquiring and transmitting infections among patients, staff, health care professionals, contract workers, volunteers, students, and visitors.

The infection risks and program activities may differ from organization to organization, depending on the organization's clinical activities and services, patient population(s) served, geographic location, patient volume, and number of employees.

Effective programs have in common identified leaders, well-trained staff, methods to identify and to proactively address infection risks, appropriate policies and procedures, staff education, and coordination throughout the organization.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

Program Leadership and Coordination

PCI.1 One or more individuals oversee all infection prevention and control activities. This individual(s) is qualified in infection prevention and control practices through education, training, experience, or certification.

PCI.2 There is a designated coordination mechanism for all infection prevention and control activities that involves physicians, nurses, and others as based on the size and complexity of the organization.

PCI.3 The infection prevention and control program is based on current scientific knowledge, accepted practice guidelines, applicable laws and regulations, and standards for sanitation and cleanliness.

PCI.4 The organization's leaders provide adequate resources to support the infection prevention and control program.
Focus of the Program

PCI.5  The organization designs and implements a comprehensive program to reduce the risks of health care–associated infections in patients and health care workers.

PCI.5.1  All patient, staff, and visitor areas of the organization are included in the infection prevention and control program.

PCI.6  The organization uses a risk-based approach in establishing the focus of the health care–associated infection prevention and reduction program.

PCI.7  The organization identifies the procedures and processes associated with the risk of infection and implements strategies to reduce infection risk.

PCI.7.1  The organization reduces the risk of infections by ensuring adequate equipment cleaning and sterilization and the proper management of laundry and linen.

PCI.7.1.1  There is a policy and procedure in place that identifies the process for managing expired supplies and defines the conditions for reuse of single-use devices when laws and regulations permit.

PCI.7.2  The organization reduces the risk of infections through proper disposal of waste.

PCI.7.3  The organization has a policy and procedure on the disposal of sharps and needles.

PCI.7.4  The organization reduces the risk of infections in the facility associated with operations of the food service and of mechanical and engineering controls.

PCI.7.5  The organization reduces the risk of infection in the facility during demolition, construction, and renovation.

Isolation Procedures

PCI.8  The organization provides barrier precautions and isolation procedures that protect patients, visitors, and staff from communicable diseases and protects immunosuppressed patients from acquiring infections to which they are uniquely prone.

Barrier Techniques and Hand Hygiene

PCI.9  Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly when required.

Integration of the Program with Quality Improvement and Patient Safety

PCI.10  The infection prevention and control process is integrated with the organization’s overall program for quality improvement and patient safety.

PCI.10.1  The organization tracks infection risks, infection rates, and trends in health care–associated infections.

PCI.10.2  Quality improvement includes using measures related to infection issues that are epidemiologically important to the organization.
PCI.10.3 The organization uses risk, rate, and trend information to design or to modify processes to reduce the risk of health care–associated infections to the lowest possible levels.

PCI.10.4 The organization compares its health care–associated infection rates with other organizations through comparative databases.

PCI.10.5 The results of infection prevention and control measurement in the organization are regularly communicated to leaders and staff.

PCI.10.6 The organization reports information on infections to appropriate external public health agencies.

Education of Staff about the Program

PCI.11 The organization provides education on infection prevention and control practices to staff, physicians, patients, families, and other caregivers when indicated by their involvement in care.
Standards, Intents, and Measurable Elements

Program Leadership and Coordination

Standard PCI.1
One or more individuals oversee all infection prevention and control activities. This individual(s) is qualified in infection prevention and control practices through education, training, experience, or certification.

Intent of PCI.1
The infection prevention and control program has oversight appropriate to the organization's size, level of risks, complexity of activities, and the program's scope. One or more individuals, acting on a full-time or part-time basis, provide that oversight as part of their assigned responsibilities or job descriptions. Their qualification depends on the activities they will carry out and may be met through
- education;
- training;
- experience; and
- certification or licensure.

Measurable Elements of PCI.1
- 1. One or more individuals oversee the infection prevention and control program.
- 2. The individual(s) is qualified for the organization's size, level of risks, and program scope and complexity.
- 3. The individual(s) fulfills program oversight responsibilities as assigned or described in a job description.

Standard PCI.2
There is a designated coordination mechanism for all infection prevention and control activities that involves physicians, nurses, and others based on the size and complexity of the organization.

Intent of PCI.2
Infection prevention and control activities reach into every part of a health care organization and involve individuals in multiple departments and services (for example, clinical departments, facility maintenance, food services (catering), housekeeping, laboratory, pharmacy, and sterilization services). There is a designated mechanism to coordinate the overall program. That mechanism may be a small work group, a coordinating committee, task force, or other mechanism. Responsibilities include, for example, setting criteria to define health care–associated infections, establishing data collection (surveillance) methods, designing strategies to address infection prevention and control risks, and reporting processes. Coordination involves communicating with all parts of the organization to ensure that the program is continuous and proactive.

Whatever the mechanism chosen by the organization to coordinate the infection prevention and control program, physicians and nurses are represented and engaged in the activities with the infection prevention and control professionals. Others may be included as determined by the organization's size and complexity of services (for example, epidemiologist, data collection expert, statistician, central sterilization manager, microbiologist, pharmacist, housekeeping services, environmental or facilities services, operating theatre supervisor).
Measurable Elements of PCI.2
- 1. There is a designated mechanism for the coordination of the infection prevention and control program.
- 2. Coordination of infection prevention and control activities involves physicians.
- 3. Coordination of infection prevention and control activities involves nurses.
- 4. Coordination of infection prevention and control activities involves infection prevention and control professionals.
- 5. Coordination of infection prevention and control activities involves housekeeping.
- 6. Coordination of infection prevention and control activities involves others based on the size and complexity of the organization.

Standard PCI.3
The infection prevention and control program is based on current scientific knowledge, accepted practice guidelines, applicable laws and regulations, and standards for sanitation and cleanliness.

Intent of PCI.3
Information is essential to an infection prevention and control program. Current scientific information is required to understand and to implement effective surveillance and control activities and can come from many national or international sources; for example, the World Health Organization (WHO) publishes hand-hygiene and other guidelines. Practice guidelines provide information on preventive practices and infections associated with clinical and support services. Applicable laws and regulations define elements of the basic program, the response to infectious disease outbreaks, and any reporting requirements.

Measurable Elements of PCI.3
- 1. The infection prevention and control program is based on current scientific knowledge.
- 2. The infection prevention and control program is based on accepted practice guidelines.
- 3. The infection prevention and control program is based on applicable laws and regulations.
- 4. The infection prevention and control program is based on standards from national or local agencies for sanitation and cleanliness.

Standard PCI.4
The organization’s leaders provide adequate resources to support the infection prevention and control program.

Intent of PCI.4
The infection prevention and control program requires adequate staff to meet the program goals and the needs of the organization, as determined by the oversight body/mechanism and approved by the organization’s leadership.

In addition, the infection prevention and control program requires resources to provide education to all staff and supplies, such as alcohol hand rubs for hand hygiene. The leaders of the organization ensure that the program has adequate resources to effectively carry out the program.

Information management systems are important resources to support the tracking of risks, rates, and trends in health care–associated infections. Information management functions support data analysis, interpretation, and presentation of findings. In addition, infection prevention and control program data and information are managed with those of the organization’s quality management and improvement program.
Measurable Elements of PCI.4
- 1. The infection prevention and control program is adequately staffed as approved by the leadership.
- 2. The organization’s leaders allocate adequate resources for the infection prevention and control program.
- 3. Information management systems support the infection prevention and control program.

Focus of the Program

Standard PCI.5
The organization designs and implements a comprehensive program to reduce the risks of health care–associated infections in patients and health care workers.

Intent of PCI.5
For an infection prevention and control program to be effective, it must be comprehensive, encompassing both patient care and employee health. The program is guided by a plan that identifies and addresses the infection issues that are epidemiologically important to the organization. In addition, the program and plan are appropriate to the organization’s size and geographic location, services, and patients. The program includes systems to identify infections and to investigate outbreaks of infectious diseases. Policies and procedures guide the program. The periodic assessment of risk and setting of risk-reduction goals guide the program.

Measurable Elements of PCI.5
- 1. There is a comprehensive program and plan to reduce the risk of health care–associated infections in patients.
- 2. There is a comprehensive program and plan to reduce the risk of health care–associated infections in health care workers. (Also see SQE.8.4)
- 3. The program includes systematic and proactive surveillance activities to determine usual (endemic) rates of infection.
- 4. The program includes systems to investigate outbreaks of infectious diseases. (Also see IPSG.5, ME 1)
- 5. The program is guided by appropriate policies and procedures.
- 6. Risk-reduction goals and measurable objectives are established and regularly reviewed.
- 7. The program is appropriate to the organization’s size and geographic location, services, and patients.

Standard PCI.5.1
All patient, staff, and visitor areas of the organization are included in the infection prevention and control program.

Intent of PCI.5.1
Infections can enter the organization via patients, families, staff, volunteers, visitors, and other individuals, such as trade representatives. Thus, all areas of the organization where these individuals are found must be included in the program of infection surveillance, prevention, and control.
Measurable Elements of PCI.5.1

- 1. All patient care areas of the organization are included in the infection prevention and control program.
- 2. All staff areas of the organization are included in the infection prevention and control program.
- 3. All visitor areas of the organization are included in the infection prevention and control program.

Standard PCI.6

The organization uses a risk-based approach in establishing the focus of the health care–associated infection prevention and reduction program.

Intent of PCI.6

Each organization must identify those epidemiologically important infections, infection sites, and associated devices, procedures, and practices that will provide the focus of efforts to prevent and to reduce the risk and incidence of health care–associated infections. A risk-based approach helps organizations identify those practices and infections on which they should focus their programs. A risk-based approach uses surveillance as an important component for gathering and analyzing the data that guide the risk assessment.

Organizations collect and evaluate data on the following relevant infections and sites:

- a) Respiratory tract—such as the procedures and equipment associated with intubation, mechanical ventilatory support, tracheostomy, and so on
- b) Urinary tract—such as the invasive procedures and equipment associated with indwelling urinary catheters, urinary drainage systems, their care, and so on
- c) Intravascular invasive devices—such as the insertion and care of central venous catheters, peripheral venous lines, and so on
- d) Surgical sites—such as their care and type of dressing and associated aseptic procedures
- e) Epidemiologically significant diseases and organisms—multidrug resistant organisms, highly virulent infections
- f) Emerging or reemerging infections with the community

Measurable Elements of PCI.6

- 1. The organization has established the focus of the program through the collection of data related to a) through f) in the intent statement.
- 2. The data collected in a) through f) are evaluated/analyzed.
- 3. Based on data evaluation/analysis, actions are taken to focus or to refocus the organization's infection prevention and control program.
- 4. The organization assesses these risks at least annually, and the assessment is documented.

Standard PCI.7

The organization identifies the procedures and processes associated with the risk of infection and implements strategies to reduce infection risk.

Intent of PCI.7

Health care organizations assess and care for patients using many simple and complex processes, each associated with a level of infection risk to patients and staff. It is thus important for an organization to measure and to review those processes and, as appropriate, implement needed policies, procedures, education, and other activities to reduce the risk of infection.
Measurable Elements of PCI.7

1. The organization has identified those processes associated with infection risk. *(Also see MMU.5, ME 1)*

2. The organization has implemented strategies to reduce infection risk in those processes. *(Also see MMU.5, ME 1)*

3. The organization identifies which risks *(also see PCI.7.1 through PCI.7.5)* require policies and or procedures, staff education, practice changes, and other activities to support risk reduction.

Standard PCI.7.1

The organization reduces the risk of infections by ensuring adequate equipment cleaning and sterilization and the proper management of laundry and linen.

Intent of PCI.7.1

Infection risk is minimized with proper cleaning, disinfection, and sterilization processes, such as the cleaning and disinfection of endoscopes and the sterilization of surgical supplies and other invasive or noninvasive patient care equipment. Cleaning, disinfection, and sterilization can take place in a centralized sterilization area or, with proper oversight, in other areas of the organization, such as an endoscope clinic. Cleaning, disinfection, and sterilization methods maintain the same standards wherever they are performed in the organization. Also, the proper management of laundry and linen can result in reduced contamination of clean linen and infection risk to staff from soiled laundry and linen.

Measurable Elements of PCI.7.1

1. Equipment cleaning and sterilization methods in a central sterilization service are appropriate for the type of equipment.

2. Equipment cleaning, disinfection, and sterilization methods conducted outside a central sterilization service are appropriate for the type of equipment.

3. Laundry and linen management are appropriate to minimize risk to staff and patients.

4. There is a coordinated oversight process that ensures all cleaning, disinfection, and sterilization methods are the same throughout the organization.

Standard PCI.7.1.1

There is a policy and procedure in place that identifies the process for managing expired supplies and defines the conditions for reuse of single-use devices when laws and regulations permit.

Intent of PCI.7.1.1

Most medical materials (IV fluids, catheters, sutures, and the like) are imprinted with an expiration date. When the expiration date on these materials has passed, the manufacturer does not guarantee the sterility, safety, or stability of the item. Some materials contain a statement indicating that the contents are sterile as long as the packaging is intact. A policy identifies the process for ensuring proper handling of expired supplies.

In addition, certain single-use devices may be reused under specific circumstances. There are two risks associated with the reuse of single-use devices: There is an increased risk of infection, and there is the risk that the performance of the device may be inadequate or unacceptable after it is reprocessed. When single-use devices are reused, there is a hospital policy that guides such reuse. The policy is consistent with national laws and regulations and professional standards and includes identification of:

a) devices and materials that can never be reused;
b) the maximum number of reuses specific for each device and material that is reused;
c) the types of wear and cracking, among others, that indicate the device cannot be reused;
d) the cleaning process for each device that starts immediately after use and follows a clear protocol; and
e) the process for the collection, analysis, and use of infection prevention and control data related to reused devices and materials.

**Measurable Elements of PCI.7.1.1**

- 1. There is a policy and procedure consistent with national laws and regulations and professional standards in place that identifies the process for managing expired supplies.
- 2. When single-use devices and materials are reused, the policy includes items a) through e) in the intent statement.
- 3. The policy is implemented.
- 4. The policy is monitored.

**Standard PCI.7.2**

The organization reduces the risk of infections through proper disposal of waste.

**Intent of PCI.7.2**

Health care organizations produce considerable waste each day. Frequently that waste is or could be infectious. Thus, the proper disposal of waste contributes to the reduction of infection risk in the organization. This is true for the disposal of body fluids and materials contaminated with body fluids, the disposal of blood and blood components, and waste from the mortuary and postmortem areas, when present.

**Measurable Elements of PCI.7.2**

- 1. Disposal of infectious waste and body fluids are managed to minimize transmission risk. *(Also see AOP.5.1, intent statement)*
- 2. The handling and disposal of blood and blood components are managed to minimize transmission risk. *(Also see AOP.5.1, intent statement)*
- 3. Operation of the mortuary and postmortem area are managed to minimize transmission risk.

**Standard PCI.7.3**

The organization has a policy and procedure on the disposal of sharps and needles.

**Intent of PCI.7.3**

The improper disposal of sharps and needles presents a major staff safety challenge. The organization ensures that a policy is implemented that adequately addresses all steps in the process, from the type and use of containers, the disposal of the containers, and the surveillance of the process of disposal.

**Measurable Elements of PCI.7.3**

- 1. Sharps and needles are collected in dedicated, puncture-proof containers that are not reused.
- 2. The hospital disposes of sharps and needles safely or contracts with sources that ensure the sharps containers are disposed of in dedicated hazardous waste sites or as determined by national laws and regulations.
- 3. The disposal of sharps and needles is consistent with infection prevention and control policies of the organization.
Standard PCI.7.4
The organization reduces the risk of infections in the facility associated with operations of the food service and of mechanical and engineering controls.

Intent of PCI.7.4
Engineering controls, such as positive ventilation systems, biological hoods in laboratories, and thermostats on refrigeration units and on water heaters used to sterilize dishes and kitchen equipment, are examples of the important role environmental standards and controls contribute to good sanitation and the reduction of infection risks in the organization.

Measurable Elements of PCI.7.4
1. Kitchen sanitation and food preparation and handling are appropriate to minimize infection risk.
2. Engineering controls are implemented to minimize infection risk in appropriate areas of the organization.

Standard PCI.7.5
The organization reduces the risk of infection in the facility during demolition, construction, and renovation.

Intent of PCI.7.5
When planning demolition, construction, or renovation, the organization uses risk criteria that address the impact of the renovation or new construction on air-quality requirements, infection prevention and control, utility requirements, noise, vibration, and emergency procedures.

Measurable Elements of PCI.7.5
1. The organization uses risk criteria to assess the impact of renovation or new construction.
2. The risks and impact of the renovation or construction on air quality and infection prevention and control activities is assessed and managed.

Isolation Procedures

Standard PCI.8
The organization provides barrier precautions and isolation procedures that protect patients, visitors, and staff from communicable diseases and protects immunosuppressed patients from acquiring infections to which they are uniquely prone.

Intent of PCI.8
The organization develops policies and procedures that establish the isolation and barrier procedures for the hospital. These are based on the method of disease transmission and address individual patients who may be infectious or immunosuppressed, as well as the influx of large numbers of patients with contagious infections.

Airborne precautions are necessary to prevent the transmission of infectious agents that can remain suspended in the air for long periods of time. The preferred placement for a patient with an airborne infection is in a negative pressure room. When the structure of the building prevents the immediate construction of a negative pressure room, the organization may recirculate the air through a high-efficiency particulate air (HEPA) filtration system at the rate of at least 12 air exchanges per hour.
Policies and procedures should address a plan to manage patients with airborne infections for short periods of time when negative pressure rooms or HEPA filtration systems are not available. The isolation procedures also address staff and visitor protection, the patient environment, and the cleaning of the room during the stay and after the patient is discharged.

**Measurable Elements of PCI.8**

- 1. Patients with known or suspected contagious diseases are isolated in accordance with organization policy and recommended guidelines.
- 2. Policies and procedures address the separation of patients with communicable diseases from patients and staff who are at greater risk due to immunosuppression or other reasons.
- 3. Policies and procedures address how to manage patients with airborne infections for short periods of time when negative pressure rooms are not available.
- 4. The organization has a strategy of dealing with an influx of patients with contagious diseases.
- 5. Negative pressure rooms are available and monitored routinely for infectious patients who require isolation for airborne infections; when negative pressure rooms are not immediately available, rooms with approved HEPA filtration systems may be used.
- 6. Staff are educated in the management of infectious patients.

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**Barrier Techniques and Hand Hygiene**

**Standard PCI.9**

Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly when required.

**Intent of PCI.9**

Hand hygiene, barrier techniques, and disinfecting agents are fundamental tools for proper infection prevention and control. The organization identifies those situations in which masks, eye protection, gowns, or gloves are required and provides training in their correct use. Soap, disinfectants, and towels or other means of drying are located in those areas where handwashing and disinfecting procedures are required. Hand-hygiene guidelines (use of guidelines is scored at IPSG.5, ME 2) are adopted by the organization and posted in appropriate areas, and staff are educated in proper handwashing, hand disinfection, or surface disinfection procedures.

**Measurable Elements of PCI.9**

- 1. The organization identifies those situations for which gloves and/or masks or eye protection are required.
- 2. Gloves and/or masks or eye protection are correctly used in those situations.
- 3. The organization identifies those situations for which hand washing and hand disinfection or surface disinfecting procedures are required.
- 4. Handwashing and hand disinfection procedures are used correctly in those areas.
- 5. The organization has adopted hand-hygiene guidelines from an authoritative source.
Integration of the Program with Quality Improvement and Patient Safety

Standard PCI.10
The infection prevention and control process is integrated with the organization’s overall program for quality improvement and patient safety.

Standard PCI.10.1
The organization tracks infection risks, infection rates, and trends in health care–associated infections.

Standard PCI.10.2
Quality improvement includes using measures related to infection issues that are epidemiologically important to the organization.

Standard PCI.10.3
The organization uses risk, rate, and trend information to design or to modify processes to reduce the risk of health care–associated infections to the lowest possible levels.

Standard PCI.10.4
The organization compares its health care–associated infection rates with other organizations through comparative databases.

Standard PCI.10.5
The results of infection prevention and control measurement in the organization are regularly communicated to leaders and staff.

Standard PCI.10.6
The organization reports information on infections to appropriate external public health agencies.

Intent of PCI.10 through PCI.10.6
The infection prevention and control process is designed to lower the risk of infection for patients, staff, and others. To reach this goal, the organization must proactively identify and track risks, rates, and trends in health care–associated infections. The organization uses measurement information to improve infection prevention and control activities and to reduce health care–associated infection rates to the lowest possible levels. An organization can best use measurement data and information by understanding similar rates and trends in other similar organizations and contributing data to infection-related databases.

Measurable Elements of PCI.10
1. Infection prevention and control activities are integrated into the organization’s quality improvement and patient safety program. (Also see QPS.1.1, ME )

2. The leadership of the infection prevention and control program is included in the organization’s quality and patient safety program’s oversight mechanism.
Measurable Elements of PCI.10.1
- 1. Health care–associated infection risks are tracked.
- 2. Health care–associated infection rates are tracked.
- 3. Health care–associated infection trends are tracked.

Measurable Elements of PCI.10.2
- 1. Infection prevention and control activities are measured.
- 2. The measures identify epidemiologically important infections.

Measurable Elements of PCI.10.3
- 1. Processes are redesigned based on risk, rate, and trend data and information.
- 2. Processes are redesigned to reduce infection risk to the lowest levels possible.

Measurable Elements of PCI.10.4
- 1. Health care–associated infection rates are compared to other organizations’ rates through comparative databases. (Also see QPS.4.2, ME 2, and MCI.20.2, ME 3)
- 2. The organization compares its rates to best practices and scientific evidence.

Measurable Elements of PCI.10.5
- 1. Measurement results are communicated to medical staff.
- 2. Measurement results are communicated to nursing staff.
- 3. Measurement results are communicated to management.

