The Joint Commission

Requirements for the Hospital Accreditation Program

Accreditation Participation Requirements (APR) Chapter

APR.01.01.01

The hospital submits information to The Joint Commission as required.

Element(s) of Performance for APR.01.01.01

1. The hospital meets all requirements for timely submissions of data and information to The Joint Commission.
   Note 1: The Joint Commission will impose the following consequence for failure to comply with this APR:
   If the hospital consistently fails to meet the requirements for the timely submission of data and information to The Joint Commission, the hospital will be required to undergo an Accreditation with Follow-up Survey. Failure to resolve this issue at the time of the Accreditation with Follow-up Survey may result in an accreditation decision change.
   Note 2: The proposed consequences address only compliance with the requirement itself. They do not address the content of the hospital's submissions to The Joint Commission. For example, if information in a hospital's electronic application for accreditation (E-App) leads to inaccuracies in the appropriate length of the survey and a longer survey is required, the hospital will incur the additional costs of the longer survey. In addition, if there is evidence that the hospital has intentionally falsified the information submitted to The Joint Commission, the requirement at APR.01.02.01, EP 1 and its consequences will apply. (See also APR.01.02.01, EP 1)

APR.01.02.01

The hospital provides accurate information throughout the accreditation process.

Element(s) of Performance for APR.01.02.01

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

   Note 2: For the purpose of this requirement, falsification is defined as the fabrication, in whole or in part, and through commission or omission, of any information provided by an applicant or accredited organization to The Joint Commission. This includes redrafting, reformatting, or deleting document content. However, the organization may submit supporting material that explains the original information submitted to The Joint Commission. These additional materials must be properly identified, dated, and accompanied by the original documents.(See also APR.01.01.01, EP 1)

APR.01.03.01

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

Element(s) of Performance for APR.01.03.01

1. The hospital notifies The Joint Commission in writing within 30 days of a change in ownership, control, location, capacity, services offered, or required licensure.
   Note 1: When the hospital changes ownership, control, location, capacity, or services offered, it may be necessary for The Joint Commission to survey the hospital again.

Note 2: If the hospital does not provide written notification to The Joint Commission within 30 days of these changes, the hospital may be denied accreditation.

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital notifies The Joint Commission immediately upon receiving notice from the Centers for Medicare & Medicaid Services (CMS) that its deemed status has been removed due to Medicare condition-level noncompliance identified during a recent CMS complaint or validation survey.

APR.02.01.01

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

Element(s) of Performance for APR.02.01.01

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

APR.04.01.01

The hospital selects and uses performance measures from among those available that are relevant to the services it provides and the population(s) it serves to meet specified ORYX® measure reporting requirements for accreditation. Note: Hospitals are encouraged to keep up-to-date on any changes in the ORYX® requirements by reviewing recent issues of The Joint Commission Perspectives® or by going to the “Measurement” area on The Joint Commission website at http://www.jointcommission.org.

Element(s) of Performance for APR.04.01.01

1. The hospital selects and uses measures that reflect the following characteristics: Relevant to the hospital
2. The hospital selects and uses measures that reflect the following characteristics: Support strategic measurement goals
3. The hospital selects and uses measures that reflect the following characteristics: Target high-volume, high-risk, problem-prone issues
4. The hospital selects and uses measures that reflect the following characteristics: Provide opportunities to improve the quality of care
5. The hospital selects chart-abstracted measures and/or electronic clinical quality measures (eCQMs) based on its patient population/services offered to meet current ORYX® requirements.
6. The hospital selects performance measures within The Joint Commission’s data submission application.
7. The hospital discusses with the surveyor how the data are used to identify, prioritize, and monitor performance improvement activities.
8. The hospital uses each individual measure to identify patterns, trends, or variations for improvement opportunities before replacing it. (For example, chart-abstracted measures should begin the first quarter of the calendar year or first quarter following receipt of an accreditation decision letter and be used for the remainder of the calendar year before replacing any measures.)
9. Based on Joint Commission statistical analysis, the hospital continues to use a measure if the data suggest an unstable pattern of performance or otherwise identify an opportunity for improvement.
10. The hospital selects a new measure if the data reflect stable and satisfactory performance.

11. The hospital notifies The Joint Commission of a change in its service line that results in specific measures no longer being applicable (for example, a hospital closes its obstetrical unit and can no longer report the Perinatal Care measures).

12. The hospital's performance measure data are submitted to The Joint Commission in the timelines established and technical manner prescribed by The Joint Commission.

13. The hospital resolves data quality issues for reported performance measures.

14. For the most recent 12-month calendar reporting period, the hospital achieves and sustains an acceptable level of performance for each measure, as defined by Joint Commission statistical analysis, before it discontinues a measure's use in performance improvement activities.

APR.05.01.01

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

Element(s) of Performance for APR.05.01.01

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

APR.06.01.01

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

Element(s) of Performance for APR.06.01.01

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

APR.07.01.01

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

Element(s) of Performance for APR.07.01.01

1. The hospital allows Joint Commission surveyor management staff or a member of the Board of Commissioners to observe the on-site survey.
   Note 1: The observer will not participate in the on-site survey process, including the scoring of standards compliance. Surveyor management staff will only participate in the survey process if they feel it is necessary to bring any potential findings or observations to the attention of the surveyor and the hospital.
   Note 2: The hospital will not incur any additional survey fees because an observer(s) is present.

APR.08.01.01

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

Element(s) of Performance for APR.08.01.01

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

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

APR.09.01.01

The hospital notifies the public it serves about how to contact its hospital management and The Joint Commission to report concerns about patient safety and quality of care.
Note: Methods of notice may include, but are not limited to, distribution of information about The Joint Commission, including contact information in published materials such as brochures and/or posting this information on the hospital's website.

Element(s) of Performance for APR.09.01.01

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

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

APR.09.02.01

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

Element(s) of Performance for APR.09.02.01

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

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

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

APR.09.04.01

The hospital provides care, treatment, services, and an environment that pose no risk of an “Immediate Threat to Health or Safety.”

Element(s) of Performance for APR.09.04.01

1. The hospital provides care, treatment, services, and an environment that pose no risk of an “Immediate Threat to Health or Safety.”

Emergency Management (EM) Chapter

EM.09.01.01

The hospital has a comprehensive emergency management program that utilizes an all-hazards approach.