Measurable Elements of PCI.10.6
- 1. Infection prevention and control program results are reported to public health agencies as required. (Also see MCI.20.1, ME 2)
- 2. The organization takes appropriate action on reports from relevant public health agencies.

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**Education of Staff about the Program**

**Standard PCI.11**
The organization provides education on infection prevention and control practices to staff, physicians, patients, families, and other caregivers when indicated by their involvement in care.

**Intent of PCI.11**
For an organization to have an effective infection prevention and control program, it must educate staff members about the program when they begin work in the organization and regularly thereafter. The education program includes professional staff, clinical and nonclinical support staff, and even patients and families, including trade people and other visitors. Patients and families are encouraged to participate in the implementation and use of infection prevention and control practices in the organization.

The education is provided as part of the orientation of all new staff and is refreshed periodically, or at least when there is a change in the policies, procedures, and practices that guide the organization’s infection prevention and control program. The education also includes the findings and trends from the measurement activities. (Also see SQE.7)
Measurable Elements of PCI.11

1. The organization develops an infection prevention and control program that includes all staff and other professionals and patients and families.

2. The organization provides education about infection prevention and control to all staff and other professionals.

3. The organization provides education about infection prevention and control to patients and families.

4. All staff are educated on the policies, procedures, and practices of the infection prevention and control program. (Also see SQE.7 and GLD.5.4)

5. Periodic staff education is provided in response to significant trends in infection data.
Overview

Providing excellent patient care requires effective leadership. That leadership comes from many sources in a health care organization, including governing leaders (governance), leaders, and others who hold positions of leadership, responsibility, and trust. Each organization must identify these individuals and involve them in ensuring that the organization is an effective, efficient resource for the community and its patients.

In particular, these leaders must identify the organization’s mission and make sure that the resources needed to fulfill this mission are available. For many organizations, this does not mean adding new resources but more efficiently using current resources, even when they are scarce. Also, leaders must work together well to coordinate and to integrate all the organization’s activities, including those designed to improve patient care and clinical services.

Effective leadership begins with understanding the various responsibilities and authority of individuals in the organization and how these individuals work together. Those who govern, manage, and lead an organization have both authority and responsibility. Collectively and individually, they are responsible for complying with laws and regulations and for meeting the organization’s responsibility to the patient population served.

Over time, effective leadership helps overcome perceived barriers and communication problems between departments and services in the organization, and the organization becomes more efficient and effective. Services become increasingly integrated. In particular, the integration of all quality management and improvement activities throughout the organization results in improved patient outcomes.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

Governance of the Organization

GLD.1  Governance responsibilities and accountabilities are described in bylaws, policies and procedures, or similar documents that guide how they are to be carried out.

GLD.1.1  Those responsible for governance approve and make public the organization’s mission statement.
GLD.1.2 Those responsible for governance approve the policies and plans to operate the organization.

GLD.1.3 Those responsible for governance approve the budget and allocate the resources required to meet the organization’s mission.

GLD.1.4 Those responsible for governance appoint the organization’s senior manager(s) or director(s).

GLD.1.5 Those responsible for governance approve the organization’s plan for quality and patient safety and regularly receive and act on reports of the quality and patient safety program.

Leadership of the Organization

GLD.2 A senior manager or director is responsible for operating the organization and complying with applicable laws and regulations.

GLD.3 The organization’s leaders are identified and are collectively responsible for defining the organization’s mission and creating the plans and policies needed to fulfill the mission.

GLD.3.1 Organization leaders plan with community leaders and leaders of other organizations to meet the community’s health care needs.

GLD.3.2 The leaders identify and plan for the type of clinical services required to meet the needs of the patients served by the organization.

GLD.3.2.1 Equipment, supplies, and medications recommended by professional organizations or by alternative authoritative sources are used.

GLD.3.3 The leaders provide oversight of contracts for clinical or management services.

GLD.3.3.1 Contracts and other arrangements are monitored as part of the organization’s quality improvement and patient safety program.

GLD.3.3.2 Independent practitioners not employed by the organization have the right credentials for the services provided to the organization’s patients.

GLD.3.4 The medical, nursing, and other leaders are educated in the concepts of quality improvement.

GLD.3.5 Organization leaders ensure that there are uniform programs for the recruitment, retention, development, and continuing education of all staff.

GLD.4 Medical, nursing, and other leaders of clinical services plan and implement an effective organizational structure to support their responsibilities and authority.

Direction of Departments and Services

GLD.5 One or more qualified individuals provide direction for each department or service in the organization.

GLD.5.1 The directors of each clinical department identify, in writing, the services to be provided by the department.

GLD.5.1.1 Services are coordinated and integrated within the department or service and with other departments and services.
GLD.5.2 Directors recommend space, equipment, staffing, and other resources needed by the department or service.

GLD.5.3 Directors recommend criteria for selecting the department or service’s professional staff and choose or recommend individuals who meet those criteria.

GLD.5.4 Directors provide orientation and training for all staff of the duties and responsibilities for the department or service to which they are assigned.

GLD.5.5 Directors monitor the department’s or service’s performance as well as staff performance.

Organizational Ethics

GLD.6 The organization establishes a framework for ethical management that ensures that patient care is provided within business, financial, ethical, and legal norms and that protects patients and their rights.

GLD.6.1 The organization’s framework for ethical management includes marketing, admissions, transfer, discharge, and disclosure of ownership and any business and professional conflicts that may not be in patients’ best interests.

GLD.6.2 The organization’s framework for ethical management supports ethical decision making in clinical care and nonclinical services.
Standards, Intents, and Measurable Elements

**Governance of the Organization**

**Standard GLD.1**
Governance responsibilities and accountabilities are described in bylaws, policies and procedures, or similar documents that guide how they are to be carried out.

**Intent of GLD.1**
There is an entity (for example, a ministry of health), an owner(s), or a group of identified individuals (for example, a board or governing body) responsible for overseeing the organization's operation and accountable for providing quality health care services to its community or to the population that seeks care. This entity's responsibilities and accountabilities are described in a document that identifies how they are to be carried out. Also described is how the governing entity and the performance of the organization's managers will be evaluated against organization-specific criteria.

The organization's governance and management structure is represented or displayed in an organizational chart or other document that shows lines of authority and accountability. The individuals represented on the chart are identified by title or name.

**Measurable Elements of GLD.1**

- 1. The organization's governance structure is described in written documents, and those responsible for governance and managing are identified by title or name.

- 2. Governance responsibilities and accountabilities are described in the documents.

- 3. The documents describe how the performance of the governing entity and managers will be evaluated and any related criteria.

- 4. There is an annual documented performance evaluation of governance.

**Standard GLD.1.1**
Those responsible for governance approve and make public the organization's mission statement.

**Standard GLD.1.2**
Those responsible for governance approve the policies and plans to operate the organization.

**Standard GLD.1.3**
Those responsible for governance approve the budget and allocate the resources required to meet the organization's mission.

**Standard GLD.1.4**
Those responsible for governance appoint the organization's senior manager(s) or director(s).
Standard GLD.1.5
Those responsible for governance approve the organization's plan for quality and patient safety and regularly receive and act on reports of the quality and patient safety program.

Intent of GLD.1.1 through GLD.1.5
The titles or location of the governance structure are not important. What is important are the responsibilities that must be carried out for the organization to have clear leadership, to operate efficiently, and to provide quality health care services. These responsibilities are primarily at the approval level and include
- approving the organization's mission (also see ACC.1, ME 2);
- approving (or defining approval authority when delegated) the organization's various strategic and management plans and the policies and procedures needed to operate the organization on a daily basis;
- approving the organization's participation in health care professional education and in research and the oversight of the quality of such programs;
- approving or providing a budget and resources to operate the organization; and
- appointing or approving the organization's senior manager(s) or director.

Identifying individuals in a single organizational chart does not ensure good communication and cooperation between those who govern and those who manage the organization. This is particularly true when the governance structure is separate from the organization, such as a distant owner or a national or regional health authority. Thus, those responsible for governance develop a process for communicating and cooperating with the organization's managers to fulfill the organization's mission and plans.

Measurable Elements of GLD.1.1
1. Those responsible for governance approve the organization's mission.
2. Those responsible for governance ensure the periodic review of the organization's mission.
3. Those responsible for governance make public the organization's mission.

Measurable Elements of GLD.1.2
1. Those responsible for governance approve the organization's strategic and management plans and operating policies and procedures.
2. When approval authority is delegated, it is defined in governance policies and procedures.
3. Those responsible for governance approve organization strategies and programs related to health care professional education and research and then provide oversight of the quality of such programs.

Measurable Elements of GLD.1.3
1. Those responsible for governance approve the organization's capital and operating budget(s).
2. Those responsible for governance allocate the resources required to meet the organization's mission.

Measurable Elements of GLD.1.4
1. Those responsible for governance appoint the organization's senior manager.
2. Those responsible for governance evaluate the performance of the organization's senior manager.
3. The evaluation of the senior management is performed at least annually.

Measurable Elements of GLD.1.5
1. Those responsible for governance approve the organization's plan for quality and patient safety. (Also see QPS.1, intent statement)
2. Those responsible for governance regularly receive and act on reports of the quality and patient safety program. (Also see QPS.1.4, ME 2)
Leadership of the Organization

Standard GLD.2
A senior manager or director is responsible for operating the organization and complying with applicable laws and regulations.

Intent of GLD.2
Effective leadership is essential for a health care organization to be able to operate efficiently and to fulfill its mission. Leadership is what individuals provide together and individually to the organization and can be carried out by any number of individuals.

The senior manager or director is responsible for the organization’s overall, day-to-day operations. This includes the procurement and inventory of essential supplies, maintenance of the physical facility, financial management, quality management, and other responsibilities. The education and experience of the individual matches the requirements in the position description. The senior manager or director cooperates with the organization’s managers to define the organization’s mission and to plan the policies, procedures, and clinical services related to that mission. Once approved by the governing body, the senior manager or director is responsible for implementing all policies and ensuring that all policies are complied with by the organization’s staff.

The senior manager or director is responsible for the organization’s

- compliance with applicable laws and regulations;
- response to any reports from inspecting and regulatory agencies; and
- processes to manage and to control human, financial, and other resources.

Measurable Elements of GLD.2
1. The education and experience of the senior manager match the requirements in the position description.
2. The senior manager or director manages the organization’s day-to-day operations, including those responsibilities described in the position description.
3. The senior manager or director recommends policies to the governing body.
4. The senior manager or director ensures compliance with approved policies.
5. The senior manager or director ensures compliance with applicable laws and regulations. (Also see ACC.6, MEs 1 and 2)
6. The senior manager or director responds to any reports from inspecting and regulatory agencies.

Standard GLD.3
The organization’s leaders are identified and are collectively responsible for defining the organization’s mission and creating the plans and policies needed to fulfill the mission.

Intent of GLD.3
The leaders of an organization arise from many sources. The governing body names the senior manager or director. The senior manager or director may name other managers. Leaders may have formal titles, such as Medical Director or Director of Nursing, or be informally recognized for their seniority, stature, or contribution.
to the organization. It is important that all leaders of an organization are recognized and brought into the process of defining the organization’s mission. Based on that mission, the leaders work collaboratively to develop the plans and policies needed to fulfill the mission. When the mission and policy framework are set by owners or agencies outside the organization, the leaders work collaboratively to carry out the mission and policies. (Also see ACC.1, MEs 2 and 3)

Measurable Elements of GLD.3

- 1. The leaders of the organization are formally or informally identified.
- 2. The leaders are collectively responsible for defining the organization’s mission.
- 3. The leaders are collectively responsible for creating the policies and procedures necessary to carry out the mission.
- 4. The leaders work collaboratively to carry out the organization’s mission and to ensure that policies and procedures are followed.

Standard GLD.3.1

Organization leaders plan with community leaders and leaders of other organizations to meet the community’s health care needs.

Intent of GLD.3.1

An organization’s mission commonly reflects the needs of the population in its community. Similarly, referral and specialty care organizations derive their missions from the needs of patients within larger geographic or political areas.

The needs of patients and communities usually change over time, and, thus, health care organizations need to engage their communities in the strategic and operational planning of the organizations. Organizations do this by seeking opinions or input on an individual or group basis through advisory groups or taskforces, for example.

Thus, it is important for the leaders of a health care organization to meet with, and to plan with, recognized community leaders and the leaders of other health care organizations (such as clinics, pharmacies, ambulance services, and the like) in the community. The leaders plan for a healthier community and recognize that they have responsibility for and an impact on the community, even in the absence of such planning. (Also see MC1.1, ME 3)

Measurable Elements of GLD.3.1

- 1. The organization’s leaders meet with recognized community leaders to develop and to revise strategic and operational plans to address community needs.
- 2. The organization’s leaders plan with the leaders of other health care organizations in its community. (Also see PFE.3, MEs 2 and 3)
- 3. The organization’s leaders seek the input of individual and group stakeholders in its community as part of its strategic and operational planning.
- 4. The organization participates in community education on health promotion and disease prevention.
Standard GLD.3.2
The leaders identify and plan for the type of clinical services required to meet the needs of the patients served by the organization.

Intent of GLD.3.2
Patient care services are planned and designed to respond to the needs of the patient population. Organization plans describe the care and services to be provided consistent with its mission. The leaders of the various clinical departments and services in the organization determine which diagnostic, therapeutic, rehabilitative, and other services are essential to the community. The leaders also determine the scope and intensity of the various services to be provided by the organization directly or indirectly.

The services planned reflect the strategic direction of the organization and the perspective of the patients cared for by the organization. When an organization uses what is identified as “experimental” technology and/or pharmaceutical agents in patient care procedures (that is, technology or agents identified as “experimental” either nationally or internationally), there is a process to review and to approve such use. It is essential that such approval occur prior to use in patient care. A determination is made if special patient consent is necessary.

Measurable Elements of GLD.3.2
1. Organization plans describe the care and services to be provided.
2. The care and services to be offered are consistent with the organization’s mission. (Also see ACC.1, ME 2)
3. Leaders determine the type of care and services to be provided by the organization.
4. Leaders have a process for reviewing and approving, before use in patient care, those procedures, technologies, and pharmaceutical agents identified as experimental.

Standard GLD.3.2.1
Equipment, supplies, and medications recommended by professional organizations or by alternative authoritative sources are used.

Intent of GLD.3.2.1
Risks in clinical care processes are significantly reduced when appropriate and well-functioning equipment is used to provide the planned services. This is especially true for clinical areas, such as anesthesia, radiology and diagnostic imaging, cardiology, radiation oncology, and other high-risk services when provided. Adequate supplies and medications are also available and appropriate for planned use and emergent situations. Each organization understands the required or recommended equipment, supplies, and medications necessary to provide the planned services to its patient population. Recommendations on equipment, supplies, and medication can come from a government agency, national or international anesthesia professional organizations, or other authoritative sources.

Measurable Elements of GLD.3.2.1
1. The organization uses the recommendations of professional organizations and other authoritative sources to identify the equipment and supplies it will need to provide the planned services. (Also see MMU.2.2, ME 1)
2. The identified equipment, supplies, and medications are obtained. (Also see MMU.2.2, ME 2)
3. The identified equipment, supplies, and medications are used. (Also see ASC.3, intent statement, and ASC.3, ME 1)
Standard GLD.3.3

The leaders are accountable for contracts for clinical or management services.

Intent of GLD.3.3

Organizations frequently have the option to either provide clinical and management services directly or to arrange for such services through referral, consultation, contractual arrangements, or other agreements. Such services may range from radiology and diagnostic imaging services to financial accounting services and services provided for housekeeping, food, or linens. The organization leaders describe, in writing, the nature and scope of services provided through contractual agreements.

In all cases, there is leadership accountability for such contracts or other arrangements to ensure that the services meet patient needs and are included as part of the organization’s quality management and improvement activities. Clinical leaders participate in the selection of clinical contracts and are accountable for clinical contracts. Management leaders participate in the selection of management contracts and are accountable for management contracts.

Measurable Elements of GLD.3.3

- 1. There is a process for leadership accountability of contracts. *(Also see AOP.5.8, ME 6; AOP.6.7, ME 6; AOP.6.9; and ASC.2, ME 5)*
- 2. The organization has a written description of the nature and scope of services provided through contractual agreements.
- 3. Services provided under contracts and other arrangements meet patient needs. *(Also see AOP.5.8, ME 6, and AOP.6.7, ME 6)*
- 4. Clinical leaders participate in the selection of clinical contracts and provide accountability for clinical contracts. *(Also see AOP.5.8, ME 5, and AOP.6.7, ME 5)*
- 5. Management leaders participate in the selection of management contracts and provide accountability for management contracts.
- 6. When contracts are renegotiated or terminated, the organization maintains the continuity of patient services.

Standard GLD.3.3.1

Contracts and other arrangements are included as part of the organization’s quality improvement and patient safety program.

Intent of GLD.3.3.1

The quality and safety of patient care require evaluation of all services provided by the organization or provided through contracts. Thus, the organization needs to receive, to analyze, and to take action on quality information from outside sources. The contract with the outside source of service includes quality and patient safety expectations and the data that are to be provided to the organization, their frequency, and their format. Department managers receive and act on quality reports from contracting agencies and ensure that the reports are integrated into the organization’s quality measurement process. *(Also see ACC.4.1, ME 2, and ACC.5, MEs 4 and 6)*
Measurable Elements of GLD.3.3.1

1. Contracts and other arrangements are evaluated, related to the nature of the contract, as part of the organization's quality improvement and patient safety program. (Also see AOP.5.8, ME 6)

2. The relevant clinical and managerial leaders participate with the quality improvement program in the analysis of quality and safety information from outside contracts. (Also see AOP.5.8, ME 5)

3. When contracted services do not meet quality and safety expectations, action is taken.

Standard GLD.3.3.2

Independent practitioners not employed by the organization have the right credentials for the services provided to the organization's patients.

Intent of GLD.3.3.2

Organizations may contract with or arrange services from physicians, dentists, and other independent practitioners outside the organization or arrange for them to come into the organization to provide services. In some cases, these individuals may even be located outside the region or country of the organization. The services provided may include telemedicine or teleradiology. If the services provided determine the care choice or course of care for the patient, the practitioner must proceed through the credentialing and privileging processes of the organization.

Measurable Elements of GLD.3.3.2

1. The leaders of the organization determine those services that will be provided by independent practitioners outside the organization.

2. All diagnostic, consultative, and treatment services provided by independent practitioners outside the organization, such as telemedicine, teleradiology, and interpretations of other diagnostics, such as electrocardiogram (ECG), electroencephalogram (EEG), and electromyogram (EMG), and the like, are privileged by the organization to provide such services. (Also see SQE.9 and SQE.10)

3. Independent practitioners who provide patient care services on the premises of the organization but are not employees or members of the clinical staff are credentialed and privileged as required in SQE.9 through SQE.10.

4. The quality of services by independent practitioners outside the organization is monitored as a component of the organization's quality improvement program.

Standard GLD.3.4

The medical, nursing, and other leaders are educated in the concepts of quality improvement.

Intent of GLD.3.4

A health care organization's primary purpose is to provide patient care and to work to improve patient care outcomes over time by applying quality improvement principles. Thus, the medical, nursing, and other leaders of an organization need to

• be educated in or familiar with the concepts and methods of quality improvement;
• personally participate in quality improvement and patient safety processes; and
• ensure that clinical quality improvement includes opportunities for measuring professional performance. (Also see QPS.4)
Measurable Elements of GLD.3.4

1. Medical, nursing, and other leaders are educated in or are familiar with the concepts and methods of quality improvement.

2. Medical, nursing, and other leaders participate in relevant quality improvement and patient safety processes. (Also see QPS.1.1, MEs 1 and 4, and QPS.4, ME 4)

3. Professional performance is measured as part of clinical performance improvement. (Also see SQE.11, SQE.14, and SQE.17)

Standard GLD.3.5

Organization leaders ensure that there are uniform programs for the recruitment, retention, development, and continuing education of all staff.

Intent of GLD.3.5

An organization's ability to care for patients is directly related to its ability to attract and to retain qualified, competent staff. Leaders recognize that staff retention, rather than recruitment, provides greater long-term benefit. Retention is increased when leaders support staff advancement through continuing education. Thus, the leaders collaborate to plan and to implement uniform programs and processes related to recruitment, retention, development, and continuing education for each category of staff. The organization's recruitment program considers published guidelines, such as those from the World Health Organization, International Council of Nurses, and World Medical Association.

Measurable Elements of GLD.3.5

1. There is a planned process for staff recruitment. (Also see SQE.2, ME 1)

2. There is a planned process for staff retention.

3. There is a planned process for staff personal development and continuing education. (Also see SQE.8)

4. The planning is collaborative and includes all departments and services in the organization.

Standard GLD.4

Medical, nursing, and other leaders of clinical services plan and implement an effective organizational structure to support their responsibilities and authority.

Intent of GLD.4

Medical, nursing, and other leaders of clinical services have special responsibilities to patients and to the organization. These leaders

- support good communication between professionals;
- jointly plan and develop policies that guide the delivery of clinical services;
- provide for the ethical practice of their professions; and
- oversee the quality of patient care.

The leaders of the medical and nursing staff create a suitable, effective organizational structure to carry out these responsibilities. The organizational structure(s) and the associated processes used to carry out these responsibilities can provide a single professional staff composed of physicians, nurses, and others or separate medical and nursing staff structures. The structure chosen can be highly organized with bylaws and rules and regulations or can be informally organized. In general, the structure(s) chosen

- includes all the relevant clinical staff;
- is consistent with the organization's ownership, mission and structure;
is appropriate for the organization’s complexity and size of the professional staff; and
is effective in carrying out the responsibilities listed above.

Measurable Elements of GLD.4

- 1. There is an effective organizational structure(s) used by medical, nursing, and other leaders to carry out their responsibilities and authority.
- 2. The structure(s) is appropriate to the organization’s size and complexity.
- 3. The organizational structure(s) and processes support professional communication.
- 4. The organizational structure(s) and processes support clinical planning and policy development.
- 5. The organizational structure(s) and processes support oversight of professional ethical issues.
- 6. The organizational structure(s) and processes support oversight of the quality of clinical services.

Direction of Departments and Services

Standard GLD.5

One or more qualified individuals provide direction for each department or service in the organization.

Intent of GLD.5

The clinical care, patient outcomes, and overall management of a health care organization are only as good as the clinical and managerial activities of each individual department or service. Good departmental or service performance requires clear leadership from a qualified individual. In larger departments or services, leadership may be separated. In such a case, the responsibilities of each role are defined in writing. (Also see ACC.6.1, ME 1; ACS.2, ME 2; AOP.5.9 related to the direction of clinical laboratory services; AOP.6.7 related to the direction of radiology and diagnostic imaging services; MMU.1.1 related to the direction of the pharmacy or pharmaceutical services; and ACS.2 related to the direction of anesthesia services)

Measurable Elements of GLD.5

- 1. Each department or service in the organization is directed by an individual with the training, education, and experience comparable to the services provided. (Also see AOP.5.8, ME 1; AOP.6.7, ME 1; and MMU.1.1, ME 1)
- 2. When more than one individual provides direction, the responsibilities of each are defined in writing.

Standard GLD.5.1

The directors of each clinical department identify, in writing, the services to be provided by the department.

Standard GLD.5.1.1

Services are coordinated and integrated within the department or service and with other departments and services.

Intent of GLD.5.1 and GLD.5.1.1

The directors of the organization’s clinical departments collaborate to determine the uniform format and content of the department-specific planning documents. In general, the documents prepared by each clinical department define its goal, as well as identify current and planned services. Department policies and procedures reflect the department’s goals and services as well as the knowledge, skills, and availability of staff required to assess and to meet patient care needs.
Clinical services provided to patients are coordinated and integrated within each department of service. For example, there is integration of medical and nursing services. Also, each department or service coordinates and integrates its services with other departments and services. Unnecessary duplication of services is avoided or eliminated to conserve resources.

**Measurable Elements of GLD.5.1**

1. Department or service directors have selected and use a uniform format and content for planning documents.
2. The departmental or service documents describe the current and planned services provided by each department or service.
3. Each department's or service's policies and procedures guide the provision of identified services.
4. Each department's or service's policies and procedures address the staff knowledge and skills needed to assess and to meet patient needs.

**Measurable Elements of GLD.5.1.1**

1. There is coordination and integration of services within each department or service.
2. There is coordination and integration of services with other departments and services.

**Standard GLD.5.2**

Directors recommend space, equipment, staffing, and other resources needed by the department or service.

**Intent of GLD.5.2**

Each department’s leaders communicate their human resources and other resource requirements to the organization’s senior managers. This helps ensure that adequate staff, space, equipment, and other resources are available to meet patients’ needs at all times. Although the directors make recommendations regarding human and other resource needs, those needs sometimes change or are not fully met. Thus, directors have a process to respond to resource shortages to ensure safe and effective care for all patients.

**Measurable Elements of GLD.5.2**

1. Directors recommend space needed to provide services.
2. Directors recommend equipment needed to provide services.
3. Directors recommend the number and qualifications of staff needed to provide services. (*Also see AOP.6.3, ME 5)*
4. Directors recommend other special resources needed to provide services.
5. Directors have a process to respond to resource shortages.

**Standard GLD.5.3**

Directors recommend criteria for selecting the department or service’s professional staff and choose or recommend individuals who meet those criteria.

**Intent of GLD.5.3**

Directors consider the services provided and planned by the department or service and the education, skills, knowledge, and experience needed by the department’s professional staff to provide those services. Directors develop criteria reflecting this consideration and then select staff. Directors may also work with human resources or other departments in the selection process based on the director’s recommendation.
Measurable Elements of GLD.5.3

1. The director develops criteria related to the needed education, skills, knowledge, and experience of the department’s professional staff.

2. The director uses such criteria in selecting or recommending professional staff.

Standard GLD.5.4

Directors provide orientation and training for all staff of the duties and responsibilities for the department or service to which they are assigned.

Intent of GLD.5.4

Directors ensure that all staff in the department or service understand their responsibilities and establish the orientation and training for new employees. The orientation includes the organization’s mission, the department’s or service’s mission, the scope of services provided, and the policies and procedures related to providing services. For example, all staff understands the infection prevention and control procedures within the organization and within the department or service. When new or revised policies or procedures are implemented, staff are trained. (Also see SQE.7; AOP.5.1, ME 5; AOP.6.2, ME 6; and PCI.11, ME 4)

Measurable Elements of GLD.5.4

1. The director has established a documented orientation program for department staff. (Also see SQE.7; AOP.5.1, ME 5; and AOP.6.2, ME 6)

2. All department staff have completed the program. (Also see SQE.7; AOP.5.1, ME 5; and AOP.6.2, ME 6)

Standard GLD.5.5

Directors evaluate the department’s or service’s performance as well as staff performance.

Intent of GLD.5.5

One of the most important responsibilities of a department or service director is to implement the organization’s quality improvement and patient safety program in the department. The selection of department or service level measures is influenced by:

a) the organization’s measurement and improvement priorities that relate to the department or service;

b) the evaluation of the provided services from sources including patient surveys and complaints;

c) the need to understand the efficiency and cost effectiveness of the services provided; and

d) the evaluation of services provided under contractual arrangements. (Also see GLD.3.3)

The director is responsible for ensuring that the measurement activities provide the opportunity for the evaluation of staff as well as the processes of care. Thus, measurement includes, over time, all the services provided. The resulting data and information are important to the department’s or service’s improvement efforts but are also important to the organization’s quality improvement and patient safety program. (Also see ASC.2, ME 7)

Measurable Elements of GLD.5.5

1. Directors implement quality measures that address the services provided in their department or service including criteria a) through d) in the intent statement as appropriate to the department of service.

2. Directors implement quality measures related to staff performance in carrying out their responsibilities in the department or service.

3. Directors implement quality control programs when indicated.
4. Department or service directors are provided the data and information needed to manage and to improve care and services.

5. Department and service quality measurement and improvement activities are reported periodically to the quality oversight mechanism of the organization.

Organizational Ethics

Standard GLD.6
The organization establishes a framework for ethical management that ensures that patient care is provided within business, financial, ethical, and legal norms and that protects patients and their rights.

Standard GLD.6.1
The organization's framework for ethical management includes marketing, admissions, transfer, discharge, and disclosure of ownership and any business and professional conflicts that may not be in patients' best interests.

Standard GLD.6.2
The organization's framework for ethical management supports ethical decision making in clinical care and nonclinical services.

Intent of GLD.6 through GLD.6.2
A health care organization has an ethical and legal responsibility to its patients and community. The leaders understand these responsibilities as they apply to the organization's business and clinical activities. The organization's actions related to financial incentives must be congruent with organizational values and ethics. The leaders create guiding documents to provide a consistent framework to carry out these responsibilities. Organization leaders consider the national and international norms* related to human rights and professional ethics when creating this framework. The organization operates within this framework to:

- disclose ownership and any conflicts of interest;
- honestly portray its services to patients;
- provide clear admission, transfer, and discharge policies;
- accurately bill for its services; and
- resolve conflicts when financial incentives and payment arrangements could compromise patient care.

The framework also supports the organization's professional staff and patients when confronted by ethical dilemmas in patient care, such as donor and transplant decisions; disagreements between patients and their families, and between patients and their health care practitioners, regarding care decisions; and interprofessional disagreements. Such support is readily available.

*In the context of patient safety and health care quality, international norms related to human rights and ethical professional practice are of increasing concern. Although the concerns are more recent and growing, the international documents intended to shape such norms are long-standing and include the Universal Declaration of Human Rights (United Nations, 1948); the Geneva Conventions (August 12, 1949); the Declaration of Tokyo: Guidelines for Physicians Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment (World Medical Assembly, 1975); the Oath of Athens (International Council of Prison Medical Services, 1979); and the International Covenant on Civil and Political Rights, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (United Nations, 1985).
Measurable Elements of GLD.6
1. Organization leaders establish ethical and legal norms that protect patients and their rights. (Also see PFR.1, MEs 1 and 2)
2. The leaders establish a framework for the organization's ethical management.
3. The leaders consider national and international ethical norms when developing the organization's framework for ethical conduct.

Measurable Elements of GLD.6.1
1. The organization discloses its ownership. (Also see AOP.5.1, ME 5, and AOP.6.1, ME 2)
2. The organization honestly portrays its services to patients.
3. The organization provides clear admission, transfer, and discharge policies. (Also see ACC.1.1, ME 2; ACC.3, ME 1; and ACC.4, MEs 1–4)
4. The organization accurately bills for services.
5. The organization discloses, evaluates, and resolves conflicts when financial incentives and payment arrangements compromise patient care.

Measurable Elements of GLD.6.2
1. The organization's framework for ethical management supports those confronted by ethical dilemmas in patient care.
2. The organization's framework for ethical management supports those confronted by ethical dilemmas for nonclinical services.
3. The support is readily available.
4. The organization's framework provides for safe reporting of ethical and legal concerns.
Facility Management and Safety (FMS)

Overview

Health care organizations work to provide safe, functional, and supportive facilities for patients, families, staff, and visitors. To reach this goal, the physical facility, medical and other equipment, and people must be effectively managed. In particular, management must strive to

- reduce and control hazards and risks;
- prevent accidents and injuries; and
- maintain safe conditions.

Effective management includes multidisciplinary planning, education, and monitoring as follows:

- The leaders plan the space, equipment, and resources needed to safely and effectively support the clinical services provided.
- All staff are educated about the facility, how to reduce risks, and how to monitor and to report situations that pose risk.
- Performance criteria are used to evaluate important systems and to identify needed improvements.

Written plans are developed and include the following six areas, when appropriate to the facility and activities of the organization:

1. Safety and Security
   - Safety—The degree to which the organization's buildings, grounds, and equipment do not pose a hazard or risk to patients, staff, or visitors.
   - Security—Protection from loss, destruction, tampering, or unauthorized access or use.
2. Hazardous materials—Handling, storage, and use of radioactive and other materials are controlled, and hazardous waste is safely disposed.
3. Emergency management—Response to epidemics, disasters, and emergencies is planned and effective.
4. Fire safety—Property and occupants are protected from fire and smoke.
5. Medical equipment—Equipment is selected, maintained, and used in a manner to reduce risks.
6. Utility systems—Electrical, water, and other utility systems are maintained to minimize the risks of operating failures.

When the organization has nonhospital entities within the patient care facilities to be surveyed (such as an independently owned coffee shop or gift shop), the organization has an obligation to ensure that these independent entities comply with the following facility management and safety plans:

- Safety and security plan
- Hazardous materials plan
Laws, regulations, and inspections by local authorities determine in large part how a facility is designed, used, and maintained. All organizations, regardless of size and resources, must comply with these requirements as part of their responsibilities to their patients, families, staff, and visitors.

Organizations begin by complying with laws and regulations. Over time, they become more knowledgeable about the details of the physical facilities they occupy. They begin to proactively gather data and to carry out strategies to reduce risks and to enhance the patient care environment.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

Leadership and Planning

FMS.1 The organization complies with relevant laws, regulations, and facility inspection requirements.

FMS.2 The organization develops and maintains a written plan(s) describing the processes to manage risks to patients, families, visitors, and staff.

FMS.3 One or more qualified individuals oversee the planning and implementation of the program to manage the risks in the care environment.

FMS.3.1 A monitoring program provides data on incidents, injuries, and other events that support planning and further risk reduction.

Safety and Security

FMS.4 The organization plans and implements a program to provide a safe and secure physical environment.

FMS.4.1 The organization inspects all patient care buildings and has a plan to reduce evident risks and to provide a safe physical facility for patients, families, staff, and visitors.

FMS.4.2 The organization plans and budgets for upgrading or replacing key systems, buildings, or components based on the facility inspection and in keeping with laws and regulations.

Hazardous Materials

FMS.5 The organization has a plan for the inventory, handling, storage, and use of hazardous materials and the control and disposal of hazardous materials and waste.

Disaster Preparedness

FMS.6 The organization develops and maintains an emergency management plan and program to respond to likely community emergencies, epidemics, and natural or other disasters.

FMS.6.1 The organization tests its response to emergencies, epidemics, and disasters.

Fire Safety

FMS.7 The organization plans and implements a program to ensure that all occupants are safe from fire, smoke, or other emergencies in the facility.
FMS.7.1 The plan includes prevention, early detection, suppression, abatement, and safe exit from the facility in response to fires and nonfire emergencies.

FMS.7.2 The organization regularly tests its fire and smoke safety plan, including any devices related to early detection and suppression, and documents the results.

FMS.7.3 The organization develops and implements a plan to limit smoking by staff and patients to designated non–patient care areas of the facility.

Medical Equipment

FMS.8 The organization plans and implements a program for inspecting, testing, and maintaining medical equipment and documenting the results.

FMS.8.1 The organization collects monitoring data for the medical equipment management program. These data are used to plan the organization’s long-term needs for upgrading or replacing equipment.

FMS.8.2 The organization has a product/equipment recall system.

Utility Systems

FMS.9 Potable water and electrical power are available 24 hours a day, seven days a week, through regular or alternate sources, to meet essential patient care needs.

FMS.9.1 The organization has emergency processes to protect facility occupants in the event of water or electrical system disruption, contamination, or failure.

FMS.9.2 The organization tests its emergency water and electrical systems on a regular basis appropriate to the system and documents the results.

FMS.10 Electrical, water, waste, ventilation, medical gas, and other key systems are regularly inspected, maintained, and, when appropriate, improved.

FMS.10.1 Designated individuals or authorities monitor water quality regularly.

FMS.10.2 The organization collects monitoring data for the utility system management program. These data are used to plan the organization’s long-term needs for upgrading or replacing the utility system.

Staff Education

FMS.11 The organization educates and trains all staff members about their roles in providing a safe and effective patient care facility.

FMS.11.1 Staff members are trained and knowledgeable about their roles in the organization’s plans for fire safety, security, hazardous materials, and emergencies.

FMS.11.2 Staff are trained to operate and to maintain medical equipment and utility systems.

FMS.11.3 The organization periodically tests staff knowledge through demonstrations, mock events, and other suitable methods. This testing is then documented.
Standards, Intents, and Measurable Elements

Leadership and Planning

Standard FMS.1
The organization complies with relevant laws, regulations, and facility inspection requirements.

Intent of FMS.1
The first consideration for any physical facility is the laws, regulations, and other requirements related to the facility. Such requirements may differ depending on the facility’s age and location and other factors. For example, many building construction codes and fire safety codes, such as for sprinkler systems, apply only to new construction.

The organization’s leaders, including governance and senior management, are responsible for
   • knowing what national and local laws, regulations, and other requirements apply to the organization’s facilities;
   • implementing the applicable requirements or approved alternative requirements; and
   • planning and budgeting for the necessary upgrading or replacement as identified by monitoring data or to meet applicable requirements and then to show progress toward meeting the plans. (Also see FMS.4.2)

When the organization has been cited for not meeting requirements, the leaders take responsibility for planning for and meeting the requirements in the prescribed time frame.

Measurable Elements of FMS.1

1. The organization’s leaders and those responsible for facility management know what laws, regulations, and other requirements apply to the organization’s facilities.

2. The leaders implement the applicable requirements or approved alternatives.

3. The leaders ensure the organization meets the conditions of facility reports or citations from inspections by local authorities.

Standard FMS.2
The organization develops and maintains a written plan(s) describing the processes to manage risks to patients, families, visitors, and staff.

Intent of FMS.2
To manage the risks within the environment in which patients are treated and staff work requires planning.

The organization develops one master plan or individual plans that include the following:
   a) Safety and Security
      Safety—The degree to which the organization’s buildings, grounds, and equipment do not pose a hazard or risk to patients, staff, and visitors.
      Security—Protection from loss, destruction, tampering, or unauthorized access or use.
   b) Hazardous materials—Handling, storage, and use of radioactive and other materials are controlled, and hazardous waste is safely disposed.
c) Emergencies—Response to epidemics, disasters, and emergencies is planned and effective.
d) Fire safety—Property and occupants are protected from fire and smoke.
e) Medical equipment—Equipment is selected, maintained, and used in a manner to reduce risks.
f) Utility systems—Electrical, water, and other utility systems are maintained to minimize the risks of operating failures.

Such plans are written and are up to date in that they reflect present or recent conditions within the organization’s environment. There is a process for their review and updating.

**Measurable Elements of FMS.2**

- 1. There are written plans that address the risk areas a) through f) in the intent statement.
- 2. The plans are current or up to date.
- 3. The plans are fully implemented.
- 4. The organization has a process to periodically review and to update the plan(s) on an annual basis.

**Standard FMS.3**

One or more qualified individuals oversee the planning and implementation of the program to manage the risks in the care environment.

**Standard FMS.3.1**

A monitoring program provides data on incidents, injuries, and other events that support planning and further risk reduction.

**Intent of FMS.3 and FMS.3.1**

A facility/environment risk management program in a large or small organization requires the assignment of one or more individuals to provide leadership and oversight. In a small organization, one individual may be assigned part-time. In a larger organization, several engineers or other specially trained individuals may be assigned. Whatever the assignment, all aspects of the program must be managed effectively and in a consistent and continuous manner. Program oversight includes

- a) planning all aspects of the program;
- b) implementing the program;
- c) educating staff;
- d) testing and monitoring the program;
- e) periodically reviewing and revising the program;
- f) providing annual reports to the governing body on the effectiveness of the program; and
- g) providing consistent and continuous organization and management.

When appropriate to the organization’s size and complexity, a facility/environment risk committee may be formed and given responsibility for overseeing the program and program continuity.

Monitoring all aspects of the program provides valuable data to improve the program and to further reduce risks in the organization.
Measurable Elements of FMS.3
- 1. Program oversight and direction are assigned to one or more individuals.
- 2. The individual(s) is qualified by experience or training.
- 3. The individual(s) plans and implements the program including elements a) through g) of the intent statement.

Measurable Elements of FMS.3.1
- 1. There is a program to monitor all aspects of the facility/environment risk management program.
- 2. Monitoring data are used to improve the program.

Safety and Security

Standard FMS.4
The organization plans and implements a program to provide a safe and secure physical environment.

Standard FMS.4.1
The organization inspects all patient care buildings and has a plan to reduce evident risks and to provide a safe physical facility for patients, families, staff, and visitors.

Standard FMS.4.2
The organization plans and budgets for upgrading or replacing key systems, buildings, or components based on the facility inspection and in keeping with laws and regulations.

Intent of FMS.4 through FMS.4.2
The organization leaders use available resources well in providing a safe, effective, and efficient facility (also see AOP5.1, ME 1, and AOP6.2, ME 1). Prevention and planning are essential to creating a safe and supportive patient care facility. To plan effectively, the organization must be aware of all the risks present in the facility. This includes safety, such as fire safety, as well as security risks. The goal is to prevent accidents and injuries; to maintain safe and secure conditions for patients, families, staff, and visitors; and to reduce and to control hazards and risks. This is particularly important during periods of construction or renovation. In addition, to ensure security, all staff, visitors, vendors, and others in the organization are identified and issued temporary or permanent badges or other identification measures, and all areas intended to be secure, such as the newborn nursery, are secure and monitored.

This can be done by developing a Facility Improvement Plan, which includes a comprehensive inspection of the facility, noting everything from sharp and broken furniture that could injure to locations where there is no escape from fire or no way to monitor a secure area. This periodic inspection is documented and helps the organization plan and carry out improvements and budget for longer-term facility upgrading or replacement.

Then, by understanding the risks present in the organization’s physical facility, the organization can develop a proactive plan to reduce those risks for patients, families, staff, and visitors. The plan may include such items as install security cameras in remote areas, replace emergency generator, replace fire doors, and the like. This plan includes safety and security.
Measurable Elements of FMS.4

1. The organization has a program to provide a safe and secure physical facility, including monitoring and securing areas identified as security risks.

2. The program ensures that all staff, visitors, and vendors are identified, and all security risk areas are monitored and kept secure. (Also see AOP.5.1, ME 2, and AOP.6.2, ME 2)

3. The program is effective in preventing injury and maintaining safe conditions for patients, families, staff, and visitors. (Also see IPSG.6, ME 1)

4. The program includes safety and security during times of construction and renovation.

5. The leaders apply resources in accordance with approved plans.

6. When independent entities are present within the patient care facilities to be surveyed, the organization ensures that the entities comply with the safety program.

Measurable Elements of FMS.4.1

1. The organization has a documented, current, accurate inspection of its physical facilities.

2. The organization has a plan to reduce evident risks based on the inspection.

3. The organization is making progress in carrying out the plan.

Measurable Elements of FMS.4.2

1. The organization plans and budgets to meet applicable laws, regulations, and other requirements.

2. The organization plans and budgets for upgrading or replacing systems, buildings, or components needed for the continued operation of a safe and effective facility. (Also see ACC.6.1, ME 5)

Hazardous Materials

Standard FMS.5
The organization has a plan for the inventory, handling, storage, and use of hazardous materials and the control and disposal of hazardous materials and waste.

Intent of FMS.5
The organization identifies and safely controls hazardous materials and waste (also see AOP.5.1, ME 1, and AOP.6.2, ME 1) according to a plan. Such materials and waste include chemicals, chemotherapeutic agents, radioactive materials and waste, hazardous gases and vapors, and other regulated medical and infectious waste. The plan provides processes for

- the inventory of hazardous materials and waste;
- handling, storage, and use of hazardous materials;
- reporting and investigation of spills, exposures, and other incidents;
- proper disposal of hazardous waste;
- proper protective equipment and procedures during use, spill, or exposure;
- documentation, including any permits, licenses, or other regulatory requirements; and
- proper labeling of hazardous materials and waste.