Element(s) of Performance for EM.09.01.01

1. The hospital has a written comprehensive emergency management program that utilizes an all-hazards approach. The program includes, but is not limited to, the following:

- Leadership structure and program accountability
- Hazard vulnerability analysis
- Mitigation and preparedness activities
- Emergency operations plan and policies and procedures
- Education and training
- Exercises and testing
- Continuity of operations plan
- Disaster recovery
- Program evaluation

CoP(s): §482.15

2. If the hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program:
   - Each separately certified hospital within the system actively participates in the development of the unified and integrated emergency management program
   - The program is developed and maintained in a manner that takes into account each separately certified hospital's unique circumstances, patient population, and services offered
   - Each separately certified hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program
   - Documented community-based risk assessment utilizing an all-hazards approach
   - Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified hospital within the health care system
   - Unified and integrated emergency plan
   - Integrated policies and procedures
   - Coordinated communication plan
   - Training and testing program

   CoP(s): §482.15(f)(1), §482.15(f)(2), §482.15(f)(3), §482.15(f)(4), §482.15(f)(4)(i), §482.15(f)(4)(ii), §482.15(f)(5)

3. The hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations.

   CoP(s): §482.15, §482.15(c), §482.15(f)(5)

4. For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital has one or more transplant programs (as defined in 42 CFR 482.70) the following must occur:
   - A representative from each transplant program must be included in the development and maintenance of the hospital's emergency preparedness program
   - The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant program, and the organ procurement organization (OPO) for the donation service area where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency

   CoP(s): §482.15(g)(1), §482.15(g)(2)

EM.11.01.01

The hospital conducts a hazard vulnerability analysis utilizing an all-hazards approach.

Element(s) of Performance for EM.11.01.01

1. The hospital conducts a facility-based hazard vulnerability analysis (HVA) using an all-hazards approach that includes the following:
   - Hazards that are likely to impact the hospital's geographic region, community, facility, and patient population
   - A community-based risk assessment (such as those developed by external emergency management agencies)
   - Separate HVAs for its other accredited facilities if they significantly differ from the main site

   The findings are documented.
   Note: A separate HVA is only required if the accredited facilities are in different geographic locations, experience different hazards or threats, or the patient population and services offered are unique to this facility.

   CoP(s): §482.15(a)(1)

2. The hospital's hazard vulnerability analysis includes the following:
   - Natural hazards (such as flooding, wildfires)
   - Human-caused hazards (such as bomb threats or cyber/information technology crimes)
   - Technological hazards (such as utility or information technology outages)
   - Hazardous materials (such as radiological, nuclear, chemical)
   - Emerging infectious diseases (such as the Ebola, Zika, or SARS-CoV-2 viruses)

   CoP(s): §482.15(a)(1)

3. The hospital evaluates and prioritizes the findings of the hazard vulnerability analysis to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the hospital and its ability to provide services. The findings are documented.

   CoP(s): §482.15(a)(2), §482.15(f)(4)

4. The hospital uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the hospital and helps reduce disruption of essential services or functions.

   CoP(s): §482.15(a)(2), §482.15(f)(4)

EM.12.01.01

The hospital develops an emergency operations plan based on an all-hazards approach.
Note: The hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.

Element(s) of Performance for EM.12.01.01

1. The hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following:

- Mobilizing incident command
- Communications plan
- Maintaining, expanding, curtailing, or closing operations
- Protecting critical systems and infrastructure
- Conserving and/or supplementing resources
- Surge plans (such as flu or pandemic plans)
- Identifying alternate treatment areas or locations
- Sheltering in place
- Evacuating (partial or complete) or relocating services
- Safety and security
- Securing information and records

CoP(s): §482.15(a), §482.15(b), §482.15(c), §482.15(f)(5)

2. The hospital's emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event.
Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident, such as medical care, communication, transportation, supervision, and maintaining independence.

CoP(s): §482.15(a)(3), §482.15(f)(4)

3. The hospital's emergency operations plan includes written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, volunteers, and patients.
Note 1: Shelter-in-place plans may vary by department and facility and may vary based on the type of emergency or situation.
Note 2: Safe evacuation from the hospital includes consideration of care, treatment, and service needs of evacuees, staff responsibilities, and transportation.

CoP(s): §482.15(b)(3), §482.15(b)(4)

4. The emergency operations plan includes written procedures for how the hospital will provide essential needs for its staff, volunteers, and patients, whether they shelter in place or evacuate, that includes, but is not limited to, the following:
- Food and other nutritional supplies
- Medications and related supplies
- Medical/surgical supplies
- Medical oxygen and supplies
- Potable or bottled water

CoP(s): §482.15(b)(1)(i)

6. The hospital's emergency operations plan includes a process for cooperating and collaborating with other health care facilities; health care coalitions; and local, tribal, regional, state, and federal emergency preparedness

officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident.

CoP(s): §482.15(a)(4), §482.15(f)(4)

7. The hospital must develop and implement emergency preparedness policies and procedures that address the role of the hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Social Security Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.
Note 1: This element of performance is applicable only to hospitals that receive Medicare, Medicaid, or Children's Health Insurance Program reimbursement.
Note 2: For more information on 1135 waivers, visit https://www.cms.gov/about-cms/what-we-do/emergency-response/how-can-we-help/waivers-flexibilities and https://www.cms.gov/about-cms/agency-information/emergency/downloads/consolidated_medicare_ffs_emergency_qsas.pdf.

CoP(s): §482.15(b)(8)

EM.12.02.01

The hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency.
Note: The hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.

Element(s) of Performance for EM.12.02.01

1. The hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following:
   - Staff
   - Physicians and other licensed practitioners
   - Volunteers
   - Other health care organizations
   - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies
   - Relevant community partners (such as fire, police, local incident command, public health departments)
   - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff)
   - Other sources of assistance (such as health care coalitions)

   Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.

   CoP(s): §482.15(c)(1)(i), §482.15(c)(1)(ii), §482.15(c)(1)(iii), §482.15(c)(1)(iv), §482.15(c)(1)(v), §482.15(c)(2)(i), §482.15(c)(2)(ii)

3. The hospital's communication plan describes how the hospital will communicate with and report information about its organizational needs, available occupancy, and ability to provide assistance to relevant authorities.

Note: Examples of hospital needs include shortages in personal protective equipment, staffing shortages, evacuation or transfer of patients, and temporary loss of part or all organization function.

CoP(s): §482.15(c)(7)

4. In the event of an emergency or evacuation, the hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation:
   - Patient's family, representative, or others involved in the care of the patient
   - Disaster relief organizations and relevant authorities
   - Other health care providers

   Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).

   CoP(s): §482.15(c)(4), §482.15(c)(5), §482.15(c)(6)

5. The hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following:
   - How and when alternate/backup communication methods are used
   - Verifying that its communications systems are compatible with those of community partners and relevant authorities the hospital plans to communicate with
   - Testing the functionality of the hospital's alternate/backup communication systems or equipment

   Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems.

   CoP(s): §482.15(b)(3), §482.15(c)(3)(i), §482.15(c)(3)(ii)

EM.12.02.03

The hospital has a staffing plan for managing all staff and volunteers during an emergency or disaster incident.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a staffing plan.