Measurable Elements of FMS.5

1. The organization identifies hazardous materials and waste and has a current list of all such materials within the organization. (Also see AOP.5.5, ME 1, and AOP.6.6, ME 1)
2. The plan for safe handling, storage, and use of hazardous waste is established and implemented. *(Also see AOP.5.1, intent statement, and ME 3; AOP.5.5, ME 3; AOP.6.2, ME 4; and AOP.6.6, ME 3)*

3. The plan for reporting and investigation of spills, exposures, and other incidents is established and implemented.

4. The plan for the proper handling of waste within the organization and disposal of hazardous waste in a safe and legal manner is established and implemented. *(Also see AOP.6.2, ME 4)*

5. The plan for the proper protective equipment and procedures during use, spill, or exposure is established and implemented. *(Also see AOP.5.1, ME 4; AOP.6.2, ME 5; and AOP.6.6, ME 5)*

6. The plan for documentation requirements, including any permits, licenses, or other regulatory requirements, is established and implemented.

7. The plan for labeling hazardous materials and waste is established and implemented. *(Also see AOP.5.5, ME 5, and AOP.6.6, ME 5)*

8. When independent entities are present within the patient care facilities to be surveyed, the organization ensures that the entities comply with the hazardous materials plan.

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**Disaster Preparedness**

**Standard FMS.6**
The organization develops and maintains an emergency management plan and program to respond to likely community emergencies, epidemics, and natural or other disasters.

**Standard FMS.6.1**
The organization tests its response to emergencies, epidemics, and disasters.

**Intent of FMS.6 and FMS.6.1**
Community emergencies, epidemics, and disasters may directly involve the organization, such as damage to patient care areas as a result of an earthquake or flu that keeps staff from coming to work. To respond effectively, the organization develops a plan and a program to manage such emergencies. The plan provides processes for

a) determining the type, likelihood, and consequences of hazards, threats, and events;
b) determining the organization's role in such events;
c) communication strategies for events;
d) the managing of resources during events, including alternative sources;
e) the managing of clinical activities during an event, including alternative care sites;
f) the identification and assignment of staff roles and responsibilities during an event; and
g) the process to manage emergencies when staff personal responsibilities conflict with the organization's responsibility for staffing patient care.

The disaster preparedness plan is tested by

- an annual test of the full plan internally or as part of a communitywide test; or
- testing of critical elements c) through g) of the plan during the year.

If the organization experiences an actual disaster, activates its plan, and debriefs properly afterward, this situation represents the equivalent to an annual test.
Measurable Elements of FMS.6

1. The organization has identified the major internal and external disasters, such as community emergencies, epidemics, and natural or other disasters, as well as major epidemic events that pose significant risks of occurring.

2. The organization plans its response to likely disasters including items a) through g) in the intent.

Measurable Elements of FMS.6.1

1. The entire plan, or at least critical elements c) through g) of the plan, is tested annually.

2. At the conclusion of every test, debriefing of the test is conducted.

3. When independent entities are present within the patient care facilities to be surveyed, the organization ensures that the entities comply with the disaster preparedness plan.

Fire Safety

Standard FMS.7
The organization plans and implements a program to ensure that all occupants are safe from fire, smoke, or other emergencies in the facility.

Standard FMS.7.1
The plan includes prevention, early detection, suppression, abatement, and safe exit from the facility in response to fires and nonfire emergencies.

Standard FMS.7.2
The organization regularly tests its fire and smoke safety plan, including any devices related to early detection and suppression, and documents the results.

Intent of FMS.7 through FMS.7.2
Fire is an ever-present risk in a health care organization. Thus, every organization needs to plan how it will keep its occupants safe in case of fire or smoke. An organization plans in particular for:

- the prevention of fires through the reduction of risks, such as safe storage and handling of potentially flammable materials, including flammable medical gases, such as oxygen;
- hazards related to any construction in or adjacent to the patient-occupied buildings;
- safe and unobstructed means of exit in the event of a fire;
- early warning, early detection systems, such as smoke detectors, fire alarms, and fire patrols; and
- suppression mechanisms, such as water hoses, chemical suppressants, or sprinkler systems.

These actions, when combined, give patients, families, staff, and visitors adequate time to safely exit the facility in the event of a fire or smoke. These actions are effective no matter what the age, size, or construction of the facility. For example, a small, one-level brick facility will use different methods than a large, multilevel wooden facility.

The organization’s fire safety plan identifies:

- the frequency of inspecting, testing, and maintaining fire protection and safety systems, consistent with requirements;
- the plan for safely evacuating the facility in the event of a fire or smoke;
• the process for testing all portions of the plan during each 12-month period;
• the necessary education of staff to effectively protect and to evacuate patients when an emergency occurs; and
• the participation of staff members in at least one fire safety test per year.

A test of the plan can be accomplished in multiple ways. For example, organizations can assign a “fire marshal” for each unit and have him or her randomly quiz the staff about what they would do if a fire occurred on their unit. The staff can be asked specific questions, such as, “Where is the oxygen shutoff valve? If you have to shut off the oxygen valve, how do you take care of patients who need oxygen? Where are the fire extinguishers on your unit located? How do you report a fire? How do you protect the patients during a fire? If you need to evacuate patients, what is your process?” Staff should be able to respond appropriately to these questions. If they do not, this should be documented and a plan for reeducation developed. The fire marshal should keep a record of those who participated. Organizations may also develop a written test for staff to take relating to fire safety as part of testing the plan.

All inspections, testing, and maintenance are documented.

**Measurable Elements of FMS.7**

- 1. The organization plans a program to ensure that all occupants of the organization’s facilities are safe from fire, smoke, or other nonfire emergencies.
- 2. The program is implemented in a continuous and comprehensive manner to ensure that all patient care and staff work areas are included.
- 3. When independent entities are present within the patient care facilities to be surveyed, the organization ensures that the entities comply with the fire safety plan.

**Measurable Elements of FMS.7.1**

- 1. The program includes the reduction of fire risks.
- 2. The program includes the assessment of fire risks when construction is present in or adjacent to the facility.
- 3. The program includes the early detection of fire and smoke.
- 4. The program includes the abatement of fire and containment of smoke.
- 5. The program includes the safe exit from the facility when fire and nonfire emergencies occur.

**Measurable Elements of FMS.7.2**

- 1. Fire detection and abatement systems are inspected, tested, and maintained at a frequency determined by the organization.
- 2. Staff are trained to participate in the fire and smoke safety plan. *(Also see FMS.11.1, ME 1)*
- 3. All staff participate in at least one fire and smoke safety plan test per year.
- 4. Staff can demonstrate how to bring patients to safety.
- 5. Inspection, testing, and maintenance of equipment and systems are documented.

**Standard FMS.7.3**

The organization develops and implements a plan to limit smoking by staff and patients to designated non–patient care areas of the facility.
Intent of FMS.7.3
The organization develops and implements a policy and plan to limit smoking that
- applies to all patients, families, staff, and visitors; and
- eliminates smoking in the organization’s facilities or minimally limits smoking to designated non–patient care areas that are ventilated to the outside.

The organization’s smoking policy identifies any exceptions to the policy related to patients, such as the medical or psychiatric reasons a patient may be permitted to smoke, and those individuals permitted to grant such an exception. When an exception is made, the patient smokes in a designated, nontreatment area, away from other patients.

Measurable Elements of FMS.7.3
- 1. The organization has developed a policy and/or procedure to eliminate or to limit smoking.
- 2. The policy and/or procedure applies to patients, families, visitors, and staff.
- 3. The policy and/or procedure has been implemented.
- 4. There is a process to grant patient exceptions to the policy and/or procedure.

Medical Equipment

Standard FMS.8
The organization plans and implements a program for inspecting, testing, and maintaining medical equipment and documenting the results.

Standard FMS.8.1
The organization collects monitoring data for the medical equipment management program. These data are used to plan the organization’s long-term needs for upgrading or replacing equipment.

Intent of FMS.8 and FMS.8.1
To ensure that medical equipment is available for use and functioning properly, the organization
- inventories medical equipment;
- regularly inspects medical equipment;
- tests medical equipment according to its use and requirements; and
- does preventive maintenance.

Qualified individuals provide these services. Equipment is inspected and tested when new and then on an ongoing basis, according to the equipment’s age and use or based on manufacturer instructions. Inspections, testing results, and any maintenance are documented. This helps ensure the continuity of the maintenance process and helps when doing capital planning for replacements, upgrades, and other changes. (Also see AOP.6.5, intent statement)

Measurable Elements of FMS.8
- 1. Medical equipment is managed throughout the organization according to a plan. (Also see AOP.5.4, ME 1, and AOP.6.5, ME 1)
- 2. There is an inventory of all medical equipment. (Also see AOP.5.4, ME 3, and AOP.6.5, ME 3)
- 3. Medical equipment is regularly inspected. (Also see AOP.5.4, ME 4, and AOP.6.5, ME 4)
4. Medical equipment is tested when new and according to age, use, and manufacturers’ recommendations thereafter. *(Also see AOP.5.4, ME 5, and AOP.6.5, ME 5)*

5. There is a preventive maintenance program. *(Also see AOP.5.4, ME 6, and AOP.6.5, ME 6)*

6. Qualified individuals provide these services.

**Measurable Elements of FMS.8.1**

1. Monitoring data are collected and documented for the medical equipment management program. *(Also see AOP.5.4, ME 7, and AOP.6.5, ME 7)*

2. Monitoring data are used for purposes of planning and improvement.

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**Standard FMS.8.2**

The organization has a product/equipment recall system.

**Intent of FMS.8.2**

The organization has a process for identifying, retrieving, and returning or destroying products and equipment recalled by the manufacturer or supplier. There is a policy or procedure that addresses the use of any product or equipment under recall.

**Measurable Elements of FMS.8.2**

1. There is a product/equipment recall system in place.

2. Policy or procedure addresses any use of any product or equipment under recall.

3. The policy or procedure is implemented.

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**Utility Systems**

**Standard FMS.9**

Potable water and electrical power are available 24 hours a day, seven days a week, through regular or alternate sources, to meet essential patient care needs.

**Intent of FMS.9**

Patient care, both routine and urgent, is provided on a 24-hour basis, every day of the week in a health care organization. Thus, an uninterrupted source of clean water and electrical power is essential to meet patient care needs. Regular and alternative sources can be used.

**Measurable Elements of FMS.9**

1. Potable water is available 24 hours a day, seven days a week.

2. Electrical power is available 24 hours a day, seven days a week.

**Standard FMS.9.1**

The organization has emergency processes to protect facility occupants in the event of water or electrical system disruption, contamination, or failure.
**Standard FMS.9.2**
The organization tests its emergency water and electrical systems on a regular basis appropriate to the system and documents the results.

**Intent of FMS.9.1 and FMS.9.2**
Health care organizations have different medical equipment and utility system needs based on their mission, patient needs, and resources. Regardless of the type of system and level of its resources, an organization needs to protect patients and staff in emergencies, such as system failure, interruption, or contamination.

To prepare for such emergencies, the organization
- identifies the equipment, systems, and locations that pose the highest risk to patients and staff (for example, it identifies where there is a need for illumination, refrigeration, life support, and clean water for cleaning and sterilization of supplies);
- assesses and minimizes the risks of utility system failures in these areas;
- plans emergency power and clean water sources for these areas and needs;
- tests the availability and reliability of emergency sources of power and water;
- documents the results of tests; and
- ensures that the testing of alternative sources of water and electricity occurs at least annually or more frequently if required by local laws, regulations, or conditions of the sources for power and water.

Conditions of the sources of power and water that may increase the frequency of testing include
- repeated repair of the water system;
- frequent contamination of the water source;
- unreliable electrical grids; and
- recurrent, unpredictable power outages.

**Measurable Elements of FMS.9.1**
- 1. The organization has identified the areas and services at greatest risk when power fails or water is contaminated or interrupted.
- 2. The organization seeks to reduce the risks of such events.
- 3. The organization plans alternative sources of power and water in emergencies.

**Measurable Elements of FMS.9.2**
- 1. The organization tests alternative sources of water at least annually or more frequently if required by local laws and regulations or conditions of the source of water.
- 2. The organization documents the results of such tests.
- 3. The organization tests alternative sources of electricity at least annually or more frequently if required by local laws and regulations or conditions of the source of electricity.
- 4. The organization documents the results of such tests.

**Standard FMS.10**
Electrical, water, waste, ventilation, medical gas, and other key systems are regularly inspected, maintained, and, when appropriate, improved.

**Standard FMS.10.1**
Designated individuals or authorities monitor water quality regularly.
**Standard FMS.10.2**
The organization collects monitoring data for the utility system management program. These data are used to plan the organization's long-term needs for upgrading or replacing the utility system.

**Intent of FMS.10 through FMS.10.2**
The safe, effective, and efficient operation of utility and other key systems in the organization is essential for patient, family, staff, and visitor safety and for meeting patient care needs. For example, waste contamination in food-preparation areas, inadequate ventilation in the clinical laboratory, oxygen cylinders that are not secured when stored, leaking oxygen lines, and frayed electrical lines all pose hazards. To avoid these and other hazards, the organization has a process for regularly inspecting such systems and performing preventive and other maintenance. During testing, attention is paid to the critical components (for example, switches and relays) of systems. Emergency and backup power sources are tested under planned circumstances that simulate actual load requirements. Improvements are made when necessary, such as enhancing electrical service to areas with new equipment.

Water quality can change suddenly due to many causes, some of which can be outside the organization, such as a break in the supply line to the organization or contamination of the city's water source. Water quality is also a critical factor in clinical care processes, such as chronic renal dialysis. Thus, the organization establishes a process to regularly monitor water quality, including the regular biological testing of water used in chronic renal dialysis. The frequency of monitoring is based in part on previous experience with water quality problems. The monitoring can be carried out by individuals designated by the organization, such as staff from the clinical laboratory, or by public health or water control authorities outside the organization judged competent to perform such tests. It is the responsibility of the organization to ensure the testing is completed as required.

Monitoring essential systems helps the organization prevent problems and provides the information necessary to make decisions on system improvements and in planning for upgrading or replacing utility systems. Monitoring data are documented.

**Measurable Elements of FMS.10**
- 1. Utility, medical gas, ventilation, and other key systems are identified by the organization.
- 2. Key systems are regularly inspected.
- 3. Key systems are regularly tested.
- 4. Key systems are regularly maintained.
- 5. Key systems are improved when necessary.

**Measurable Elements of FMS.10.1**
- 1. Water quality is monitored regularly.
- 2. Water used in chronic renal dialysis is tested regularly.

**Measurable Elements of FMS.10.2**
- 1. Monitoring data are collected and documented for the medical utility management program.
- 2. Monitoring data are used for purposes of planning and improvement.
Staff Education

**Standard FMS.11**
The organization educates and trains all staff members about their roles in providing a safe and effective patient care facility.

**Standard FMS.11.1**
Staff members are trained and knowledgeable about their roles in the organization's plans for fire safety, security, hazardous materials, and emergencies.

**Standard FMS.11.2**
Staff are trained to operate and to maintain medical equipment and utility systems.

**Standard FMS.11.3**
The organization periodically tests staff knowledge through demonstrations, mock events, and other suitable methods. This testing is then documented.

**Intent of FMS.11 through FMS.11.3**
The organization's staff are the primary source of contact with patients, families, and visitors. Thus, they need to be educated and trained to carry out their roles in identifying and reducing risks, protecting others and themselves, and creating a safe and secure facility. *(Also see FMS.7.2, ME 3)*

Each organization must decide the type and level of training for staff and then carry out and document a program for this training and education. The program can include group instruction, printed educational materials, a component of new staff orientation, or some other mechanism that meets the organization’s needs. The program includes instruction on the processes for reporting potential risks, reporting incidents and injuries, and handling hazardous and other materials that pose risks to themselves and others.

Staff responsible for operating or maintaining medical equipment receive special training. The training can be from the organization, the manufacturer of the equipment, or some other knowledgeable source.

The organization plans a program designed to periodically test staff knowledge on emergency procedures, including fire safety procedures; the response to hazards, such as the spill of a hazardous material; and the use of medical equipment that poses a risk to patients and staff. Knowledge can be tested through a variety of means, such as individual or group demonstrations; the staging of mock events such as an epidemic in the community; the use of written or computer tests; or other means suitable to the knowledge being tested. The organization documents who was tested and the results of the testing.

**Measurable Elements of FMS.11**
- 1. For each component of the organization’s facility management and safety program, there is planned education to ensure that staff members on all shifts can effectively carry out their responsibilities. *(Also see AOP.5.1, ME 5, and AOP6.2, ME 6)*
- 2. The education includes visitors, vendors, contract workers, and others as identified by the organization and multiple shifts of staff.
Measurable Elements of FMS.11.1
- 1. Staff members can describe and/or demonstrate their roles in response to a fire.
- 2. Staff can describe and/or demonstrate actions to eliminate, to minimize, or to report safety, security, and other risks.
- 3. Staff can describe and/or demonstrate precautions, procedures, and participation in the storage, handling, and disposal of medical gases, hazardous waste and materials, and in related emergencies.
- 4. Staff members can describe and/or demonstrate procedures and their roles in internal and community emergencies and disasters.

Measurable Elements of FMS.11.2
- 1. Staff are trained to operate medical equipment and utility systems appropriate to their job requirements.
- 2. Staff are trained to maintain medical equipment and utility systems appropriate to their job requirements.

Measurable Elements of FMS.11.3
- 1. Staff knowledge is tested regarding their roles in maintaining a safe and effective facility.
- 2. Staff training and testing are documented as to who was trained and tested and the results.
Overview

A health care organization needs an appropriate variety of skilled, qualified people to fulfill its mission and to meet patient needs. The organization's leaders work together to identify the number and types of staff needed based on the recommendations from department and service directors.

Recruiting, evaluating, and appointing staff are best accomplished through a coordinated, efficient, and uniform process. It is also essential to document applicant skills, knowledge, education, and previous work experience. It is particularly important to carefully review the credentials of medical and nursing staff, because they are involved in clinical care processes and work directly with patients.

Health care organizations should provide staff with opportunities to learn and to advance personally and professionally. Thus, in-service education and other learning opportunities should be offered to staff.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

SQE.1  Organization leaders define the desired education, skills, knowledge, and other requirements of all staff members.

SQE.2  Organization leaders develop and implement processes for recruiting, evaluating, and appointing staff as well as other related procedures identified by the organization.

SQE.3  The organization uses a defined process to ensure that clinical staff knowledge and skills are consistent with patient needs.

SQE.4  The organization uses a defined process to ensure that nonclinical staff knowledge and skills are consistent with organization needs and the requirements of the position.

SQE.5  There is documented personnel information for each staff member.
A staffing plan for the organization, developed collaboratively by the leaders, identifies the number, types, and desired qualifications of staff.

The staffing plan is reviewed on an ongoing basis and updated as necessary.

Orientation and Education

All clinical and nonclinical staff members are oriented to the organization, the department, or unit to which they are assigned and to their specific job responsibilities at appointment to the staff.

Each staff member receives ongoing in-service and other education and training to maintain or to advance his or her skills and knowledge.

Staff members who provide patient care and other staff identified by the organization are trained and can demonstrate appropriate competence in resuscitative techniques.

The organization provides facilities and time for staff education and training.

Health professional education, when provided within the organization, is guided by the educational parameters defined by the sponsoring academic program.

The organization provides a staff health and safety program.

Medical Staff

Determining Medical Staff Membership

The organization has an effective process for gathering, verifying, and evaluating the credentials (license, education, training, competence, and experience) of those medical staff permitted to provide patient care without supervision.

Leadership makes an informed decision about renewing permission for each medical staff member to continue providing patient care services at least every three years.

The Assignment of Clinical Privileges

The organization has a standardized objective, evidence-based procedure to authorize all medical staff members to admit and to treat patients and to provide other clinical services consistent with their qualifications.

Ongoing Monitoring and Evaluation of Medical Staff Members

The organization uses an ongoing standardized process to evaluate the quality and safety of the patient services provided by each medical staff member.

Nursing Staff

The organization has an effective process to gather, to verify, and to evaluate the nursing staff’s credentials (license, education, training, and experience).

The organization has a standardized procedure to identify job responsibilities and to make clinical work assignments based on the nursing staff member’s credentials and any regulatory requirements.

The organization has a standardized procedure for nursing staff participation in the organization’s quality improvement activities, including evaluating individual performance when indicated.
Other Health Care Practitioners

SQE.15 The organization has a standardized procedure to gather, to verify, and to evaluate other health professional staff members’ credentials (license, education, training, and experience).

SQE.16 The organization has a standardized procedure to identify job responsibilities and to make clinical work assignments based on other health professional staff members’ credentials and any regulatory requirements.

SQE.17 The organization has an effective process for other health professional staff members’ participation in the organization’s quality improvement activities.
Standards, Intents, and Measurable Elements

Planning

Standard SQE.1
Organization leaders define the desired education, skills, knowledge, and other requirements of all staff members.

Intent of SQE.1
The organization's leaders define the particular requirements of staff positions. They define the desired education, skills, knowledge, and any other requirements as part of projecting staffing to meet the patients' needs. Leaders use the following factors to project staffing needs:

- The organization's mission
- The mix of patients served by the organization and the complexity and severity of their needs
- The services provided by the organization
- The technology used in patient care

The organization complies with laws and regulations that define desired education levels, skills, or other requirements of individual staff members or that define staffing numbers or a mix of staff for the organization. The leaders use the organization's mission and patients' needs in addition to requirements of laws and regulations.

Measurable Elements of SQE.1
1. The organization's mission, mix of patients, services, and technology are used in planning.
2. The desired education, skills, and knowledge are defined for staff.
3. Applicable laws and regulations are incorporated into the planning.

Standard SQE.1.1
Each staff member's responsibilities are defined in a current job description.

Intent of SQE.1.1
Individual staff members who are not licensed to practice independently have their responsibilities defined in current job descriptions. The job descriptions are the basis for their assignments, orientation to their work, and evaluation of how well they fulfill job responsibilities.

Job descriptions are also needed for health professionals when:

a) The individual serves in primarily a managerial role, such as a department manager, or in dual clinical and managerial roles, with the managerial responsibilities identified in a job description;

b) The individual has some clinical responsibilities for which he or she has not been authorized to practice independently, such as an independent practitioner learning a new role or new skills (privileging under SQE.10 is an alternative);

c) The individual is in an educational program and under supervision, and the academic program identifies, for each stage or level of training, what can be done independently and what must be under supervision. The program description can serve as the job description in such cases; and
d) The individual is permitted to temporarily provide services in the organization. (Privileging under SQE.10 is an alternative.)

When an organization uses national or generic job descriptions (for example, a job description for a “nurse”) it is necessary to augment this type of job description with specific job responsibilities for the types of nurses (for example, intensive care nurse, pediatric nurse, or operating theatre nurse, among others).

For those permitted by law and the organization to practice independently, there is a process to identify and to authorize the individual to practice based on education, training, and experience. This process is identified in SQE.9 for medical staff members and in SQE.12 for nursing staff members.

The requirements of this standard apply to all types of “staff” who require job descriptions (for example, full-time, part-time, employed, voluntary, or temporary).

Measurable Elements of SQE.1.1
- 1. Each staff member not permitted to practice independently has a job description. (Also see AOP.3, ME 5)
- 2. Those individuals identified in a) through d) in the intent statement, when present in the organization, have job descriptions appropriate to their activities and responsibilities or have been privileged if noted as an alternative. (Also see AOP.3, ME 5)
- 3. Job descriptions are current according to hospital policy.

Standard SQE.2
Organization leaders develop and implement processes for recruiting, evaluating, and appointing staff as well as other related procedures identified by the organization.

Intent of SQE.2
The organization provides an efficient, coordinated, or centralized process for
- recruiting individuals for available positions;
- evaluating the training, skills, and knowledge of candidates; and
- appointing individuals to the organization’s staff.

If the process is not centralized, similar criteria, processes, and forms result in a uniform process across the organization. Department and service directors participate by recommending the number and qualifications of staff needed to provide clinical services to patients, as well as nonclinical support functions, and to fulfill any teaching or other departmental responsibilities. Department and service directors also help make decisions about individuals to be appointed to the staff. Thus, the standards in this chapter complement the Governance, Leadership, and Direction standards that describe a department or service director’s responsibilities.

Measurable Elements of SQE.2
- 1. There is a process in place to recruit staff. (Also see GLD.3.5, ME 1)
- 2. There is a process in place to evaluate the qualifications of new staff.
- 3. There is a process in place to appoint individuals to the staff.
- 4. The process is uniform across the organization.
- 5. The process is implemented.
Standard SQE.3
The organization uses a defined process to ensure that clinical staff knowledge and skills are consistent with patient needs.

Intent of SQE.3
Qualified staff members are hired by the organization through a process that matches the requirements of the position with the qualifications of the prospective staff member. This process also ensures that the staff member’s skills are initially and over time consistent with the needs of patients.

For the organization’s health professional staff who do not practice under job descriptions, the process is identified in SQE.9 through SQE.11.

For clinical staff under job descriptions, the process includes

- An initial evaluation to ensure that he or she can actually assume those responsibilities in the job description. This evaluation is carried out before or at the time of starting to perform work responsibilities. The organization may have a “probationary” or other period during which the clinical staff member is closely supervised and evaluated, or the process may be less formal. Whatever the process, the organization ensures that staff providing high-risk services or providing care to high-risk patients are evaluated at the time they begin providing care. This evaluation of necessary skills and knowledge and desired work behaviors is carried out by the department or service to which the staff member is assigned.

- The organization then defines the process for and the frequency of the ongoing evaluation of staff abilities.

Ongoing evaluation ensures that training occurs when needed and that the staff member is able to assume new or changed responsibilities. Although such evaluation is best carried out in an ongoing manner, there is at least one documented evaluation of each clinical staff working under a job description each year. (The evaluation of those permitted to work independently is found at SQE.11.)

Measurable Elements of SQE.3
- 1. The organization uses a defined process to match clinical staff knowledge and skills with patient needs. (Also see COP.6, ME 4)
- 2. New clinical staff members are evaluated at the time they begin their work responsibilities.
- 3. The department or service to which the individual is assigned conducts the evaluation.
- 4. The organization defines the frequency of ongoing clinical staff evaluation.
- 5. There is at least one documented evaluation of each clinical staff member working under a job description each year or more frequently as defined by the organization.

Standard SQE.4
The organization uses a defined process to ensure that nonclinical staff knowledge and skills are consistent with organization needs and the requirements of the position.

Intent of SQE.4
The organization seeks staff that can competently fill the requirement of nonclinical positions. The supervisor of the staff member provides an orientation to the position and ensures that the worker can fulfill the responsibilities of the job description. The staff member receives the required level of supervision and on a periodic basis is evaluated to ensure continuing competence in the position.
**Measurable Elements of SQE.4**
- 1. The organization uses a defined process to match nonclinical staff knowledge and skills with the requirements of the position. *(Also see AOP.5.2, MEs 2 and 3, and AOP.6.3, MEs 2 and 3)*
- 2. New nonclinical staff are evaluated at the time they begin their work responsibilities.
- 3. The department or service to which the individual is assigned conducts the evaluation.
- 4. The organization defines the frequency of ongoing nonclinical staff evaluation.
- 5. There is at least one documented evaluation of nonclinical staff members each year or more frequently as defined by the organization.

**Standard SQE.5**
There is documented personnel information for each staff member.

**Intent of SQE.5**
Each staff member in the organization has a record(s) with information about his or her qualifications, results of evaluations, and work history. The process and records for clinical health profession staff, including those permitted by law and the organization to work independently, are described in SQE.9 for medical staff, SQE.12 for nursing staff, and SQE.15 for other health professionals. The records are standardized and kept current according to organization policy.

**Measurable Elements of SQE.5**
- 1. Personnel information is maintained for each staff member.
- 2. Personnel files contain the qualifications of the staff member.
- 3. Personnel files contain the job description of the staff member when applicable.
- 4. Personnel files contain the work history of the staff member.
- 5. Personnel files contain the results of evaluations.
- 6. Personnel files contain a record of in-service education attended by the staff member.
- 7. Personnel files are standardized and kept current.

**Standard SQE.6**
A staffing plan for the organization, developed collaboratively by the leaders, identifies the number, types, and desired qualifications of staff.

**Standard SQE.6.1**
The staffing plan is reviewed on an ongoing basis and updated as necessary.

**Intent of SQE.6 and SQE.6.1**
Appropriate and adequate staffing is critical to patient care as well as to all teaching and research activities in which the organization may be engaged. Staff planning is carried out by the organization's leaders. The planning process uses recognized methods for determining levels of staffing. For example, a patient acuity system is used to determine the number of licensed nurses with pediatric intensive care experience to staff a 10-bed pediatric intensive care unit.
The plan is written and identifies the number and types of required staff and the skills, knowledge, and other requirements needed in each department and service. The plan addresses
- the reassignment of staff from one department or service to another in response to changing patient need or staff shortages;
- the consideration of staff requests for reassignment based on cultural values or religious beliefs; and
- the policy and procedure for transferring responsibility from one individual to another (for example, from a physician to a nurse) when the responsibility would fall outside such an individual’s normal responsibility area.

Planned and actual staffing is monitored on an ongoing basis, and the plan is updated as necessary. When monitored on a department and service level, there is a collaborative process for the organization’s leaders to update the overall plan.

**Measurable Elements of SQE.6**

- 1. There is a written plan for staffing the organization.
- 2. The leaders developed the plan collaboratively.
- 3. The number, types, and desired qualifications of staff are identified in the plan using a recognized staffing method. (*Also see* AOP.6.3, ME 5)
- 4. The plan addresses the assignment and reassignment of staff.
- 5. The plan addresses the transfer of responsibility from one individual to another.

**Measurable Elements of SQE.6.1**

- 1. The effectiveness of the staffing plan is monitored on an ongoing basis.
- 2. The plan is revised and updated when necessary.

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**Orientation and Education**

**Standard SQE.7**

All clinical and nonclinical staff members are oriented to the organization, the department, or unit to which they are assigned and to their specific job responsibilities at appointment to the staff.

**Intent of SQE.7**

The decision to appoint an individual to the staff of an organization sets several processes in motion. To perform well, a new staff member, no matter what his or her employment status, needs to understand the entire organization and how his or her specific clinical or nonclinical responsibilities contribute to the organization’s mission. This is accomplished through a general orientation to the organization and his or her role in the organization and a specific orientation to the job responsibilities of his or her position. The orientation includes the reporting of medical errors, infection prevention and control practices, the organization’s policies on telephone medication orders, and so on. (*Also see* GLD.5.4, MEs 1 and 2, and PCI.11, ME 4)

Contract workers, volunteers, and students/trainees are also oriented to the organization and their specific assignments or responsibilities, such as patient safety and infection prevention and control.

**Measurable Elements of SQE.7**

- 1. New clinical and nonclinical staff members are oriented to the organization, to the department or unit to which they are assigned, and to their job responsibilities and any specific assignments.
2. Contract workers are oriented to the organization, to the department or unit to which they are assigned, and to their job responsibilities and any specific assignments.

3. Volunteers are oriented to the organization and assigned responsibilities.

4. Students/trainees are oriented to the organization and assigned responsibilities.

**Standard SQE.8**

Each staff member receives ongoing in-service and other education and training to maintain or to advance his or her skills and knowledge.

**Intent of SQE.8**

The organization collects data from several sources to understand its staff’s ongoing education needs. The results of quality and safety measurement activities are one source of information to identify staff education needs. Also, monitoring data from the facility management program, the introduction of new technology, skill and knowledge areas identified through the review of job performance, new clinical procedures, and future plans to provide new services represent such sources of data. The organization has a process to gather and to integrate data from sources to plan the staff education program. Also, the organization determines which staff, such as health professional staff, are required to obtain continuing education to maintain their credentials and how the education of these staff will be monitored and documented. (*Also see GLD.3.5, ME 3*)

To maintain acceptable staff performance, to teach new skills, and to provide training on new equipment and procedures, the organization provides or arranges for facilities, educators, and time for ongoing in-service and other education. This education is relevant to each staff member as well as to the continuing advancement of the organization in meeting patient needs. For example, medical staff members may receive education on infection prevention and control, advances in medical practice, or new technology. Each staff member’s educational achievements are documented in his or her personnel record.

In addition, each organization develops and implements a staff health and safety program appropriate for the health needs of the staff and safety concerns of the organization and staff.

**Measurable Elements of SQE.8**

1. The organization uses various sources of data and information, including the results of quality and safety measurement activities, to identify staff education needs. (*Also see AOP.5.1, ME 6, and AOP.6.2, ME 7*)

2. Education programs are planned based on these data and information.

3. Organization staff are provided ongoing in-service education and training. (*Also see AOP.5.1, ME 6, and AOP.6.2, ME 7*)

4. The education is relevant to each staff member’s ability to meet patient needs and/or continuing education requirements. (*Also see AOP.5.1, ME 6, and AOP.6.2, ME 7*)

**Standard SQE.8.1**

Staff members who provide patient care and other staff identified by the organization are trained and can demonstrate appropriate competence in resuscitative techniques.

**Intent of SQE.8.1**

Each organization identifies those staff to be trained in resuscitative techniques and the level of training (basic or advanced) appropriate to their roles in the organization.
The appropriate level of training for those identified is repeated based on the requirements and/or time frames identified by a recognized training program, or every two years if a recognized training program is not used. There is evidence to show if each staff member attending the training actually achieved the desired competency level.

**Measurable Elements of SQE.8.1**
- 1. Staff members who provide patient care and other staff identified by the organization to be trained in cardiac life support are identified.
- 2. The appropriate level of training is provided with sufficient frequency to meet staff needs.
- 3. There is evidence to show if a staff member passed the training.
- 4. The desired level of training for each individual is repeated based on the requirements and/or time frames established by a recognized training program, or every two years if a recognized training program is not used.

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**Standard SQE.8.2**
The organization provides facilities and time for staff education and training.

**Intent of SQE.8.2**
The organization's leaders support the commitment to ongoing staff in-service education by making available space, equipment, and time for education and training programs. The availability of current scientific information supports the education and training.

The education and training can take place in a centralized location or in several smaller learning and skill development locations throughout the facility. The education can be offered once to all or repeated for staff on a shift-by-shift basis to minimize the impact on patient care activities.

**Measurable Elements of SQE.8.2**
- 1. The organization provides facilities and equipment for staff in-service education and training.
- 2. The organization provides adequate time for all staff to participate in relevant education and training opportunities.

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**Standard SQE.8.3**
Health professional education, when provided within the organization, is guided by the educational parameters defined by the sponsoring academic program.

**Intent of SQE.8.3**
Frequently health care organizations are the clinical setting for medical, nursing, other health care practitioners, and other student training. When the organization participates in such training programs, the organization
- provides a mechanism(s) for oversight of the program(s);
- obtains and accepts the parameters of the sponsoring academic program;
- has a complete record of all trainees within the organization;
- has documentation of the enrollment status, licensure or certifications achieved, and academic classification of the trainees;
- understands and provides the required level of supervision for each type and level of trainee; and
- integrates trainees into the organization's orientation, quality, patient safety, infection prevention and control, and other programs.
**Measurable Elements of SQE.8.3**

- 1. The organization provides a mechanism(s) for oversight of the training program(s).
- 2. The organization obtains and accepts the parameters of the sponsoring academic program.
- 3. The organization has a complete record of all trainees within the organization.
- 4. The organization has documentation of the enrollment status, licensure or certifications achieved, and academic classification of the trainees.
- 5. The organization understands and provides the required level of supervision for each type and level of trainee.
- 6. The organization integrates trainees into its orientation, quality, patient safety, infection prevention and control, and other programs.

**Standard SQE.8.4**

The organization provides a staff health and safety program.

**Intent of SQE.8.4**

The health and safety of an organization’s staff are important to maintain staff health, satisfaction, and productivity. Staff safety is also a part of the organization’s quality and patient safety program. How an organization orients and trains staff, provides a safe workplace, maintains biomedical and other equipment, prevents or controls health care-associated infections, and many other factors determine the health and well-being of staff. *(Also see PCI.5.1, ME 2)*

A staff health and safety program can be located within the organization or be integrated into external programs. Whatever the staffing and structure of the program, staff understand how to report, to be treated for, and to receive counseling and follow-up for such injuries as needlesticks, exposure to infectious diseases, the identification of risks and hazardous conditions in the facility, and other health and safety matters. The program may also provide for initial employment health screening, periodic preventive immunizations and examinations, treatment for common work-related conditions, such as back injuries, or more urgent injuries.

The design of the program includes staff input and draws upon the organization’s clinical resources as well as those in the community.

**Measurable Elements of SQE.8.4**

- 1. The organization’s leaders and staff plan the health and safety program.
- 2. The program is responsive to urgent and nonurgent staff needs through direct treatment and referral.
- 3. Program data informs the organization’s quality and safety program.
- 4. There is a policy on the provision of staff vaccinations and immunizations.
- 5. There is a policy on the evaluation, counseling, and follow-up of staff exposed to infectious diseases that is coordinated with the infection prevention and control program. *(Also see PCI.5, ME 2)*
Medical Staff
Determining Medical Staff Membership

Standard SQE.9
The organization has an effective process for gathering, verifying, and evaluating the credentials (license, education, training, competence, and experience) of those medical staff permitted to provide patient care without supervision.

Standard SQE.9.1
Leadership makes an informed decision about renewing permission for each medical staff member to continue providing patient care services at least every three years.

Intent of SQE.9 and SQE.9.1
Medical staff is defined as all physicians, dentists, and other professionals who are licensed to practice independently (without supervision) and who provide preventive, curative, restorative, surgical, rehabilitative, or other medical or dental services to patients; or who provide interpretative services for patients, such as pathology, radiology, or laboratory services, regardless of the organization’s classification of appointment, employment status, contract, or other arrangements with the individual to provide such patient care services. These individuals represent those primarily responsible for patient care and care outcomes. Thus, the organization has the highest level of accountability to ensure that each of these practitioners is qualified to provide safe and effective care and treatment to patients.

The organization assumes this accountability by
- understanding the applicable laws and regulations that identify those permitted to work independently and confirming that the organization will also permit such practitioners to work independently within the organization;
- gathering all available credentials on the practitioner including, at least, evidence of education and training, evidence of current licensure, evidence of current competence through information from other organizations in which the practitioner practiced, and also letters of recommendation and/or other information the organization may require, such as health history, pictures, among others; and
- verification of the essential information, such as current registry or licensure, especially when such documents are periodically renewed, and any certifications and evidence of completion of postgraduate education.

The organization needs to make every effort to verify essential information, even when the education took place in another country and a significant time ago. Secure Web sites, documented phone confirmation from the source, written confirmation, and third parties, such as a designated, official governmental or nongovernmental agency, can be used.

The three following situations are acceptable substitutes for an organization performing primary source verification of credentials:
1. Applicable to hospitals overseen directly by governmental bodies, the government’s verification process, supported by the availability of transparent governmental regulations about primary source verification, plus government licensure and the granting of specific status (for example, consultant, specialist, and others) acceptable.
2. Applicable to all hospitals, the existence of an affiliated hospital that has already conducted primary source verification of the candidate, that verification is acceptable as long as the affiliated hospital has current Joint Commission International (JCI) accreditation with “full compliance” on its verification process found in SQE.9, ME 2.

3. Applicable to all hospitals, the credentials have been verified by an independent third party, such as a designated, official governmental or nongovernmental agency, as long as the following conditions apply: Any hospital that bases its decisions in part on information from a designated, official governmental or nongovernmental agency should have confidence in the completeness, accuracy, and timeliness of that information. To achieve this level of confidence in the information, the hospital should evaluate the agency providing the information initially and then periodically thereafter. The principles that guide such an evaluation include the following:

- The agency makes known to the user which data and information it can provide.
- The agency provides documentation to the user describing how its data collection, information and development, and verification process(es) are performed.
- The user and agency agree on the format for transmission of an individual's credentials information from the agency.
- The user can easily discern which information, transmitted by the agency, is from a primary source and which is not.
- When the agency transmits information that can become out of date, it provides the date on which the information was last updated from the primary source.
- The agency certifies that the information transmitted to the user accurately presents the information obtained by it.
- The user can discern whether the information transmitted by the agency from a primary source is all the primary source information in the agency's possession pertinent to a given item and, if not, where additional information can be obtained.
- When necessary, the user can engage the agency's quality control processes to resolve concerns about transmission errors, inconsistencies, or other data issues that may be identified from time to time.
- The user has a formal arrangement with the agency for communication of any changes in credentialing information.

Standards compliance requires that verification of an individual's credentials be from the primary source. For purposes of phasing in this requirement, primary source verification is required for new practitioners beginning four months prior to initial accreditation survey. All other practitioners must have primary source verification by the time of the organization's triennial accreditation survey.

This is accomplished over the three-year period, according to a plan that places priority on the verification of the credentials of active practitioners providing high-risk services.

Note: This requirement refers only to the “verification” of credentials. All medical practitioners have their credentials gathered and reviewed, and their privileges granted. There is no phasing in of this process. (Also see SQE.9 ME 3)

When verification is not possible, such as with the loss of records in a disaster, this is documented.

The organization gathers and maintains a file of each practitioner's credentials. The process applies to all types and levels of staff (employed, honorary, contract, and private community staff members).

The organization reviews the files of each medical staff member on initial appointment and at least every three years to ensure that the medical staff member is currently licensed, is not compromised by disciplinary actions of licensing and certification agencies, has sufficient documentation for seeking new or expanded privileges or duties in the organization, and is physically and mentally able to provide patient care and treatment
without supervision. Organization policy identifies the individuals or mechanism accountable for this review, any criteria used to make decisions, and how decisions will be documented.

**Measurable Elements of SQE.9**

- 1. Those permitted by laws, regulations, and the organization to provide patient care without supervision are identified.
- 2. Required credentials (education, licensure, registration, among others) as determined by regulation and organization policy for each medical staff member are copied by the organization and maintained in the personnel file or in a separate credential file for each medical staff member.
- 3. All credentials (education, licensure, registration, among others) are verified with the source that issued the credential before the individual begins providing services to or for patients.
- 4. All credentials on file (education, licensure, registration, among others) are current and updated as required.
- 5. At initial appointment, an informed determination is made about the current qualification of the individual to provide patient care services.

**Measurable Elements of SQE.9.1**

- 1. There is a process described in policy for the review of each medical staff member’s credential file at uniform intervals at least once every three years.
- 2. Designated individuals make an official decision to renew permission for each medical staff member to continue to provide patient care services in the organization.
- 3. The renewal decision is documented in the staff member’s credential file.

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### Medical Staff

**The Assignment of Clinical Privileges**

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**Standard SQE.10**

The organization has a standardized objective, evidence-based procedure to authorize all medical staff members to admit and to treat patients and to provide other clinical services consistent with their qualifications.

**Intent of SQE.10**

The determination of the current clinical competence and making a decision about what clinical services the medical staff member will be permitted to perform, often called “privileging,” is the most critical determination an organization will make to protect the safety of patients and to advance the quality of its clinical services.

Privileging decisions are made as follows:

1. The organization chooses a standardized process to identify the clinical services for each individual. On initial appointment to the organization, the credentials identified in SQE.9 will be the primary basis for the determination of privileges. If available, letters from previous places of practice, from professional peers, awards, and other sources of information are also considered.

2. On reappointment, every three years, the organization seeks and uses information in the following general competency areas of clinical practitioners:
   a) Patient care—the practitioner provides patient care that is compassionate, appropriate, and effective for health promotion, disease prevention, treatment of disease, and care at the end of life.
b) Medical/clinical knowledge—of established and evolving biomedical, clinical, and social sciences, and the application of knowledge to patient care and the education of others.

c) Practice-based learning and improvement—using scientific evidence and methods to investigate, to evaluate, and to improve patient care practices.

d) Interpersonal and communication skills—that enable them to establish and to maintain professional relationships with patients, families, and other members of health care teams.

e) Professionalism—reflected in a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward patients, their profession, and society.

f) System-based practices—through the understanding of the contexts and systems in which health care is provided.