Element(s) of Performance for EM.12.02.03

1. The hospital develops a staffing plan for managing all staff and volunteers to meet patient care needs during the duration of an emergency or disaster incident or during a patient surge. The plan includes the following:
   - Methods for contacting off-duty staff
   - Acquisition of staff from its other health care facilities
   - Use of volunteer staffing, such as staffing agencies, health care coalition support, and those deployed as part of the disaster medical assistance teams

   Note: If the hospital determines that it will never use volunteers during disasters, this is documented in its plan.

   CoP(s): §482.15(b)(6)

2. The hospital's staffing plan addresses the management of all staff and volunteers as follows:

- Reporting processes
- Roles and responsibilities for essential functions
- Integration of staffing agencies, volunteer staffing, or deployed medical assistance teams into assigned roles and responsibilities

CoP(s): §482.15(b)(6)

EM.12.02.05

The hospital has a plan for providing patient care and clinical support during an emergency or disaster incident.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for patient care and clinical support.

Element(s) of Performance for EM.12.02.05

1. The hospital's plan for providing patient care and clinical support includes written procedures and arrangements with other hospitals and providers for how it will share patient care information and medical documentation and how it will transfer patients to other health care facilities to maintain continuity of care.

   CoP(s): §482.15(b)(7), §482.15(c)(4)

EM.12.02.07

The hospital has a plan for safety and security measures to take during an emergency or disaster incident.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for safety and security.

Element(s) of Performance for EM.12.02.07

2. The hospital's plan for safety and security measures includes a system to track the location of its on-duty staff and volunteers and patients when sheltered in place, relocated, or evacuated. If on-duty staff and volunteers and patients are relocated during an emergency, the hospital documents the specific name and location of the receiving facility or evacuation location.
   Note: Examples of systems used for tracking purposes include the use of established technology or tracking systems or taking head counts at defined intervals.

   CoP(s): §482.15(b)(2)

EM.12.02.09

The hospital has a plan for managing resources and assets during an emergency or disaster incident.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for resources and assets.

Element(s) of Performance for EM.12.02.09

1. The hospital's plan for managing its resources and assets describes in writing how it will document, track, monitor, and locate the following resources (on-site and off-site inventories) and assets during and after an emergency or disaster incident:
   - Medications and related supplies
   - Medical/surgical supplies
   - Medical gases, including oxygen and supplies
   - Potable or bottled water and nutrition
   - Non-potable water
   - Laboratory equipment and supplies
   - Personal protective equipment
   - Fuel for operations
   - Equipment and nonmedical supplies to sustain operations

   Note: The hospital should be aware of the resources and assets it has readily available and what resources and assets may be quickly depleted depending on the type of emergency or disaster incident.

   CoP(s): §482.15(e)(3)

2. The hospital's plan for managing its resources and assets describes in writing how it will obtain, allocate, mobilize, replenish, and conserve its resources and assets during and after an emergency or disaster incident, including the following:
   - If part of a health care system, coordinating within the system to request resources
   - Coordinating with local supply chains or vendors
   - Coordinating with local, state, or federal agencies for additional resources
   - Coordinating with regional health care coalitions for additional resources
   - Managing donations (such as food, water, equipment, materials)

   Note: High priority should be given to resources that are known to deplete quickly and are extremely competitive to acquire and replenish (such as fuel, oxygen, personal protective equipment, ventilators, intravenous fluids, antiviral and antibiotic medications).

   CoP(s): §482.15(e)(3)

EM.12.02.11

The hospital has a plan for managing essential or critical utilities during an emergency or disaster incident.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.

Element(s) of Performance for EM.12.02.11

1. The hospital's plan for managing utilities describes in writing the utility systems that it considers as essential or critical to provide care, treatment, and services.

Note: Essential or critical utilities to consider may include systems for electrical distribution; emergency power; vertical and horizontal transport; heating, ventilation, and air conditioning; plumbing and steam boilers; medical gas; medical/surgical vacuum; and network or communication systems.

CoP(s): §482.15(e)

2. The hospital's plan for managing utilities describes in writing how it will continue to maintain essential or critical utility systems if one or more are impacted during an emergency or disaster incident.

   CoP(s): §482.15(e), §482.15(e)(3)

3. The hospital's plan for managing utilities describes in writing alternative means for providing essential or critical utilities, such as water supply, emergency power supply systems, fuel storage tanks, and emergency generators.

   CoP(s): §482.15(e), §482.15(e)(3)

4. The hospital's plan for managing utilities includes alternate sources for maintaining energy to the following:
   - Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions
   - Emergency lighting
   - Fire detection, extinguishing, and alarm systems
   - Sewage and waste disposal

   Note: It is important for hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the hospital considers partial or full evacuation or closure.

   CoP(s): §482.15(b)(1)(ii)(A), §482.15(b)(1)(ii)(B), §482.15(b)(1)(ii)(C), §482.15(b)(1)(ii)(D)

EM.13.01.01

The hospital has a continuity of operations plan.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a continuity of operations plan.

Element(s) of Performance for EM.13.01.01

1. The hospital has a written continuity of operations plan (COOP) that is developed with the participation of key executive leaders, business and finance leaders, and other department leaders as determined by the hospital. These key leaders identify and prioritize the services and functions that are considered essential or critical for maintaining operations.
   Note: The COOP provides guidance on how the hospital will continue to perform its essential business functions to deliver essential or critical services. Essential business functions to consider include administrative/vital records, information technology, financial services, security systems, communications/telecommunications, and

building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption.

CoP(s): §482.15(a)(3), §482.15(f)(4)

2. The hospital's continuity of operations plan identifies in writing how and where it will continue to provide its essential business functions when the location of the essential or critical service has been compromised due to an emergency or disaster incident.
Note: Example of options to consider for providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth.

CoP(s): §482.15(a)(3), §482.15(f)(4)

3. The hospital has a written order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties.

CoP(s): §482.15(a)(3), §482.15(f)(4)

4. The hospital has a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the hospital for specified purposes and to carry out specific duties.
Note: Delegations of authority are an essential part of an organization's continuity program and should be sufficiently detailed to make certain the hospital can perform its essential functions. Delegations of authority will specify a particular function that an individual is authorized to perform and includes restrictions and limitations associated with that authority.

CoP(s): §482.15(a)(3), §482.15(f)(4)

EM.15.01.01

The hospital has an emergency management education and training program.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.

Element(s) of Performance for EM.15.01.01

1. The hospital has a written education and training program in emergency management that is based on the hospital's prioritized risks identified as part of its hazard vulnerability analysis, emergency operations plan, communications plan, and policies and procedures.
Note: If the hospital has developed multiple hazard vulnerability analyses based on the location of other services offered, the education and training for those facilities are specific to their needs.

CoP(s): §482.15(d), §482.15(f)(5)

2. The hospital provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The initial education and training include the following:
   - Activation and deactivation of the emergency operations plan
   - Communications plan

- Emergency response policies and procedures
- Evacuation, shelter-in-place, lockdown, and surge procedures
- Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment)

Documentation is required.