There is a standardized objective and evidence-based procedure to turn all this information into a decision regarding the privileges for a practitioner. The procedure is documented in policies and is followed. The medical staff leaders can demonstrate how the procedure was effective in the initial appointment process and in the reappointment process.

The clinical privileges, once determined or redetermined, are made available by hard copy, electronic, or other means to those individuals or locations (for example, operating room, emergency department) in the organization in which the medical staff member will provide services. This information will help ensure that medical staff members practice within the bounds of their competency and authorized privileges. The information is periodically updated.

**Measurable Elements of SQE.10**

1. The organization uses a standardized process that is documented in official organization policy for granting privileges to each medical staff member to provide services on initial appointment and on reappointment. *(Also see AOP.3, ME 5, and MMU.4.2, ME 2)*

2. The decision to grant reappointment to provide patient services is guided by items a) through f) in the intent statement and the annual performance review of the practitioner.

3. The patient services to be provided by each medical staff member are clearly delineated and communicated by organization leaders across the organization and to the medical staff member.

4. Each medical staff member provides only those services that have been specifically permitted by the organization.

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**Medical Staff**

**Ongoing Monitoring and Evaluation of Medical Staff Members**

**Standard SQE.11**

The organization uses an ongoing standardized process to evaluate the quality and safety of the patient services provided by each medical staff member.

**Intent of SQE.11**

There is a standardized process to, at least annually, gather relevant data on each practitioner for review by the relevant department head or medical staff review body. Such a review allows the organization to identify professional practice trends that impact quality of care and patient safety. Criteria used in the ongoing professional practice evaluation include, but are not limited to, the following:
Review of operative and other clinical procedures performed and their outcomes
Pattern of blood and pharmaceutical usage
Requests for tests and procedures
Length-of-stay patterns
Morbidity and mortality data
Practitioner’s use of consultation and specialists
Other relevant criteria as determined by the organization

This information may be acquired through the following:

- Periodic chart review
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Clinical quality monitoring
- Discussion with peers and other staff

The appraisal of the activities of senior medical staff and department heads is conducted by an appropriate internal or external authority.

The ongoing professional practice evaluation process is objective and evidence based. The result of the review process can be no change in the medical staff member’s responsibilities, expansion of responsibilities, limitation of responsibilities, a period of counseling and oversight, or other appropriate action. At any time during the year, when evidence of questionable or poor performance arises, there is a review, and appropriate actions are taken. The results of reviews, actions taken, and any impact on privileges are documented in the medical staff member’s credentials or other file.

**Measurable Elements of SQE.11**

- 1. An ongoing professional practice evaluation of the quality and safety of patient services provided by each medical staff member is reviewed and communicated to the medical staff member at least annually. *(Also see QPS.1.1, ME 1)*
- 2. The ongoing professional practice evaluation and annual review of each medical staff member are accomplished by a uniform process that is defined by organization policy.
- 3. The evaluation considers and uses comparative data in a proactive manner such as benchmarking to literature-based medicine.
- 4. The evaluation considers and uses the conclusions of in-depth analysis of known complications as applicable. *(Also see QPS.5; QPS.6; and GLD.3.4, ME 3)*
- 5. Information from the professional practice evaluation process is documented in the medical staff member’s credentials file and other relevant files.

**Nursing Staff**

**Standard SQE.12**

The organization has an effective process to gather, to verify, and to evaluate the nursing staff’s credentials (license, education, training, and experience).

**Intent of SQE.12**

The organization needs to ensure that it has a qualified nursing staff that appropriately matches its mission, resources, and patient needs. The nursing staff are responsible for providing direct patient care. In addition,
nursing care contributes to the overall patient outcomes. The organization must ensure that nurses are qualified to provide nursing care and must specify the types of care they are permitted to provide if not identified in laws or regulations. The organization ensures that each nurse is qualified to provide safe and effective care and treatment to patients by

- understanding the applicable laws and regulations that apply to nurses and nursing practice;
- gathering all available credentials on each nurse, including at least
  — evidence of education and training;
  — evidence of current licensure;
  — evidence of current competence through information from other sources in which the nurse was employed; and
  — letters of recommendation and/or other information the organization may require, such as health history, pictures, among others; and
- verification of the essential information, such as current registry or licensure, especially when such documents are periodically renewed, and any certifications and evidence of completion of specialized or advanced education.

The organization needs to make every effort to verify essential information, even when the education took place in another country and a significant time ago. Secure Web sites, documented phone confirmation from the source, written confirmation, and third parties, such as a designated, official governmental or nongovernmental agency, can be used.

The situations described for medical staff in the intent statement of SQE.9 are considered acceptable substitutes for an organization performing primary source verification of nurse credentials.

Standards compliance requires that primary source verification is carried out for

- new nurse applicants beginning four months prior to initial accreditation survey; and
- current employed nurses during a period of three years to ensure that verification has been accomplished by the organization's triennial accreditation survey. This is accomplished according to a plan that places priority on the verification of the credentials of nurses providing high-risk services, such as in the operating theatre, emergency department, or intensive care unit.

When verification is not possible, such as with the loss of records in a disaster, this is documented.

The organization has a process that ensures that the credentials of each contract nurse have also been gathered, verified, and reviewed to ensure current clinical competence prior to assignment.

The organization gathers and maintains a file of each nurse's credentials. The files contain current licenses when regulations require periodic renewal. There is documentation of training related to any additional competencies.

**Measurable Elements of SQE.12**

- 1. The organization has a standardized procedure to gather the credentials of each nursing staff member.
- 2. Licensure, education, training, and experience are documented.
- 3. Such information is verified from the original source according to the parameters found in the intent statement of SQE.9.
- 4. There is a record maintained of the credentials of every nursing staff member.
- 5. The organization has a process to ensure that the credentials of contract nurses are valid and complete prior to assignment.
- 6. The organization has a process to ensure that nurses who are not employees of the organization, but accompany private physicians and provide services to the organization's patients have valid credentials.
Standard SQE.13
The organization has a standardized procedure to identify job responsibilities and to make clinical work assignments based on the nursing staff member’s credentials and any regulatory requirements.

Intent of SQE.13
Review of the qualifications of the nurse staff member provides the basis for assigning job responsibilities and clinical care activities. This assignment may be described in a job description or described in other ways or documents. Assignments made by the organization are consistent with any applicable laws and regulations regarding nursing responsibilities and clinical care. (Also see MMU.6, ME 3)

Measurable Elements of SQE.13
- 1. Licensure, education, training, and experience of a nursing staff member are used to make clinical work assignments.
- 2. The process takes into account relevant laws and regulations.

Standard SQE.14
The organization has a standardized procedure for nursing staff participation in the organization’s quality improvement activities, including evaluating individual performance when indicated.

Intent of SQE.14
The nursing staff’s essential clinical role requires them to actively participate in the organization’s clinical quality improvement program. If at any point during clinical quality measurement, evaluation, and improvement, a nursing staff member’s performance is in question, the organization has a process to evaluate that individual’s performance. The results of reviews, actions taken, and any impact on job responsibilities are documented in the nurse’s credentials or other file.

Measurable Elements of SQE.14
- 1. Nursing staff participate in the organization’s quality improvement activities. (Also see QPS.1.1, ME 1)
- 2. The performance of individual nursing staff members is reviewed when indicated by the findings of quality improvement activities.
- 3. Appropriate information from the review process is documented in the nurse’s credentials or other file.

Other Health Care Practitioners

Standard SQE.15
The organization has a standardized procedure to gather, to verify, and to evaluate other health professional staff members’ credentials (license, education, training, and experience).

Intent of SQE.15
Health care organizations employ or may permit a variety of other health professionals to provide care and services to their patients or to participate in patient care processes. For example, these professionals include nurse midwives, surgical assistants, emergency medical care specialists, pharmacists, and pharmacy
technicians. In some countries or cultures, this group also includes traditional healers or those who provide alternative services or services that complement traditional medical practice (for example, acupuncture, herbal medicine). Often, these individuals do not actually practice in the organization; instead, they refer to the organization or provide continuing or follow-up care for patients in the community. Many of these professionals complete formal training programs and receive licenses or certificates or are registered with local or national authorities. Others may complete less-formal apprentice programs or other supervised experiences.

For those other health professionals permitted to work or to practice in the health care organization, the organization is responsible for gathering and verifying their credentials. The organization must ensure that other health professional staff are qualified to provide care and treatments and must specify the types of care and treatment they are permitted to provide if not identified in laws or regulations. The organization ensures that other health professionals are qualified to provide safe and effective care and treatment to patients by

- understanding the applicable laws and regulations that apply to such practitioners;
- gathering all available credentials on each individual, including at least evidence of education and training, evidence of current licensure or certification when required; and
- verification of the essential information, such as current registry, licensure, or certification.

The organization needs to make every effort to verify essential information relevant to the individual’s intended responsibilities, even when the education took place in another country and a significant time ago. Secure Web sites, documented phone confirmation from the source, written confirmation, and third parties, such as a designated, official governmental or nongovernmental agency, can be used.

The situations described for medical staff in the intent statement of SQE.9 are acceptable substitutes for an organization performing primary source verification for the credentials of other health professional staff.

Standards compliance requires that primary source verification is carried out for

- new applicants beginning four months prior to initial accreditation survey; and
- current employed health professionals during a period of three years to ensure that verification has been accomplished by the organization’s triennial accreditation survey.

When there is no required formal education process, licensure, or registry process or other credential or evidence of competency, this is documented in the individual’s record. When verification is not possible, such as with the loss of records in a disaster, this is documented in the individual’s record.

The organization gathers and maintains a file of each health professional’s credentials. The files contain current licenses or registry when regulations require periodic renewal.

**Measurable Elements of SQE.15**

- 1. The organization has a standardized procedure to gather the credentials of each health professional staff member.
- 2. Licensure, education, training, and experience are documented when relevant.
- 3. Such information is verified from the original source according to the parameters found in the intent statement of SQE.9.
- 4. There is a record maintained on other health professional staff members.
- 5. The record contains copies of any required license, certification, or registration.
- 6. The organization has a process to ensure that other staff who are not employees of the organization but accompany private physicians and provide services to the organization’s patients have valid credentials that are comparable to the organization’s requirement for credentials.
Standard SQE.16
The organization has a standardized procedure to identify job responsibilities and to make clinical work assignments based on other health professional staff members’ credentials and any regulatory requirements.

Standard SQE.17
The organization has an effective process for other health professional staff members’ participation in the organization’s quality improvement activities.

Intent of SQE.16 and SQE.17
The organization is responsible for identifying the types of activities or range of services these individuals will provide in the organization. This can be accomplished through agreements, job assignments, job descriptions, or other methods. In addition, the organization defines the level of supervision (consistent with existing laws and regulations), if any, for these professionals.

Other health professionals are included in the organization’s quality management and improvement program.

Measurable Elements of SQE.16
- 1. Licensure, education, training, and experience of other health professional staff members are used to make clinical work assignments.
- 2. The process takes into account relevant laws and regulations.

Measurable Elements of SQE.17
- 1. Other health professional staff participate in the organization’s quality improvement activities. (Also see QPS.1.1, ME 1)
- 2. The performance of other health professional staff members is reviewed when indicated by the findings of quality improvement activities.
- 3. Appropriate information from the review process is documented in the health professional’s file.
Overview

Providing patient care is a complex endeavor that is highly dependent on the communication of information. This communication is to and with the community, patients and their families, and other health professionals. Failures in communication are one of the most common root causes of patient safety incidents.

To provide, coordinate, and integrate services, health care organizations rely on information about the science of care, individual patients, care provided, results of care, and their own performance. Like human, material, and financial resources, information is a resource that must be managed effectively by the organization’s leaders. Every organization seeks to obtain, to manage, and to use information to improve patient outcomes as well as individual and overall organization performance.

Over time, organizations become more effective in
- identifying information needs;
- designing an information management system;
- defining and capturing data and information;
- analyzing data and transforming it into information;
- transmitting and reporting data and information; and
- integrating and using information.

Although computerization and other technologies improve efficiency, the principles of good information management apply to all methods, whether paper based or electronic. These standards are designed to be equally compatible with noncomputerized systems and future technologies.
Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

Communication with the Community

MCI.1 The organization communicates with its community to facilitate access to care and access to information about its patient care services.

Communication with Patients and Families

MCI.2 The organization informs patients and families about its care and services and how to access those services.

MCI.3 Patient and family communication and education are provided in an understandable format and language.

Communication Between Practitioners Within and Outside of the Organization

MCI.4 Communication is effective throughout the organization.

MCI.5 The leaders ensure that there is effective communication and coordination among those individuals and departments responsible for providing clinical services.

MCI.6 Information about the patient's care and response to care is communicated among medical, nursing, and other health care practitioners during each staffing shift and between shifts.

MCI.7 The patient's record(s) is available to the health care practitioners to facilitate the communication of essential information.

MCI.8 Information related to the patient's care is transferred with the patient.

Leadership and Planning

MCI.9 The organization plans and designs information management processes to meet internal and external information needs.

MCI.10 Information privacy and confidentiality are maintained.

MCI.11 Information security, including data integrity, is maintained.

MCI.12 The organization has a policy on the retention time of records, data, and information.

MCI.13 The organization uses standardized diagnosis codes, procedure codes, symbols, abbreviations, and definitions.

MCI.14 The data and information needs of those in and outside the organization are met on a timely basis in a format that meets user expectations and with the desired frequency.

MCI.15 Appropriate clinical and managerial staff participate in selecting, integrating, and using information management technology.

MCI.16 Records and information are protected from loss, destruction, tampering, and unauthorized access or use.
MCI.17 Decision makers and other appropriate staff members are educated and trained in the principles of information management.

MCI.18 A written policy or protocol defines the requirements for development and maintenance of internal policies and procedures and a process for managing external policies and procedures.

Patient Clinical Record
MCI.19 The organization initiates and maintains a clinical record for every patient assessed or treated.

MCI.19.1 The clinical record contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment, to document the course and results of treatment, and to promote continuity of care among health care practitioners.

MCI.19.1.1 The clinical record of every patient receiving emergency care includes the time of arrival, the conclusions at termination of treatment, the patient’s condition at discharge, and follow-up care instructions.

MCI.19.2 Organization policy identifies those authorized to make entries in the patient clinical record and determines the record’s content and format.

MCI.19.3 Every patient clinical record entry identifies its author and when the entry was made in the record.

MCI.19.4 As part of its performance improvement activities, the organization regularly assesses patient clinical record content and the completeness of patient clinical records.

Aggregate Data and Information
MCI.20 Aggregate data and information support patient care, organization management, and the quality management program.

MCI.20.1 The organization has a process to aggregate data and has determined what data and information are to be regularly aggregated to meet the needs of clinical and managerial staff in the organization and agencies outside the organization.

MCI.20.2 The organization has a process for using or participating in external databases.

MCI.21 The organization supports patient care, education, research, and management with timely information from current sources.
Standards, Intents, and Measurable Elements

Communication with the Community

Standard MCI.1
The organization communicates with its community to facilitate access to care and access to information about its patient care services.

Intent of MCI.1
Health care organizations define their communities and patient populations and plan ongoing communication with those key groups. The communications may be directly to individuals or through public media and through agencies within the community or third parties. The types of information communicated include:
- information on services, hours of operation, and the process to obtain care; and
- information on the quality of services, which is provided to the public and to referral sources.

Measurable Elements of MCI.1

1. The organization has identified its communities and populations of interest.
2. The organization has implemented a communication strategy with these populations.
3. The organization provides information on its services, hours of operation, and the process to obtain care. (Also see GLD.3.1)
4. The organization provides information on the quality of its services.

Communication with Patients and Families

Standard MCI.2
The organization informs patients and families about its care and services and how to access those services.

Intent of MCI.2
Patients and families need complete information on the care and services offered by the organization as well as how to access those services. Providing this information is essential to building open and trusting communication among patients, families, and the organization. This information helps match the patient's expectations with the organization's ability to meet those expectations. Information on alternative sources of care and services is provided when the needed care is beyond the organization's mission and capabilities.

Measurable Elements of MCI.2

1. Patients and families are provided information on the care and services provided by the organization. (Also see ACC.1.2, ME 2)
2. Patients and families are provided information on how to access services in the organization. (Also see ACC.1.2, ME 2)
3. Information on alternative sources of care and services is provided when the organization cannot provide the care or services.
Standard MCI.3
Patient and family communication and education are provided in an understandable format and language.

Intent of MCI.3
Patients can only make informed decisions and participate in the care process if they understand the information provided to them. Thus, particular attention is given to the format and language used in communicating with and providing education to patients and families. Patients respond differently to spoken instructions, printed materials, videotapes, demonstrations, and so on. Also, it is important to understand the language preferred. On occasion, family members or interpreters/ translators may need to assist with the education or translate materials. It is important to recognize the limitations of family members, particularly children, to serve as translators to communicate important clinical and other information and education. Thus, child translators should be used only as last resorts. When nonfamily members are used to translate or interpret, they are aware of any patient barriers to communication and understanding. (Also see ACC.1.3; PFE.3, ME 1; and PFE.5, MEs 1–3)

Measurable Elements of MCI.3
- 1. Patient and family communication and education are in an understandable format. (Also see PFE.5, MEs 1 and 2, and PFR.5, intent statement)
- 2. Patient and family communication and education are provided in an understandable language. (Also see PFE.5, MEs 1 and 2, and PFR.5, intent statement)
- 3. Family members, particularly child translators, are used as translators only as last resorts.

Communication Between Practitioners Within and Outside of the Organization

Standard MCI.4
Communication is effective throughout the organization.

Intent of MCI.4
Effective communication within an organization is a leadership issue. Thus, the organization’s leaders understand the dynamics of communication among and between professional groups; structural units, such as departments; between professional and nonprofessional groups; between health professionals and management; between health professionals and families; and with outside organizations, to name a few. The organization’s leaders not only set the parameters of effective communication but also serve as role models with the effective communication of the organization’s mission, strategies, plans, and other relevant information. The leaders pay attention to the accuracy and timeliness of information in the organization.

Measurable Elements of MCI.4
- 1. The leaders ensure processes are in place for communicating relevant information throughout the organization in a timely manner. (Also see ACC.2, ME 1, and MMU.5.1, ME 1)
- 2. Effective communication occurs in the organization among the organization’s programs. (Also see ACC.2, ME 1)
- 3. Effective communication occurs with outside organizations. (Also see ACC.3.1, MEs 2 and 3, and MMU.5.1, ME 1)
4. Effective communication occurs with patients and families. *(Also see ACC.2, ME 4)*

5. The leaders communicate the organization’s mission and appropriate policies, plans, and goals to all staff.

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**Standard MCI.5**

The leaders ensure that there is effective communication and coordination among those individuals and departments responsible for providing clinical services.

**Intent of MCI.5**

To coordinate and to integrate patient care, the leaders develop a culture that emphasizes cooperation and communication. The leaders develop formal (for example, standing committees, joint teams) and informal (for example, newsletters and posters) methods for promoting communication among services and individual staff members. Coordination of clinical services comes from an understanding of each department’s mission and services and collaboration in developing common policies and procedures. Regular communication channels that are both clinical and nonclinical in nature are established between governance and management.

**Measurable Elements of MCI.5**

1. Leaders ensure effective and efficient communication among clinical and nonclinical departments, services, and individual staff members. *(Also see ACC.2.1, ME 1)*

2. Leaders foster communication in the delivery of clinical services.

3. There are regular communication channels established between governance and management.

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**Standard MCI.6**

Information about the patient’s care and response to care is communicated among medical, nursing, and other health care practitioners during each staffing shift and between shifts.

**Intent of MCI.6**

Communicating and exchanging information between and among health care professionals is essential to a smooth care process. Essential information can be communicated through verbal, written, or electronic means. Each organization decides what information needs to be communicated, by what means, and with what frequency. The information communicated from one health care practitioner to another includes:

- the patient’s health status;
- a summary of the care provided; and
- the patient's response to care.

**Measurable Elements of MCI.6**

1. There is a process to communicate patient information among the health care practitioners on an ongoing basis or at key times in the care process. *(Also see AOP.1.4, ME 3)*

2. Information communicated includes the patient’s health status.

3. Information communicated includes a summary of the care provided.

4. Information communicated includes the patient’s progress.
Standard MCI.7
The patient's record(s) is available to the health care practitioners to facilitate the communication of essential information.

Intent of MCI.7
The patient's record(s) is a primary source of information on the care process and the patient's progress and thus is an essential communication tool. For this information to be useful and to support the continuity of the patient's care, it needs to be available during inpatient care, for outpatient visits, and at other times as needed and kept up to date. Medical nursing and other patient care notes are available to all the patient's health care practitioners. Organization policy identifies those health care practitioners who have access to the patient's record to ensure confidentiality of patient information.

Measurable Elements of MCI.7
- 1. Policy establishes those health care practitioners who have access to the patient's record(s).
- 2. The record(s) is available to those practitioners who need it for the care of the patient. (Also see AOP1.2, intent statement, and AOP1.5, ME 2)
- 3. The record(s) is up to date to ensure communication of the latest information.

Standard MCI.8
Information related to the patient's care is transferred with the patient.

Intent of MCI.8
Patients are frequently transferred within the organization during their care. When the care team changes as a result of the transfer, continuity of patient care requires that essential information related to the patient be transferred with him or her. Thus, medications and other treatments can continue uninterrupted, and the patient's status can be appropriately monitored. To accomplish this information transfer, the patient's record(s) is transferred or information from the patient's record is summarized at transfer. Such a summary includes the reason for admission, significant findings, diagnosis, procedures performed, medications and other treatments, and the patient's condition at transfer.

Measurable Elements of MCI.8
- 1. The patient's record or a summary of patient care information is transferred with the patient to another service or unit in the organization.
- 2. The summary contains the reason for admission.
- 3. The summary contains the significant findings.
- 4. The summary contains any diagnosis made.
- 5. The summary contains any procedures performed.
- 6. The summary contains any medications and other treatments.
- 7. The summary contains the patient's condition at transfer.