CoP(s): §482.15(d)(1)(i), §482.15(d)(1)(iii), §482.15(d)(1)(iv)

3. The hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times:
   - At least every two years
   - When roles or responsibilities change
   - When there are significant revisions to the emergency operations plan, policies, and/or procedures
   - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training

   Documentation is required.
   Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization.
   Note 2: Hospitals are not required to retrain staff on the entire emergency operations plan but can choose to provide education and training specific to the new or revised elements of the emergency management program.

   CoP(s): §482.15(d)(1)(ii), §482.15(d)(1)(iii), §482.15(d)(1)(iv), §482.15(d)(1)(v)

EM.16.01.01

The hospital plans and conducts exercises to test its emergency operations plan and response procedures.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.

Element(s) of Performance for EM.16.01.01

1. The hospital describes in writing a plan for when and how it will conduct annual testing of its emergency operations plan (EOP). The planned exercises are based on the following:
   - Likely emergencies or disaster scenarios
   - EOP and policies and procedures
   - After-action reports (AAR) and improvement plans
   - Six critical areas (communications, staffing, patient care and clinical support, safety and security, resources and assets, utilities)

   Note 1: The planned exercises should attempt to stress the limits of its emergency response procedures to assess how prepared the hospital may be if a real event or disaster were to occur based on past experiences.
   Note 2: An AAR is a detailed critical summary or analysis of an emergency or disaster incident, including both planned and unplanned events. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement.

   CoP(s): §482.15(d), §482.15(f)(5)

2. The hospital is required to conduct two exercises per year to test the emergency operations plan.
   - One of the annual exercises must consist of an operations-based exercise as follows:
   - Full-scale, community-based exercise; or

- Functional, facility-based exercise when a community-based exercise is not possible
- The other annual exercise must consist of either an operations-based or discussion-based exercise as follows:
- Full-scale, community-based exercise; or
- Functional, facility-based exercise; or
- Mock disaster drill; or
- Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

Exercises and actual emergency or disaster incidents are documented (after-action reports).
Note 1: The hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the hospital provides documentation that it activated its emergency operations plan.
Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.

CoP(s): §482.15(d)(2), §482.15(d)(2)(i), §482.15(d)(2)(i)(A), §482.15(d)(2)(i)(B), §482.15(d)(2)(ii)(A), §482.15(d)(2)(ii)(B), §482.15(d)(2)(ii)(C)

EM.17.01.01

The hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.

Element(s) of Performance for EM.17.01.01

1. The multidisciplinary committee that oversees the emergency management program reviews and evaluates all exercises and actual emergency or disaster incidents. The committee reviews after-action reports (AARs), identifies opportunities for improvement, and recommends actions to take to improve the emergency management program. The AARs and improvement plans are documented.
Note 1: The review and evaluation addresses the effectiveness of its emergency response procedure, continuity of operations plans (if activated), training and exercise programs, evacuation procedures, surge response procedures, and activities related to communications, resources and assets, security, staff, utilities, and patients.
Note 2: An AAR provides a detailed critical summary or analysis of a planned exercise or an actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement.

   CoP(s): §482.15(d)(2)(iii)

3. The hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary:
   - Hazard vulnerability analysis
   - Emergency management program
   - Emergency operations plan, policies, and procedures
   - Communications plan
   - Continuity of operations plan
   - Education and training program

- Testing program

CoP(s): §482.15(a), §482.15(b), §482.15(c), §482.15(d), §482.15(d)(2)(iii), §482.15(f)(5)

Human Resources (HR) Chapter

HR.11.01.01

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

Element(s) of Performance for HR.11.01.01

1. The hospital's food and dietetic services administrative and technical staff are competent to perform their responsibilities.

   CoP(s): §482.28(a)(3)

HR.11.01.03

The hospital determines how staff function within the organization.

Element(s) of Performance for HR.11.01.03

1. All staff who provide patient care, treatment, and services are qualified and possess a current license, certification, or registration, in accordance with law and regulation.

   CoP(s): §482.11(c)

3. The hospital develops and implements a procedure to verify and document the following:
   - Credentials of staff using the primary source when licensure, certification, or registration is required by federal, state, or local law and regulation. This is done at the time of hire and at the time credentials are renewed.
   - Credentials of staff (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed.

   Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented.
   Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source.
   Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.
   Note 4: The hospital determines the required qualifications for staff based on job responsibilities.

   CoP(s): §482.23(b)(2)

HR.11.02.01

The hospital defines and verifies staff qualifications.

Element(s) of Performance for HR.11.02.01

1. The hospital defines staff qualifications specific to their job responsibilities.
   Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).
   Note 2: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments (CLIA), under Subpart M: “Personnel for Nonwaived Testing” §493.1351-§493.1495. A complete description of the requirement is located at https://www.ecfr.gov/cgi-bin/text-idx?SID=0854acca5427c69e771e5beb52b0b986&mc=true&node=sp42.5.493.m&rgn=div6.
   Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists, as defined in 42 CFR 484, provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist.
   Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964.
   Note 5: If respiratory care services are provided, staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing.

   CoP(s): §482.42(a)(1), §482.56(a)(2), §482.57(b)(1), §482.58(b)(6), §483.65(b)

2. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a director of psychiatric nursing that is a registered nurse who has a master’s degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing or is qualified by education and experience in the care of the mentally ill. The director of psychiatric nursing demonstrates competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care provided.

   CoP(s): §482.62(d), §482.62(d)(1), §482.62(d)(1)

3. The director of rehabilitation services has the knowledge, experience, and capabilities to supervise and administer the services.

   CoP(s): §482.56(a)(1)

4. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:
   The hospital does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property.

   CoP(s): §482.58(b)(3), §483.12(a)(3)(i), §483.12(a)(3)(ii)

5. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The director of social services has a master's degree from an accredited school of social work or is qualified by education and experience in the social services needs of the mentally ill.
Note: If the director does not hold a master's degree in social work, at least one staff member has this qualification.

   CoP(s): §482.62(f)(1)

HR.11.03.01

The hospital provides orientation, education, and training to their staff.

Element(s) of Performance for HR.11.03.01

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

   CoP(s): §482.42(c)(2)(iv)

HR.11.04.01

The hospital evaluates staff competence and performance.

Element(s) of Performance for HR.11.04.01

1. Staff competence is initially assessed and documented as part of orientation and once every three years, or more frequently as required by hospital policy or in accordance with law and regulation.

   CoP(s): §482.42(c)(2)(iv)

Infection Prevention and Control (IC) Chapter

IC.04.01.01

The hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.