Leadership and Planning

**Standard MCI.9**
The organization plans and designs information management processes to meet internal and external information needs.

**Intent of MCI.9**
Information is generated and used during patient care and for managing a safe and effective organization. The ability to capture and to provide information requires effective planning. Planning incorporates input from a variety of sources, including the following:

- The health care practitioners
- The organization’s managers and leaders
- Those outside the organization who need or require data or information about the organization’s operation and care processes

The planning also includes the organization’s mission, services provided, resources, access to affordable technology, and support for effective communication among caregivers.

The priority information needs of these sources influence the organization’s information management strategies and ability to implement those strategies. The strategies are appropriate for the organization’s size, complexity of services, availability of trained staff, and other human and technical resources. The plan is comprehensive and includes all the departments and services of the organization.

Planning for the management of information does not require a formal written information plan but does require evidence of a planned approach that identifies the organization’s information needs.

**Measurable Elements of MCI.9**

- 1. The information needs of those who provide clinical services are considered in the planning process.
- 2. The information needs of those who manage the organization are considered in the planning process.
- 3. The information needs and requirements of individuals and agencies outside the organization are considered in the planning process.
- 4. The planning is based on the organization’s size and complexity.

**Standard MCI.10**
Information privacy and confidentiality are maintained.

**Intent of MCI.10**
The organization maintains the privacy and confidentiality of data and information and is especially careful about preserving the confidentiality of sensitive data and information. The balance between data sharing and data confidentiality is addressed. The organization determines the level of privacy and confidentiality maintained for different categories of information (for example, the patient’s record, research data, and the like).

**Measurable Elements of MCI.10**

- 1. There is a written policy for addressing the privacy and confidentiality of information that is based on and consistent with laws and regulations.
2. The policy defines the extent to which patients have access to their health information and the process to gain access when permitted. *(Also see PFR.1.6, intent statement)*

3. The policy is implemented.

4. Compliance with the policy is monitored.

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**Standard MCI.11**

Information security, including data integrity, is maintained.

**Intent of MCI.11**

Policies and procedures address security procedures that allow only authorized staff to gain access to data and information. Access to different categories of information is based on need and defined by job title and function, including students in academic settings. An effective process defines:

- who has access to information;
- the information to which an individual has access;
- the user’s obligation to keep information confidential; and
- the process followed when confidentiality and security are violated.

One aspect of maintaining security of patient information is to determine who is authorized to obtain a patient clinical record and make entries into the patient clinical record. The organization develops a policy to authorize such individuals and identifies the content and format for entries into patient clinical records. There is a process to ensure that only authorized individuals make entries in patient clinical records.

**Measurable Elements of MCI.11**

1. The organization has a written policy for addressing information security, including data integrity that is based on or consistent with laws or regulations.

2. The policy includes levels of security for each category of data and information are identified.

3. Those who have the need or job position that permits access to each category of data and information are identified.

4. The policy is implemented.

5. Compliance with the policy is monitored.

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**Standard MCI.12**

The organization has a policy on the retention time of records, data, and information.

**Intent of MCI.12**

The organization develops and implements a policy that guides the retention of patient clinical records and other data and information. Patient clinical records and other data and information are retained for sufficient periods to comply with laws and regulations and to support patient care, management, legal documentation, research, and education. The retention policy is consistent with the confidentiality and security of such information. When the retention period is complete, patient clinical records and other records, data, and information are destroyed appropriately.

**Measurable Elements of MCI.12**

1. The organization has a policy on retaining patient clinical records and other data and information.

2. The retention process provides expected confidentiality and security.

3. Records, data, and information are destroyed appropriately.
Standard MCI.13
The organization uses standardized diagnosis codes, procedure codes, symbols, abbreviations, and definitions.

Intent of MCI.13
Standardized terminology, definitions, vocabulary, and nomenclature facilitate comparison of data and information within and among organizations. Uniform use of diagnosis and procedure codes supports data aggregation and analysis. Abbreviations and symbols are also standardized and include a “do not use” listing. Such standardization is consistent with recognized local and national standards.

Measurable Elements of MCI.13
- 1. Standardized diagnosis codes are used and use monitored.
- 2. Standardized procedure codes are used and use monitored.
- 3. Standardized definitions are used.
- 4. Standardized symbols are used, and those not to be used are identified and monitored.
- 5. Standardized abbreviations are used, and those not to be used are identified and monitored.

Standard MCI.14
The data and information needs of those in and outside the organization are met on a timely basis in a format that meets user expectations and with the desired frequency.

Intent of MCI.14
The format and methods of disseminating data and information to the intended user are tailored to meet the user’s expectations. Dissemination strategies include
- providing only the data and information the user requests or needs;
- formatting the report to aid use in the decision process;
- providing reports with the frequency needed by the user;
- linking sources of data and information; and
- providing interpretation or clarification of data.

Measurable Elements of MCI.14
- 1. Data and information dissemination meet user needs.
- 2. Users receive data and information on a timely basis.
- 3. Users receive data and information in a format that aids its intended use.
- 4. Staff have access to the data and information needed to carry out their job responsibilities.

Standard MCI.15
Appropriate clinical and managerial staff participate in selecting, integrating, and using information management technology.

Intent of MCI.15
Information management technology represents a major investment of resources for a health care organization. For this reason, technology is carefully matched to the organization’s current and future needs and its resources. Available technology needs to be integrated with existing information management processes and
helps integrate the activities of all the organization’s departments and services. This level of coordination requires that key clinical and managerial staff participate in the selection process.

Measurable Elements of MCI.15
- 1. Clinical staff participate in information technology decisions.
- 2. Managerial staff participate in information technology decisions.

Standard MCI.16
Records and information are protected from loss, destruction, tampering, and unauthorized access or use.

Intent of MCI.16
Patient records and other data and information are secure and protected at all times. For example, active patient records are kept in areas where only authorized health professional staff have access, and records are stored in locations where heat, water, fire, or other damage is not likely to occur. The organization implements processes to prevent unauthorized access to electronically stored information. (Also see PFR.1.6, intent statement, related to the confidentiality of patient information.)

Measurable Elements of MCI.16
- 1. Records and information are protected from loss or destruction.
- 2. Records and information are protected from tampering and unauthorized access or use.

Standard MCI.17
Decision makers and other appropriate staff members are educated and trained in the principles of information management.

Intent of MCI.17
Individuals in the organization who generate, collect, analyze, and use data and information are educated and trained to effectively participate in managing information. This education and training enable these individuals to
- understand security and confidentiality of data and information;
- use measurement instruments, statistical tools, and data analysis methods;
- assist in interpreting data;
- use data and information to help in decision making;
- educate and support the participation of patients and families in care processes; and
- use measures to assess and to improve care and work processes.

Individuals are educated and trained according to their responsibilities, job descriptions, and data and information needs.

The information management process makes it possible to combine information from various sources and generate reports to support decision making. In particular, the combination of clinical and managerial information helps organization leaders to plan collaboratively. The information management process supports leaders with integrated longitudinal data and comparative data.
Measurable Elements of MCI.17
1. Decision makers and others are provided education on the principles of information management.
2. The education is appropriate to needs and job responsibilities.
3. Clinical and managerial data and information are integrated as needed to support decision making.

Standard MCI.18
A written policy or protocol defines the requirements for development and maintenance of internal policies and procedures and a process for managing external policies and procedures.

Intent of MCI.18
Policies and procedures are intended to provide uniform knowledge on organizational function. A policy or protocol outlines how policies in the organization will be controlled. The policy or protocol contains the following information on how policy control will be carried out, including the following steps:

a) Review and approval of all policies and procedures by an authorized person before issue
b) The process and frequency of review and continued approval of policies and procedures
c) The controls for ensuring that only current, relevant versions of policies and procedures are available wherever they are used
d) Identification of changes in policies and procedures
e) Maintenance of document identity and legibility
f) A process for managing policies and procedures that originated outside the organization
g) Retention of obsolete policies and procedures for at least the time required by laws and regulations, while ensuring that they will not be mistakenly used
h) Identification and tracking of all policies and procedures in circulation

The tracking system allows each document to be identified by title, date of issue, edition and/or current revision date, number of pages, who authorized issue and/or reviewed the document, and database identification (if applicable).

There is a process to ensure that staff members have read and are familiar with policies and procedures relevant to their work.

The processes for developing and maintaining policies and procedures are implemented.

Measurable Elements of MCI.18
1. There is a written policy or protocol that defines the requirements for developing and maintaining policies and procedures including at least items a) through h) in the intent, and it is implemented.
2. There is a written protocol that outlines how policies and procedures that originated outside the organization will be controlled, and it is implemented.
3. There is a written policy or protocol that defines retention of obsolete policies and procedures for at least the time required by laws and regulations, while ensuring that they will not be mistakenly used, and it is implemented.
4. There is a written policy or protocol that outlines how all policies and procedures in circulation will be identified and tracked, and it is implemented.
**Patient Clinical Record**

**Standard MCI.19**
The organization initiates and maintains a clinical record for every patient assessed or treated.

**Intent of MCI.19**
Every patient assessed or treated in a health care organization as an inpatient, outpatient, or urgent care patient has a clinical record. The record is assigned an identifier unique to the patient, or some other mechanism is used to link the patient with his or her clinical record. A single record and a single identifier enable the organization to easily locate patient clinical records and to document the care of patients over time.

**Measurable Elements of MCI.19**

- 1. A clinical record is initiated for every patient assessed or treated by the organization.
- 2. Patient clinical records are maintained through the use of an identifier unique to the patient or some other effective method.

**Standard MCI.19.1**
The clinical record contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment, to document the course and results of treatment, and to promote continuity of care among health care practitioners.

**Standard MCI.19.1.1**
The clinical record of every patient receiving emergency care includes the time of arrival, the conclusions at termination of treatment, the patient’s condition at discharge, and follow-up care instructions.

**Intent of MCI.19.1 and MCI.19.1.1**
The clinical record of each patient needs to present sufficient information to support the diagnosis, to justify the treatment provided, and to document the course and results of the treatment. A standardized format and content of a patient's clinical record help promote the integration and continuity of care among the various practitioners of care to the patient.

The organization determines the specific data and information recorded in the clinical record of each patient assessed or treated on an outpatient, emergency, or inpatient basis. The record of each patient receiving emergency care includes the specific information identified in standard MCI.20.1.1.

**Measurable Elements of MCI.19.1**

- 1. The specific content of patient clinical records has been determined by the organization. (*Also see AOP.1.5, ME 1*)
- 2. Patient clinical records contain adequate information to identify the patient. (*Also see ASC.7, ME 3*)
- 3. Patient clinical records contain adequate information to support the diagnosis. (*Also see ASC.7.3, ME 2*)
- 4. Patient clinical records contain adequate information to justify the care and treatment. (*Also see ASC.7.3, ME 2*)
- 5. Patient clinical records contain adequate information to document the course and results of treatment. (*Also see AOP.1.5, ME 1; AOP.2, intent statement; COP.5, ME 4; ASC.5.2, ME 1; ASC.5.3, ME 2; ASC.6, ME 2; ASC.7.3, ME 3; and MMU.4.3, ME 1*)
Measurable Elements of MCI.19.1.1

- 1. The clinical records of emergency patients include arrival time.
- 2. The clinical records of emergency patients include conclusions at the termination of treatment.
- 3. The clinical records of emergency patients include the patient’s condition at discharge.
- 4. The clinical records of emergency patients include any follow-up care instructions.

Standard MCI.19.2

Organization policy identifies those authorized to make entries in the patient clinical record and determines the record’s content and format.

Standard MCI.19.3

Every patient clinical record entry identifies its author and when the entry was made in the record.

Intent of MCI.19.2 and MCI.19.3

Access to each category of information is based on need and defined by job title and function, including students in academic settings. An effective process defines
- who has access to information;
- the information to which an individual has access;
- the user’s obligation to keep information confidential; and
- the process followed when confidentiality and security are violated.

One aspect of maintaining the security of patient information is to determine who is authorized to obtain a patient clinical record and to make entries into the patient clinical record. The organization develops a policy to authorize such individuals and identifies the content and format for entries into patient clinical records. There is a process to ensure that only authorized individuals make entries in patient clinical records and that each entry identifies the author of the entry and the date. The policy must also include the process for how entries in the patient record are corrected or overwritten. If required by the organization, the time of the entry is also noted, such as for timed treatments or medication orders.

Measurable Elements of MCI.19.2

- 1. Those authorized to make entries in the patient clinical record are identified in organization policy. *(Also see IPSG.2, ME 1)*
- 2. The format and location of entries are determined by organization policy.
- 3. There is a process to ensure that only authorized individuals make entries in patient clinical records.
- 4. There is a process that addresses how entries in the patient record are corrected or overwritten.
- 5. Those authorized to have access to the patient clinical record are identified in organization policy.
- 6. There is a process to ensure that only authorized individuals have access to the patient clinical record.

Measurable Elements of MCI.19.3

- 1. The author can be identified for each patient clinical record entry.
- 2. The date of each patient clinical record entry can be identified.
- 3. When required by the organization, the time of an entry can be identified.
**Standard MCI.19.4**

As part of its performance improvement activities, the organization regularly assesses patient clinical record content and the completeness of patient clinical records.

**Intent of MCI.19.4**

Each organization determines the content and format of the patient clinical record and has a process to assess record content and the completeness of records. That process is a part of the organization's performance improvement activities and is carried out regularly. Patient clinical record review is based on a sample representing the practitioners providing care and the types of care provided. The review process is conducted by the medical staff, nursing staff, and other relevant clinical professionals who are authorized to make entries in the patient record. The review focuses on the timeliness, completeness, legibility, and so forth of the record and clinical information. Clinical record content required by laws or regulations is included in the review process. The organization's clinical record review process includes records of patients currently receiving care as well as records of discharged patients.

**Measurable Elements of MCI.19.4**

- 1. Patient clinical records are reviewed regularly.
- 2. The review uses a representative sample.
- 3. The review is conducted by physicians, nurses, and others authorized to make entries in patient records or to manage patient records.
- 4. The review focuses on the timeliness, legibility, and completeness of the clinical record.
- 5. Record contents required by laws or regulations are included in the review process.
- 6. Records of active and discharged patients are included in the review process.
- 7. The results of the review process are incorporated into the organization's quality oversight mechanism.

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**Aggregate Data and Information**

**Standard MCI.20**

Aggregate data and information support patient care, organization management, and the quality management program.

**Standard MCI.20.1**

The organization has a process to aggregate data and has determined which data and information are to be regularly aggregated to meet the needs of clinical and managerial staff in the organization and agencies outside the organization.

**Standard MCI.20.2**

The organization has a process for using or participating in external databases.

**Intent of MCI.20 through MCI.20.2**

The organization collects and analyzes aggregate data to support patient care and organization management. Aggregate data provides a profile of the organization over time and allows the comparison of the organization's
performance with other organizations. Thus, aggregate data are an important part of the organization’s performance improvement activities. In particular, aggregate data from risk management, utility system management, infection prevention and control, and utilization review can help the organization understand its current performance and identify opportunities for improvement.

By participating in external performance databases, an organization can compare its performance to that of other similar organizations locally, nationally, and internationally. Performance comparison is an effective tool for identifying opportunities for improvement and documenting the organization’s performance level. Health care networks and those purchasing or paying for health care often ask for such information. External databases vary widely from insurance databases to those maintained by professional societies. Organizations may be required by laws or regulations to contribute to some external databases (also see QPS.4.2 and PCI.10.6, ME 1). In all cases, the security and confidentiality of data and information are maintained.

**Measurable Elements of MCI.20**
- 1. Aggregate data and information support patient care.
- 2. Aggregate data and information support organization management.
- 3. Aggregate data and information support the quality management program.

**Measurable Elements of MCI.20.1**
- 1. The organization has a process to aggregate data in response to identified user needs.
- 2. The organization provides needed data to agencies outside the organization. (Also see PCI.10.6, ME 1)

**Measurable Elements of MCI.20.2**
- 1. The organization has a process to participate in or to use information from external databases.
- 2. The organization contributes data or information to external databases in accordance with laws or regulations.
- 3. The organization compares its performance using external reference databases. (Also see QPS.4.2, ME 2, and PCI.10.4, ME 1)
- 4. Security and confidentiality are maintained when contributing to or using external databases.

**Standard MCI.21**
The organization supports patient care, education, research, and management with timely information from current sources.

**Intent of MCI.21**
Health care practitioners, researchers, educators, and managers often need information to assist with their responsibilities. Such information may include scientific and management literature, clinical practice guidelines, research findings, and educational methodologies. The Internet, print materials in a library, online search sources, and personal materials are all valuable sources of current information.

**Measurable Elements of MCI.21**
- 1. Current scientific and other information supports patient care.
- 2. Current scientific and other information supports clinical education.
- 3. Current scientific and other information supports research.
- 4. Current professional and other information supports management.
- 5. Information is provided in a time frame that meets user expectations.
**Glossary**

**accreditation**  Determination by the Joint Commission International (JCI) accrediting body that an eligible health care organization complies with applicable JCI standards.

**accreditation decisions**  Categories of accreditation that an organization can achieve based on a JCI survey. These decision categories are as follows:

- **Accredited**  The organization demonstrates acceptable compliance with all standards and International Patient Safety Goals.

- **Denial of Accreditation**  The organization is consistently not in compliance with JCI standards and International Patient Safety Goals, JCI withdraws its accreditation for other reasons, or the organization voluntarily withdraws from the accreditation process.

**accreditation framework**  The structures and processes in an organization that are necessary for an accrediting organization to do the following:

- Consistently and reliably evaluate applicant organizations against standards
- Recruit and send out trained evaluators
- Reach consistent and defensible accreditation decisions
- Carry out related policies and procedures

**accreditation process**  A continuous process whereby health care organizations are required to demonstrate to JCI that they are providing safe, high-quality care, as determined by compliance with JCI standards and International Patient Safety Goal recommendations. The key component of this process is an on-site evaluation of an organization by JCI surveyors.

**Accreditation Program (JCI)**  See JCI Accreditation Program

**accreditation survey**  An evaluation of an organization to assess its compliance with applicable standards and to determine its accreditation status. Also known as a “triennial survey,” the JCI accreditation survey includes the following:

- Evaluation of documents provided by organization staff that show compliance
- Verbal information about the implementation of standards or examples of their implementation that enables compliance to be determined
- On-site observations by surveyors
- Tracking of patients through the care process by the tracer methodology
- Education about standards compliance and performance improvement

**extension survey**  An organizational evaluation made necessary by any of the following factors:

- An organization has offered at least 25% of its services at a new location or in a significantly altered physical plan.
- An organization has expanded its capacity to provide services by 25% or greater, as measured by patient volume or other relevant measures.
- An organization has merged with, consolidated with, or acquired an unaccredited site, service, or program for which there are applicable JCI standards.

**focused survey**  Narrow, limited evaluation of an organization subsequent to an initial or triennial survey, which concentrates solely on issues deemed noncompliant during the initial or triennial survey.

**follow-up focused survey**  Evaluation conducted because of the need for surveyor observation, staff or patient interviews, or the
inspection of the physical facility to confirm that an organization has taken sufficient action to achieve acceptable compliance with any JCI standards and/or International Patient Safety Goals identified as “not met” or “partially met” at the time of initial or triennial full survey.

**for-cause focused survey** An organizational evaluation undertaken when JCI becomes aware of potentially serious issues involving standards compliance, patient care, or patient safety.

**initial survey** Evaluation of an organization that is seeking JCI accreditation for the first time or has not been unaccredited by JCI during the previous six months.

**validation survey** An evaluation of the survey process subsequent to an organization’s initial or triennial re-survey, assessing standards compliance in health care organizations, as part of JCI’s internal quality improvement efforts. Similar in scope to an initial or triennial survey, the validation survey is voluntary and in no way affects the results of an organization’s initial or triennial survey.

**acute care** A branch of health care where necessary treatment of a disease is provided for only a short period of time for a brief but severe episode of illness. Many hospitals are acute care facilities with the goal of discharging the patient as soon as the patient is deemed healthy and stable, with appropriate discharge instructions.

**adverse event** An unanticipated, undesirable, or potentially dangerous occurrence in a health care organization.

**ambulatory care** Types of health care services provided to individuals on an outpatient basis. Ambulatory care services are provided in many settings ranging from freestanding surgical facilities to cardiac catheterization centers.

**anesthesia and sedation** The administration of medication to an individual, in any setting, for any purpose, by any route to induce a partial or total loss of sensation for the purpose of conducting an operative or other procedure.