Element(s) of Performance for IC.04.01.01

2. The infection preventionist(s) or infection control professional(s) is responsible for the following:
   - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines
   - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities
   - Competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on infection prevention and control policies and procedures and their application

• Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures
• Communication and collaboration with all components of the hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program
• Communication and collaboration with the hospital's quality assessment and performance improvement program to address infection prevention and control issues

Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1).(See also PE.04.01.05, EP 2)

CoP(s): §482.42, §482.42(c)(2)(i), §482.42(c)(2)(ii), §482.42(c)(2)(iii), §482.42(c)(2)(iv), §482.42(c)(2)(v), §482.42(c)(2)(vi)

3. The hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references:
a. Applicable law and regulation.
b. Manufacturers' instructions for use.
c. Nationally recognized evidence-based guidelines and standards of practice, including the Centers for Disease Control and Prevention's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures.
Note 1: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services' Conditions of Participation, Food and Drug Administration's regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators.
Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.html.
Note 3: The hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its policies and procedures.

CoP(s): §482.42, §482.42(a)(2)

4. The hospital's policies and procedures for cleaning, disinfection, and sterilization of reusable medical and surgical devices and equipment address the following:
• Cleaning, disinfection, and sterilization of reusable medical and surgical devices in accordance with the Spaulding classification system and manufacturers' instructions
• Use of disinfectants registered by the Environmental Protection Agency for noncritical devices and equipment according to the directions on the product labeling, including but not limited to indication, specified use dilution, contact time, and method of application

• Use of FDA-approved liquid chemical sterilants for the processing of critical devices and high-level disinfectants for the processing of semicritical devices in accordance with FDA-cleared label and device manufacturers' instructions
• Required documentation for device reprocessing cycles, including but not limited to sterilizer cycle logs, the frequency of chemical and biological testing, and the results of testing for appropriate concentration for chemicals used in high-level disinfection
• Resolution of conflicts or discrepancies between a medical device manufacturer's instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment
• Criteria and process for the use of immediate-use steam sterilization
• Actions to take in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use

Note 1: The Spaulding classification system classifies medical and surgical devices as critical, semicritical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate-level disinfection, and low-level disinfection) to be used for the three classes of devices.
Note 2: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up.

CoP(s): §482.42(a)(2)

5. The infection prevention and control program reflects the scope and complexity of the hospital services provided by addressing all locations, patient populations, and staff.(See also LD.11.01.01, EP 10)

   CoP(s): §482.42, §482.42(a)(4)

IC.05.01.01

The hospital's governing body is accountable for the implementation, performance, and sustainability of the infection prevention and control program.

Element(s) of Performance for IC.05.01.01

1. The hospital's governing body is responsible for the implementation, performance, and sustainability of the infection prevention and control program and provides resources to support and track the implementation, success, and sustainability of the program's activities.
   Note: To make certain that systems are in place and operational to support the program, the governing body provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies.

   CoP(s): §482.42, §482.42(c)(1)(i)

2. The hospital's governing body ensures that the problems identified by the infection prevention and control program are addressed in collaboration with hospital quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders).

   CoP(s): §482.42, §482.42(c)(1)(ii)

IC.06.01.01

The hospital implements its infection prevention and control program through surveillance, prevention, and control activities.

Element(s) of Performance for IC.06.01.01

3. The hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the hospital.

   CoP(s): §482.42, §482.42(a)(3)

4. The hospital implements its policies and procedures for infectious disease outbreaks, including the following:
   - Implementing infection prevention and control activities when an outbreak is first recognized by internal surveillance or public health authorities
   - Reporting an outbreak in accordance with state and local public health authorities' requirements
   - Investigating an outbreak
   - Communicating information necessary to prevent further transmission of the infection among patients, visitors, and staff, as appropriate

   CoP(s): §482.42(a)(3)

5. The hospital implements policies and procedures to minimize the risk of communicable disease exposure and acquisition among its staff, in accordance with law and regulation. The policies and procedures address the following:
   - Screening and medical evaluations for infectious diseases
   - Immunizations
   - Staff education and training
   - Management of staff with potentially infectious exposures or communicable illnesses

   CoP(s): §482.42(a)(3)

Information Management (IM) Chapter

IM.11.01.01

The hospital plans for continuity of its information management processes.

Element(s) of Performance for IM.11.01.01

1. The hospital develops and implements policies and procedures regarding medical documentation and patient information during emergencies and other interruptions to information management systems, including security and availability of patient records to support continuity of care.
   Note: These policies and procedures are based on the emergency plan, risk assessment, and emergency communication plan and are reviewed and updated at least every 2 years.

   CoP(s): §482.15(b)(5)

IM.12.01.01

The hospital protects the privacy and confidentiality of health information.

Element(s) of Performance for IM.12.01.01

1. The hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information.
   Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Policies and procedures also address the resident's personal records.

   CoP(s): §482.13(d)(1), §482.24(b)(3), §482.58(b)(1), §483.10(h), §483.10(h)(3)

2. The hospital discloses health information only as authorized by the patient with the patient's written consent or as otherwise required by law and regulation.
   Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with state law.

   CoP(s): §482.58(b)(1), §483.10(h)(3)(i), §483.10(h)(3)(ii)

3. The hospital develops and implements policies and procedures for the release of medical records. The policies and procedures are in accordance with law and regulation, court orders, or subpoenas.
   Note: Information from or copies of records may be released only to authorized individuals, and the hospital makes certain that unauthorized individuals cannot gain access to or alter patient records.

   CoP(s): §482.24(b)(3)

IM.12.01.03

The hospital maintains the security and integrity of health information.

Element(s) of Performance for IM.12.01.03

1. The hospital develops and implements a written policy that addresses the security of health information, including the following:
   - Access and use of health information
   - Integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction
   - Intentional destruction of health information
   - When and by whom the removal of health information is permitted

   Note: Removal refers to those actions that place health information outside the hospital's control.

   CoP(s): §482.24(b)(3)

IM.13.01.01

The hospital records health information in standardized formats.

Element(s) of Performance for IM.13.01.01

1. The hospital uses standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.

IM.13.01.03

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

Element(s) of Performance for IM.13.01.03

1. The hospital has a system for coding and indexing medical records to make health information accessible when needed for patient care, treatment, and services.
   Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical records system allows for timely retrieval of patient information by diagnosis and procedure.

   CoP(s): §482.24(b)(2)

IM.13.01.05

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets requirements for the electronic exchange of patient health information.
Note: This standard only applies to hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).

Element(s) of Performance for IM.13.01.05

1. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital demonstrates that its electronic health records system's (or other electronic administrative system's) notification capacity is fully operational and is used in accordance with applicable state and federal laws and regulations for the exchange of patient health information.

   CoP(s): §482.24(d)(1), §482.61(f)(1)

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital demonstrates that its electronic health records system (or other electronic administrative system) sends notifications that include, at a minimum, the patient’s name, treating licensed practitioner’s name, and sending institution’s name.