Definitions of four levels of anesthesia and sedation include the following:

**minimal sedation (anxiolysis)** A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

**procedural (or moderate) sedation** (formerly “conscious sedation”) A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

**deep sedation/analgesia** A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

**anesthesia** Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

**best practice** Clinical, scientific, or professional technique, method, or process that is recognized by a majority of professionals in a particular
field as more effective at delivering a particular outcome than any other practice. These practices, also sometimes referred to as “good practice” or “better practice,” are typically evidence based and consensus driven.

capital cost The cost of investing in the development of new or improved facilities, services, or equipment. Does not include operational costs.

care plan See plan of care.

certification
1. The procedure and action by which an authorized organization evaluates and certifies that an individual, institution, or program meets requirements, such as standards. Certification differs from accreditation in that certification can also be applied to individuals (for example, a medical specialist).
2. The process by which a nongovernment agency or association certifies that an individual has met predetermined qualifications specified by that agency or association.

cleaning Removal of all visible dust, soil, and any other visible material that microorganisms might find favorable for continued life and growth. This is usually done by scrubbing with hot water and detergent.

clinical pathology Services relating to solving clinical problems, particularly using laboratory methods in clinical diagnosis. Includes clinical chemistry, bacteriology and mycology, parasitology, virology, clinical microscopy, hematology, coagulation immunohematology, immunology, serology, and radiobioassay.

clinical pathway An agreed-on treatment regime that includes all elements of care.

clinical practice guidelines Statements that help practitioners and patients choose appropriate health care for specific clinical conditions (for example, recommendations on the case management of diarrhea in children under the age of 5 years). The practitioner is guided through all steps of consultation (questions to ask, physical signs to look for, lab exams to prescribe, assessment of the situation, and treatment to prescribe).

clinical record See patient record/medical record/clinical record.

clinical staff See staff.

clinical trial Therapy testing in three or sometimes four stages depending on the purpose, size, and scope of the test. “Phase I” trials evaluate the safety of diagnostic, therapeutic, or prophylactic drugs, devices, or techniques to determine the safe dosage range (if appropriate). They involve a small number of healthy subjects. The trial usually lasts about one year. “Phase II” trials are usually controlled to assess the effectiveness and dosage (if appropriate) of the drugs, devices, or techniques. These studies involve several hundred volunteers, including a limited number of patients with the target disease or disorder. The trial usually lasts about two years. “Phase III” trials verify the effectiveness of the drugs, devices, or techniques determined in Phase II studies. Phase II patients are monitored to identify any adverse reactions from long-term use. These studies involve groups of patients large enough to identify clinically significant responses. The trial usually lasts about three years. “Phase IV” trials study the drugs, devices, or techniques that have been approved for general sale. These studies are often conducted to obtain more data about a product’s safety and efficacy.

competence A determination of an individual’s skills, knowledge, and capability to meet defined expectations, as frequently described in a job description.

confidentiality
1. The restricted access to data and information to individuals who have a need, a reason, and permission for such access.
2. An individual’s right to personal and informational privacy, including for his or her health care records.

contamination The presence of an infectious agent on an animate or inanimate surface.

continuity of care The degree to which the care of individuals is coordinated among practitioners, among organizations, and over time.
**continuum of care**  Matching the individual’s ongoing needs with the appropriate level and type of care, treatment, and service within an organization or across multiple organizations.

**contracted services**  Services provided through a written agreement with another organization, agency, or individual. The agreement specifies the services or personnel to be provided on behalf of the applicant organization and the fees to provide these services or personnel.

**credentialing**  The process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care services in or for a health care organization. The process of periodically checking staff qualifications is called “recredentialing.”

**credentials**  Evidence of competence, current and relevant licensure, education, training, and experience. Other criteria may be added by a health care organization. *Also see* competence; credentialing.

**curative services**  Services provided to overcome disease and to promote recovery. Curative services or therapy are different from palliative services, which give relief but not cure. *Also see* palliative services.

**data**  Facts, clinical observations, or measurements collected during an assessment activity. Data before they are analyzed are called “raw data.”

**disaster**  See emergency.

**discharge**  The point at which an individual’s active involvement with an organization or program is terminated and the organization or program no longer maintains active responsibility for the care of the individual.

**discharge summary**  A section of a patient record that summarizes the reasons for admittance, the significant findings, the procedures performed, the treatment rendered, the patient’s condition on discharge, and any specific instructions given to the patient or family (for example, follow-up, medications).

**disinfection**  The use of a chemical procedure that eliminates most disease-producing organisms, but not all microbial forms.

**“do not use” list**  A written catalog of abbreviations, acronyms, and symbols that are not to be used throughout an organization—whether handwritten or entered as free text into a computer—due to their potentially confusing nature.

**efficiency**  The relationship between the outcomes (results of care) and the resources used to deliver care. For example, when two programs use the same amount of resources, the one that achieves a higher immunization coverage rate is the more efficient. Increasing efficiency involves achieving the same outputs with fewer resources or more outputs with the same amount of resources.

**emergency**  1. An unanticipated or sudden occasion, as in emergency surgery needed to prevent death or serious disability.

2. A natural or man-made event that significantly disrupts the environment of care (for example, damage to the organization’s building[s] and grounds due to severe winds, storms, or earthquakes); that significantly disrupts care and treatment (for example, loss of utilities, such as power, water, or telephones due to floods, civil disturbances, accidents, or emergencies in the organization or its community); or that results in sudden, significantly changed or increased demands for the organization’s services (for example, bioterrorist attack, building collapse, or plane crash in the organization’s community). Some emergencies are called “disasters” or “potential injury-creating events” (PICEs).

**emergent**  A classification of acuity used in the triage systems to signify that the patient’s condition is life-threatening and requires immediate intervention. *Also see* urgent.

**environmental management plan(s)**  The organization’s written document describing the process it has in place for the following areas of its operations: safety and security, hazardous materials, emergencies, fire safety, medical equipment, and utility systems. The plan identifies specific procedures that describe mitigation, preparedness, response and recovery strategies, actions, and responsibilities.
equipment maintenance, preventive The planned, scheduled, visual, mechanical, engineering, and functional evaluation of equipment conducted before using new equipment and at specified intervals throughout the equipment’s lifetime. The purpose is to maintain equipment performance within manufacturers’ guidelines and specifications and to help ensure accurate diagnosis, treatment, or monitoring. It includes measuring performance specifications and evaluating specific safety factors.

equipment maintenance, routine The performance of basic safety checks—that is, the visual, technical, and functional evaluations of equipment—to identify obvious deficiencies before they have a negative impact. It normally includes inspections of the case, power cord, structural frame, enclosure, controls, indicators, and so on.

evidence-based (or scientific-based) guidelines Making clinical decisions based on empirical evidence or, in the absence of empirical evidence, expert consensus (such as consensus statements promoted by professional societies). The approach requires understanding conflicting results and assessing the quality and strength of evidence. Finally, practitioners must know how this applies to patient care and health care policy.

failure mode and effects analysis (FMEA) A systematic way of examining a design prospectively for possible ways in which failure can occur. It assumes that no matter how knowledgeable or careful people are, errors will occur in some situations and may even be likely to occur.

family The person(s) with a significant role in the patient’s life. This may include a person(s) not legally related to the patient. This person(s) is often referred to as a surrogate decision maker if authorized to make care decisions for a patient if the patient loses decision-making ability.

functional status The ability of individuals to take care of themselves physically and emotionally according to the expected norms of their age group. Functional status may be divided into “social,” “physical,” and “psychological” functions. Functional status may be assessed by asking questions during periodic health examinations or using formal screening instruments. Also see measure.

governance The individual(s), group, or agency that has ultimate authority and responsibility for establishing policy, maintaining quality of care, and providing for organization management and planning. Other names for this group include “board,” “board of trustees,” “board of governors,” “board of commissioners,” and “governing body.”

harvesting, of organs Removal of an organ for means of transplantation.

hazardous materials and waste Materials whose handling, use, and storage are guided or defined by local, regional, or national regulation, hazardous vapors, and hazardous energy sources. Although JCI identifies infectious waste as falling into this category of materials, not all laws and regulations define infectious or medical waste as hazardous waste.

hazard vulnerability analysis The identification of potential emergencies and the direct and indirect effects these emergencies may have on the health care organization’s operations and the demand for its services.

health care–associated infection(s) (HAI) Any infection(s) acquired by an individual while receiving care or services in a health care organization. Common HAIs are urinary infections, surgical wound infections, pneumonia, and bloodstream infections.

health care organization A generic term used to describe many types of organizations that provide health care services. This includes ambulatory care centers, behavioral/mental health institutions, home care organizations, hospitals, laboratories, and long term care organizations. Also known as a “health care institution.”

health care organization management standards For purposes of JCI accreditation, standards that are organized according to what is done directly or indirectly to provide for a safe, effective, and well-managed organization and facility (for example, prevention and control of infection, facility management, staff qualifications).
independent practitioner  Any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license. In many countries, licensed independent practitioners include physicians, dentists, some categories of nurses, podiatrists, optometrists, and chiropractors. Also see practitioner.

infectious waste  See hazardous materials and waste.

information management  The creation, use, sharing, and disposal of data or information across an organization. This practice is critical to the effective and efficient operation of organization activities. It includes the role of management to produce and to control the use of data and information in work activities, information resources management, information technology, and information services.

informed consent  Agreement or permission accompanied by full information on the nature, risks, and alternatives of a medical procedure or treatment before the physician or other health care professional begins the procedure or treatment. After receiving this information, the patient either consents to or refuses such a procedure or treatment.

inpatient  Generally, persons who are admitted to and housed in a health care organization at least overnight.

in-service education  Organized education, usually provided in the workplace, designed to enhance the skills of staff members or to teach them new skills relevant to their jobs and disciplines.

integrated provider (system)  A health care provider organization that offers a broad corporate system for managing a diversified health care delivery system. The system typically includes one or more hospitals, a large group practice, a health plan, and other health care operations. Health care practitioners are employees of the system or in a tightly affiliated practitioner group. The system can provide several levels of health care to patients in the same geographic areas.

intent statement  A brief explanation of a standard's rationale, meaning, and significance, noted in this manual under the heading “Intent.” Intent statements may contain detailed expectations of the standard that are evaluated in the on-site survey process.

invasive procedure  A procedure involving puncture or incision of the skin or insertion of an instrument or foreign material into the body.

JCI Accreditation Program  The division of JCI responsible for administration of all activities related to organizational health care accreditation or certification.

job description  Explanation of an employment position, including duties, responsibilities, and conditions required to perform the job.

leader  An individual who sets expectations, develops plans, and implements procedures to assess and to improve the quality of the organization's governance, management, clinical, and support functions and processes. The leaders described in the JCI standards include at least the leaders of the governing body, the chief executive officer and other senior managers, departmental leaders, the elected and the appointed leaders of the medical staff and the clinical departments and other medical staff members in organizational administrative positions, and the nurse executive and other senior nursing leaders.

levels of care  A classification of health care service levels. They are divided by the kind of care given, the number of people served, and the people providing the care. The main levels of care are primary, secondary, and tertiary. Levels of care classified by the acuity of the patient or intensity of the services provided are emergency, intensive, and general. Also see continuum of care.

licensure  A legal right that is granted by a government agency in compliance with a statute governing an occupation (such as physicians, dentists, nurses, psychiatry, or clinical social work, or the operation of a health care facility).

measure  
1. To collect quantifiable data about a function, system, or process (one “measures”).
2. A quantitative tool.
medical equipment  Fixed and portable equipment used for the diagnosis, treatment, monitoring, and direct care of individuals.

medical record  See patient record/medical record/clinical record.

medical staff  All physicians, dentists, and other professionals who are licensed to practice independently (without supervision) and who provide preventive, curative, restorative, surgical, rehabilitative, or other medical or dental services to patients; or who provide interpretative services for patients, such as pathology, radiology, or laboratory services, regardless of the organization’s classification of appointment, employment status, contract, or other arrangements with the individual to provide such patient care services.

medical waste  See hazardous materials and waste.

medication  Any prescription medications; sample medications; herbal remedies; vitamins; nutriceuticals; over-the-counter drugs; vaccines; diagnostic and contrast agents used on or administered to persons to diagnose, to treat, or to prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood derivatives; and intravenous solutions (plain, with electrolytes and/or drugs).

medication, high-risk or high-alert  Those drugs that carry a risk for errors that can lead to significant adverse outcomes.

medication error  Any preventable event that may cause inappropriate medication use or jeopardize patient safety. Also see sentinel event.

mission statement  A written expression that sets forth the purpose, or “mission,” of an organization or one of its components. The generation of a mission statement usually precedes the formation of goals and objectives.

monitoring  The review of information on a regular basis. The purpose of monitoring is to identify the changes in a situation. For example, the health information specialist of the district health management team reports every month the cases of meningitis occurring in villages at risk.

multidisciplinary  Including representatives of a range of professions, disciplines, or service areas.

near miss  Any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome. Such a “near miss” falls within the scope of the definition of an adverse event. Also see adverse event.

nonclinical staff  See staff.

nosocomial infection(s)  See health care–associated infection(s).

nutritional care  Interventions and counseling to promote appropriate nutrition intake. This activity is based on nutrition assessment and information about food, other sources of nutrients, and meal preparation. It includes the patient’s cultural background and socioeconomic status.

nutrition therapy  Medical treatment that includes enteral and parenteral nutrition.

observation  The time during which a patient is watched closely by a caregiver (or caregivers).

organizational chart  A graphic representation of titles and reporting relationships in an organization, sometimes referred to as an “organogram” or “organization table.”

outcome  The effect(s) that an intervention has on a specific health problem. It reflects the purpose of the intervention. For example, the outcome(s) of a rural health education program on safe drinking water could be fewer diarrhea episodes in children under 5 or decreased child mortality by diarrhea.

outpatient  Generally, persons who do not need the level of care associated with the more structured environment of an inpatient or a residential program. In many countries, outpatient care is also known as “ambulatory care.” In some countries, outpatients are considered “admitted” to a health care organization; in others, outpatients are considered “registered.” Also see ambulatory care.
**palliative services** Treatments and support services intended to alleviate pain and suffering rather than to cure illness. Palliative therapy may include surgery or radiotherapy undertaken to reduce or to shrink tumors compressing vital structures and thereby to improve the quality of life. Palliative services include attending to the patient's psychological and spiritual needs and supporting the dying patient and his or her family.

**patient** An individual who receives care, treatment, and services. For JCI standards, the patient and family are a single unit of care.

**patient care process** The act of providing accommodations, comfort, and treatment to an individual. This implies responsibility for safety, including treatment, services, habilitation, rehabilitation, or other programs requested by the organization or network for the individual.

**patient-centered standards** For purposes of JCI accreditation, standards that are organized according to what is done directly or indirectly for or to patients (for example, patient education, creation of patient records, patient assessment).

**patient record/medical record/clinical record** A written account of a variety of patient health information, such as assessment findings, treatment details, progress notes, and discharge summary. This record is created by health care professionals.

**physiologic-based criteria** Criteria centered on the branch of biology dealing with the functions of the living organism and its parts of the physical and chemical factors and processes involved.

**plan** A detailed method, formulated beforehand, that identifies needs, lists strategies to meet those needs, and sets goals and objectives. The format of the plan may include narratives, policies and procedures, protocols, practice guidelines, clinical paths, care maps, or a combination of these.

**plan of care** A plan that identifies the patient's care needs, lists the strategy to meet those needs, documents treatment goals and objectives, outlines the criteria for ending interventions, and documents the individual's progress in meeting specified goals and objectives. It is based on data gathered during patient assessment. The format of the plan in some organizations may be guided by specific policies and procedures, protocols, practice guidelines, clinical paths, or a combination of these. The plan of care may include prevention, care, treatment, habilitation, and rehabilitation. Also see plan.

**point-of-care testing** Analytical testing performed at sites outside the traditional laboratory environment, usually at or near where care is delivered to individuals.

**practice guidelines** Tools that describe processes found by clinical trials or by consensus opinion of experts to be the most effective in evaluating and/or treating a patient who has a specific symptom, condition, or diagnosis, or that describe a specific procedure. Synonyms include practice parameter, protocol, preferred practice pattern, and guideline. Also see evidence-based (or scientific-based) guidelines; clinical practice guidelines.

**practitioner** Any person who has completed a course of study and is skilled in a field of health care. This includes a physician, dentist, nurse, pharmacist, respiratory therapist, among others. Practitioners are licensed by a government agency or certified by a professional organization. Also see independent practitioner.

**preventive services** Interventions to promote health and prevent disease. These include identification of and counseling on risk factors (for example, smoking, lack of physical activity), screening to detect disease (for example, breast cancer, sexually transmitted diseases), immunizations, and chemoprophylaxis (for example, hormone replacement therapy).

**primary source verification** Verification of an individual health care practitioner's reported qualifications by the original source or an approved agent of that source. Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification, secure electronic verification from the original qualification source, or reports from credentials verification organizations that meet JCI requirements.
privilaging The process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization, based on evaluation of the individual’s credentials and performance.

process A series of actions (or activities) that transform the inputs (resources) into outputs (services). For example, a rural health education program will require that staff develop an education strategy, develop educational materials, and deliver the education sessions.

protocol Scientific treatment plan or study outline—including types of trial participants, schedule, procedures, medications and dosages, among others—for using an experimental procedure or a new treatment with the intent of measuring human applications.

qualified individual An individual or staff member who can participate in one or all of the organization’s care activities or services. Qualification is determined by the following: education, training, experience, competence, applicable licensure, laws or regulations, registration, or certification.

quality improvement An approach to the continuous study and improvement of the processes of providing health care services to meet the needs of patients and others. Synonyms include continuous quality improvement, continuous improvement, organizationwide performance improvement, and total quality management.

quality of care The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Dimensions of performance include the following: patient perspective issues; safety of the care environment; and accessibility, appropriateness, continuity, effectiveness, efficacy, efficiency, and timeliness of care.

recruitment Seeking—usually new—employees or other members of an organization.

referral The sending of an individual (1) from one clinician to another clinician or specialist or (2) from one setting or service to another or other resource, either for consultation or care that the referring source is not prepared or qualified to provide.

rehabilitation services The use of medical, social, educational, and vocational measures together for training or retraining individuals disabled by disease or injury. The goal is to enable patients to achieve their highest possible level of functional ability.

reliability The ability of the measure to accurately and consistently identify the events it was designed to identify across multiple health settings.

representative sample A sample in which each case in an initially identified population of cases has equal probability of being included in the sample. A representative sample is obtained if random sampling is used to select the sample cases.

risk management program Clinical and administrative activities that organizations undertake to identify, to evaluate, and to reduce the risk of injury to patients, staff, and visitors and the risk of loss to the organization itself.

root cause analysis A process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event. Also see sentinel event.

safety The degree that the organization’s buildings, grounds, and equipment do not pose a hazard or risk to patients, staff, or visitors.

scope of practice The range of activities performed by a practitioner in a health care organization. The scope is determined by training, tradition, laws or regulations, or the organization.

scope of services The range of activities performed by governance, managerial, clinical, and support personnel.

screening criteria A set of standardized rules or tests applied to patient groups on which to base a preliminary judgment that further evaluation is warranted, such as the need for a nutritional evaluation based on nutritional screening.

security Protection from loss, destruction, tampering, or unauthorized access or use.
sedation  See anesthesia and sedation.

sentinel event  An unanticipated occurrence involving death or major permanent loss of function.

side effect  Pharmacological effect of a drug, normally adverse, other than the one(s) for which the drug is prescribed.

specialty laboratory programs  Programs that include laboratory disciplines, such as chemistry (including toxicology, therapeutic drug testing, and drugs of abuse testing), clinical cytogenetics-immunogenetics, diagnostic immunology, embryology, hematology (including coagulation testing), histocompatibility, immunohematology, microbiology (including bacteriology, mycobacteriology, mycology, virology, and parasitology), molecular biology, pathology (including surgical pathology, cytopathology, and necropsy), and radiobioassay.

staff  According to their roles and responsibilities, all people who provide care, treatment, and services in the organization (for example, medical staff and nursing staff), including those receiving pay (permanent, temporary, and part-time personnel, as well as contract employees), volunteers, and health profession students.

clinical staff  Those who provide direct patient care (physicians, dentists, nurses, among others).

nonclinical staff  Those who provide indirect patient care (admissions, food service, among others).

standard  A statement that defines the performance expectations, structures, or processes that must be in place for an organization to provide safe and high-quality care, treatment, and service.

standards-based evaluation  An assessment process that determines a health care organization's or practitioner's compliance with preestablished standards. Also see accreditation.

sterilization  The use of a physical or chemical procedure to destroy all microbial life, including highly resistant bacterial endospores.

surgery  Those procedures that investigate and/or treat diseases and disorders of the human body through cutting, removing, altering, or insertion of diagnostic/therapeutic scopes.

survivor risk factors  Chances for surviving family members or other loved ones to experience difficulties with the death of a loved one.

symptom, primary  First or most prominent indication of an illness, disease, or other disorder.

symptom, secondary  An indication of illness, disease, or other disorder that appears after or because of a primary symptom.

therapeutic duplication  One person using two drugs, usually unnecessarily, from the same therapeutic category at the same time.

time-out  A pause, just prior to performing a surgical or other procedure, during which any unanswered questions or confusion about patient, procedure, or site are resolved by the entire surgical or procedural team. Even when there is only one person doing the procedure, a brief pause to confirm the correct patient, procedure, and site is appropriate.

tracer methodology  A process that JCI surveyors use during the on-site survey to analyze an organization's systems by following individual patients through the organization's health care process in the sequence experienced by the patients. Depending on the health care setting, this may require surveyors to visit multiple care units, departments, or areas within an organization or a single care unit to “trace” the care rendered to a patient.

patient tracer  The process used by JCI to evaluate an individual patient's total care experience within a health care organization.

system tracer  A session during the on-site survey devoted to evaluating high-priority safety and quality-of-care issues on a systemwide basis throughout the organization. Examples of such issues may include infection prevention and control, medication management, staffing effectiveness, and the use of data.
**transfer**  The formal shifting of responsibility for the care of a patient from (1) one care unit to another, (2) one clinical service to another, (3) one qualified practitioner to another, or (4) one organization to another.

**urgent**  A classification of acuity used in triage systems to signify that the patient’s condition is potentially life-threatening and requires timely assessment and possible intervention.

**utility system**  Organizationwide system and equipment that support the following: electrical distribution; emergency power; water; vertical and horizontal transport; heating, ventilating, and air-conditioning; plumbing, boiler, and steam; piped gases; vacuum systems; or communication systems, including data-exchange systems. May also include systems for life support; surveillance, prevention, and control of infection; and environment support.

**utilization**  The use, patterns of use, or rates of use of a specified health care service. Overuse occurs when a health care service is provided under circumstances in which its potential for harm exceeds the possible benefits. Underuse is the failure to use a necessary health care service when it would have produced a favorable outcome for a patient. Misuse occurs when an appropriate service has been selected but a preventable complication occurs. All three reflect a problem in quality of health care. They can increase mortality risk and diminish quality of life. 

*Also see utilization management.*

**utilization management**  The planning, organization, direction, and control of resources. How this relates to patient care by a health care organization is significant.

**validity**  Ability to identify opportunities for improvement in the quality of care; demonstration that the measure used results in improvements in outcomes and/or quality of care.

**variation**  The differences in results obtained in measuring the same event more than once. The sources of variation can be grouped into two major classes: common causes and special causes. Too much variation often leads to waste and loss, such as the occurrence of undesirable patient health outcomes and increased cost of health services.
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