   CoP(s): §482.24(d)(2), §482.61(f)(2)

3. For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the patient’s expressed privacy preferences and applicable laws and regulations, the hospital’s electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the following times, when applicable:
   - The patient’s emergency department registration
   - The patient's inpatient admission

   CoP(s): §482.24(d)(3), §482.24(d)(3)(i), §482.24(d)(3)(ii), §482.61(f)(3), §482.61(f)(3)(i), §482.61(f)(3)(ii)

4. For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the hospital's emergency department or inpatient services.

   CoP(s): §482.24(d)(4), §482.24(d)(4)(i), §482.24(d)(4)(ii), §482.61(f)(4), §482.61(f)(4)(i), §482.61(f)(4)(ii)

5. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post–acute care service providers and suppliers, as well as any of the following who need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes:
   - Patient's established primary care licensed practitioner
   - Patient's established primary care practice group or entity
   - Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care

   Note: The term "reasonable effort" means that the hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the hospital system's capabilities.

   CoP(s): §482.24(d)(5), §482.24(d)(5)(i), §482.24(d)(5)(ii), §482.24(d)(5)(iii), §482.61(f)(5), §482.61(f)(5)(i), §482.61(f)(5)(ii), §482.61(f)(5)(iii)

Leadership (LD) Chapter

LD.11.01.01

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

Element(s) of Performance for LD.11.01.01

1. The hospital has a governing body that assumes full legal responsibility for the conduct of the hospital. If the hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital carry out the functions that pertain to the governing body.

   CoP(s): §482.12

2. The governing body does the following:
   - Approves and is responsible for the effective operation of the grievance process
   - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee
   - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff
   - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff
   - Makes certain that the medical staff has bylaws
   - Approves medical staff bylaws and other medical staff rules and regulations

- Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients
- Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment
- Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society
- Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations

CoP(s): §482.12(a)(1), §482.12(a)(2), §482.12(a)(3), §482.12(a)(4), §482.12(a)(5), §482.12(a)(6), §482.12(a)(7), §482.12(f)(2), §482.12(f)(3), §482.13(a)(2)

3. The governing body provides the organized medical staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the organized medical staff.

4. Organized medical staff members are eligible for full membership in the hospital's governing body, unless legally prohibited.

5. For hospitals that use Joint Commission accreditation for deemed status purposes: The governing body consults directly with the individual assigned the responsibility for the organization and conduct of the hospital's medical staff, or with the individual's designee. At a minimum, this direct consultation occurs periodically throughout the fiscal or calendar year and includes a discussion of matters related to the quality of medical care provided to the hospital's patients. For a multi-hospital system using a single governing body, the single multihospital system governing body consults directly with the individual responsible for the organized medical staff (or the individual's designee) of each hospital within its system.

   CoP(s): §482.12(a)(10)

6. The governing body appoints the chief executive officer responsible for managing the hospital.

   CoP(s): §482.12(b)

7. The governing body makes certain that patients are under the care of the appropriate licensed practitioners.

   CoP(s): §482.12(c)(1)(i), §482.12(c)(1)(ii), §482.12(c)(1)(iii), §482.12(c)(1)(iv), §482.12(c)(1)(v), §482.12(c)(1)(vi), §482.12(c)(2), §482.12(c)(3), §482.12(c)(4), §482.12(c)(4)(i), §482.12(c)(4)(ii), §482.12(c)(4)(ii)(A), §482.12(c)(4)(ii)(B), §482.12(c)(4)(ii)(C)

8. The governing body is responsible for making sure that performance improvement activities reflect the complexity of the hospital's organization and services; involve all departments and services including services provided under contract or arrangement; and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. (For more information on contracted services, see Standard LD.14.03.03)

Note: For hospitals that do not use Joint Commission accreditation for deemed status purposes: If the hospital does not have a governing body, it identifies the leadership structure that is responsible for these activities.

CoP(s): §482.21

9. For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital is part of a system consisting of multiple separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member hospitals after determining that such decision is in accordance with all applicable state and local laws.
Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program does the following:
• Accounts for each member hospital's unique circumstances and any significant differences in patient populations and services offered
• Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated program has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed
Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 482.21.

CoP(s): §482.21(f), §482.21(f)(1), §482.21(f)(2)

10. For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital is part of a hospital system consisting of separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member hospitals after determining that such a decision is in accordance with applicable law and regulation. Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following:
• Account for each member hospital's unique circumstances and any significant differences in patient populations and services offered
• Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified hospital, regardless of practice or location, are given due consideration
• Have mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed
• Designate a qualified individual(s) at the hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to hospital staff
Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meet all of the requirements at 42 CFR 482.42(d).(See also IC.04.01.01, EP 5)

CoP(s): §482.42(d), §482.42(d)(1), §482.42(d)(2), §482.42(d)(3), §482.42(d)(4)

11. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home evaluates the effectiveness of how the primary care clinician and the interdisciplinary team partner with the patient to support continuity of care and comprehensive, coordinated care.

LD.11.02.01

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

Element(s) of Performance for LD.11.02.01

1. The hospital has an organized medical staff that is accountable to the governing body for the quality of care provided to patients.

   CoP(s): §482.22(b)

2. The governing body approves the structure of the organized medical staff.

   CoP(s): §482.22(b)(1)

3. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy or, if permitted by state law, a doctor of dental surgery or dental medicine, or a doctor of podiatric medicine is responsible for the organization and conduct of the medical staff.

   CoP(s): §482.22(b)(3)(i), §482.22(b)(3)(ii), §482.22(b)(3)(iii)

4. For hospitals that do not use Joint Commission accreditation for deemed status purposes: There is a single organized medical staff unless criteria are met for an exception to the single medical staff requirements.

LD.12.01.01

Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)

Element(s) of Performance for LD.12.01.01

1. The hospital develops, implements, maintains, and documents an effective, ongoing, data-driven, hospitalwide quality assessment and performance improvement program.
   Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains and demonstrates evidence of its QAPI program for review by CMS.

   CoP(s): §482.21

2. As part of performance improvement, leaders (including the governing body) do the following:
   - Set priorities for performance improvement activities related to health outcomes that are shown to be predictive of desired patient outcomes, patient safety, and quality of care
   - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and consider the incidence, prevalence, and severity of problems in those areas
   - Identify the frequency and detail of data collection for performance improvement activities

   CoP(s): §482.21(b)(3), §482.21(c)(1)(i), §482.21(c)(1)(ii), §482.21(c)(1)(iii)

3. The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for the following:
   • An ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained
   • The hospitalwide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and all improvement actions are evaluated
   • Clear expectations for safety are established
   • Adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients
   • The determination of the number of distinct improvement projects is conducted annually

   CoP(s): §482.21(e)(1), §482.21(e)(2), §482.21(e)(3), §482.21(e)(4), §482.21(e)(5)

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

5. For hospitals that elect The Joint Commission Primary Care Medical Home option: Leaders use qualitative data collection methods to involve patients in performance improvement activities.
   Note: Qualitative data collection methods are used to provide insight into patients' opinions, along with underlying reasons, and motivations. Examples of qualitative methods include focus groups, telephonic or in-person patient interviews or patient rounding, and patient participation on performance improvement committees.

LD.13.01.01

The hospital complies with law and regulation.

Element(s) of Performance for LD.13.01.01

1. The hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations.
   Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) definition of a hospital in accordance with 42 CFR 482.1(a)(1) and (b). (Refer to https://www.ecfr.gov/ for the language of this CMS requirement)

   CoP(s): §482.1(a)(1)(i), §482.1(a)(1)(ii), §482.1(b), §482.11(a)

2. The hospital is licensed or approved as meeting the standards for licensing established by the state or responsible locality, in accordance with law and regulation to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission.

   CoP(s): §482.11(b)(1), §482.11(b)(2)

7. The hospital maintains the following:
   • Records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval
   • A fully funded plan to transfer these records to another hospital or other entity if the hospital ceases operation for any reason

   CoP(s): §482.27(b)(5)(i), §482.27(b)(5)(ii)

LD.13.01.03

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reviews services for medical necessity.

Element(s) of Performance for LD.13.01.03

1. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan that provides for review of services provided by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.
   Note: The hospital does not need to have a utilization review plan if either a quality improvement organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245.

   CoP(s): §482.30, §482.30(a)(1), §482.30(a)(2)

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's utilization review plan provides for the review of Medicare and Medicaid patients with respect to the medical necessity of the following:
   - Admissions to the hospital
   - Duration of stays
   - Professional services provided, including drugs and biologicals

   Note 1: The hospital may perform reviews of admissions before, during, or after hospital admission.
   Note 2: The hospital may perform reviews on a sample basis, except for reviews of extended stay cases.

   CoP(s): §482.30(c)(1), §482.30(c)(1)(i), §482.30(c)(1)(ii), §482.30(c)(1)(iii), §482.30(c)(2), §482.30(c)(3)

3. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review committee that is either a staff committee or a group outside the hospital established by the local medical society and some or all the hospitals in the locality or in a manner approved by the Centers for Medicare & Medicaid Services.
   Note: If, because of the small size of the hospital, it is impracticable to have a properly functioning staff committee, the utilization review committee is established by a group outside the hospital, as specified in 42 CFR 482.30(b)(1)(ii).

   CoP(s): §482.30(b)(1)(i), §482.30(b)(1)(ii), §482.30(b)(1)(ii)(A), §482.30(b)(1)(ii)(B), §482.30(b)(2)

4. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's utilization review committee consists of two or more licensed practitioners, and at least two of the members of the committee are doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in 42 CFR 482.12(c)(1).

Note: The committee or group's reviews are not conducted by any individual who has a direct financial interest (for example, an ownership interest) in that hospital or who was professionally involved in the care of the patient whose case is being reviewed.(See also MS.16.01.03, EP 5)

CoP(s): §482.30(b), §482.30(b)(3), §482.30(b)(3)(i), §482.30(b)(3)(ii)

5. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's utilization review committee reviews professional services provided to determine medical necessity and to promote the most efficient use of available health facilities and services.

   CoP(s): §482.30(f)

6. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements a process to determine if an admission or continued stay is not medically necessary. This determination is made by one of the following:
   • One member of the utilization review committee if the licensed practitioner(s) responsible for the patient's care, as specified in 42 CFR 482.12(c), concurs with the determination or fails to present their views when afforded the opportunity
   • At least two members of the utilization review committee in all other cases

   Note: Before determining that an admission or continued stay is not medically necessary, the utilization review committee consults the licensed practitioner(s) responsible for the patient's care, as specified in 42 CFR 482.12(c), and affords the practitioner(s) the opportunity to present their views.

   CoP(s): §482.30(d)(1)(i), §482.30(d)(1)(ii), §482.30(d)(2)

7. For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital is paid for inpatient hospital services under the prospective payment system set forth in 42 CFR Part 412, it conducts a review of duration of stays and a review of professional services as follows:
   • For duration of stays, the hospital reviews only cases that it determines to be outlier cases based on extended length of stay, as described in 42 CFR 412.80(a)(1)(i).
   • For professional services, the hospital reviews only cases that it determines to be outlier cases based on extraordinarily high costs, as described in 42 CFR 412.80(a)(1)(ii).

   CoP(s): §482.30(c)(4), §482.30(c)(4)(i), §482.30(c)(4)(ii)

8. For hospitals that use Joint Commission accreditation for deemed status purposes: In hospitals that are not paid under the prospective payment system, the utilization review (UR) committee periodically reviews, as specified in the UR plan, each current inpatient during a continuous period of extended duration. The scheduling of the periodic reviews may be the same for all cases or differ for different classes of cases.
   Note: The UR committee conducts its review no later than 7 days after the day required in the UR plan.

   CoP(s): §482.30(e)(1), §482.30(e)(1)(i), §482.30(e)(1)(ii)

9. For hospitals that use Joint Commission accreditation for deemed status purposes: In hospitals paid under the prospective payment system, the utilization review (UR) committee reviews all cases where the extended length of stay exceeds the threshold criteria for the diagnosis, as described in 42 CFR 412.80 (a)(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis.

Note: The UR committee conducts its review no later than 7 days after the day required in the UR plan.

CoP(s): §482.30(e)(2), §482.30(e)(3)

10. For hospitals that use Joint Commission accreditation for deemed status purposes: If the utilization review committee determines that admission to or continued stay in the hospital is not medically necessary, the committee gives written notification to the hospital, the patient, and the licensed practitioner(s) responsible for the patient's care, as specified in 42 CFR 482.12(c), no later than 2 days after the determination.

    CoP(s): §482.30(d)(3)

LD.13.01.05

For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.

Element(s) of Performance for LD.13.01.05

1. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has an overall institutional plan that meets the following conditions:
    - The plan includes an annual operating budget that is prepared according to generally accepted accounting principles and that has all anticipated income and expenses. This provision does not require that the budget identify item by item the components of each anticipated income or expense.
    - The plan provides for capital expenditures for at least a 3-year period, including the year in which the operating budget is applicable.

    CoP(s): §482.12(d)(1), §482.12(d)(2), §482.12(d)(3)

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan includes and identifies in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure in excess of $600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Social Security Act [42 U.S.C. 1320a–1(g)(1)], by the state in which the hospital is located) that relates to any of the following:
    - Acquisition of land
    - Improvement of land, buildings, and equipment
    - Replacement, modernization, and expansion of buildings and equipment

    CoP(s): §482.12(d)(4), §482.12(d)(4)(i), §482.12(d)(4)(ii), §482.12(d)(4)(iii)

3. For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan is prepared by representatives of the hospital's governing body, the administrative staff, and the medical staff under the direction of the governing body. The institutional plan is reviewed and updated annually.

    CoP(s): §482.12(d)(6), §482.12(d)(7)(i), §482.12(d)(7)(ii)

4. For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan is submitted for review to the planning agency designated in accordance with section 1122(b) of the Social Security Act (42 U.S.C. 1320a–1(b)), or if an agency is not designated, to the appropriate health planning agency in the

state. A capital expenditure is not subject to section 1122 review if 75 percent of the health care facility's patients who are expected to use the service for which the capital expenditure is made are individuals enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP) that meets the requirements of section 1876(b) of the Social Security Act (42 U.S.C. 1395mm(b)), and if the US Department of Health and Human Services determines that the capital expenditure is for services and facilities that are needed by the HMO or CMP in order to operate efficiently and economically and that are not otherwise readily accessible to the HMO or CMP because of one of the following:

- The facilities do not provide common services at the same site.
- The facilities are not available under a contract of reasonable duration.
- Full and equal medical staff privileges in the facilities are not available.
- Arrangements with these facilities are not administratively feasible.
- The purchase of these services is more costly than if the HMO or CMP provided the services directly.

CoP(s): §482.12(d)(5), §482.12(d)(5)(i), §482.12(d)(5)(ii), §482.12(d)(5)(iii), §482.12(d)(5)(iv), §482.12(d)(5)(v)

LD.13.01.07

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

Element(s) of Performance for LD.13.01.07

1. The hospital’s emergency services are supervised by a qualified member of the medical staff.

   CoP(s): §482.55(b)(1)

2. The hospital assigns one or more individuals who are responsible for outpatient services.

   CoP(s): §482.54(b)(1)

3. For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services, when provided:
   - Anesthesia
   - Nuclear medicine
   - Respiratory care

   Note 1: The anesthesia service is responsible for all anesthesia administered in the hospital.
   Note 2: For respiratory care services, the director may serve on either a full-time or part-time basis.

   CoP(s): §482.52, §482.53(a)(1), §482.57(a)(1)

LD.13.01.09

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

Element(s) of Performance for LD.13.01.09

5. The hospital develops and implements policies and procedures that minimizes drug errors. The medical staff develops these policies and procedures unless delegated to the pharmaceutical service.

   CoP(s): §482.25

6. The hospital develops and implements surgical care policies and procedures that maintain high standards for medical practice and patient care.

   CoP(s): §482.51(b)

7. If respiratory care services are provided, services are delivered in accordance with policies and procedures approved by the medical staff.

   CoP(s): §482.57(b)

LD.13.02.01

Ethical principles guide the hospital's business practices.

Element(s) of Performance for LD.13.02.01

2. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Each Medicaid-eligible resident is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following:
   - Items and services included in the state plan for which the resident may not be charged
   - Items and services that the hospital offers, those for which the resident may be charged, and the amount of charges for those services

   Note: The hospital informs residents when changes are made to the items and services.

   CoP(s): §482.58(b)(1), §483.10(g)(17)(i)(A), §483.10(g)(17)(i)(B), §483.10(g)(17)(ii)

3. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital informs residents before or at the time of admission, and periodically during the resident's stay, of services available in the hospital and of charges for those services not covered under Medicare, Medicaid, or by the hospital's per diem rate.

   CoP(s): §482.58(b)(1), §483.10(g)(18)

LD.13.03.01

The hospital provides services that meet patient needs.

Element(s) of Performance for LD.13.03.01

1. The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following:
   - Outpatient
   - Emergency
   - Medical records

- Diagnostic and therapeutic radiology
- Nuclear medicine
- Surgical
- Anesthesia
- Laboratory
- Respiratory
- Dietetic

CoP(s): §482.24, §482.24(a), §482.26, §482.26(a), §482.27, §482.27(a), §482.28, §482.51, §482.51(a), §482.51(b), §482.52, §482.52(a), §482.52(b), §482.53, §482.53(a), §482.54, §482.55, §482.55(a)(1), §482.55(a)(2), §482.57, §482.57(a)

2. The hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides 24-hour nursing services.
Note: For hospitals that use The Joint Commission for deemed-status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services.

   CoP(s): §482.23, §482.23(a), §482.23(b)(1)

5. If the hospital provides outpatient services, the services are integrated with inpatient services.

   CoP(s): §482.54(a)

7. If the hospital provides emergency services, the services are organized under the direction of a qualified member of the medical staff, and are integrated with other departments of the hospital.

   CoP(s): §482.55, §482.55(a)(1), §482.55(a)(2)

8. For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55.

   CoP(s): §482.12(f)(1)

9. For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital provides nuclear medicine services, and nuclear medicine staff perform laboratory tests, the services meet the applicable requirements for laboratory services specified in 42 CFR 482.27.

   CoP(s): §482.53(b)(3)

10. If the hospital provides outpatient surgical services, the services are consistent with the quality of inpatient surgical care.

    CoP(s): §482.51

11. The surgical services are consistent with the resources available.

    CoP(s): §482.51(a), §482.51(b)

12. The hospital has laboratory services available, either directly or through a contractual agreement with a Clinical Laboratory Improvement Amendments (CLIA)–certified laboratory that meets the requirements of 42 CFR 493.

    CoP(s): §482.27, §482.27(a)

13. Emergency laboratory services are available 24 hours a day, 7 days a week.

    CoP(s): §482.27(a)(1)

14. The hospital maintains a written description of the scope of laboratory services provided that is available to the medical staff.

    CoP(s): §482.27(a)(2)

15. For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital provides respiratory care services, and respiratory care staff perform blood gasses or other clinical laboratory tests, the applicable requirements for laboratory services specified in 42 CFR 482.27 are met.

    CoP(s): §482.57(b)(2)

18. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities to meet the needs of its patients.
    Note: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

    CoP(s): §482.62(e), §482.62(g), §482.62(g)(1)

LD.13.03.03

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

Element(s) of Performance for LD.13.03.03

1. The hospital maintains a list of all contracted services, including the scope and nature of the services provided.

   CoP(s): §482.12(e), §482.12(e)(2)

2. The governing body is responsible for all services provided in the hospital, including contracted services. The governing body assesses that services are provided in a safe and effective manner and takes action to address issues pertaining to quality and performance.

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The governing body makes certain that a contractor of services (including one for shared services and joint ventures) provides services that permit the hospital to comply with applicable Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and standards for contract services.

CoP(s): §482.12(e), §482.12(e)(1)

3. For hospitals that use Joint Commission accreditation for deemed status purposes: When telemedicine services are furnished to the hospital's patients, the originating site has a written agreement with the distant site that specifies the following:
   • The distant site is a contractor of services to the hospital.
   • The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation.
   • The originating site makes certain through the written agreement that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4).

   Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.

   If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply:
   • The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.17.01.01 through MS.17.04.01).
   • The governing body of the originating site grants privileges to a distant site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site.

   The written agreement includes that it is the responsibility of the governing body of the distant-site hospital to meet the requirements of this element of performance.

   CoP(s): §482.12(a)(9)

5. If the hospital routinely uses the services of an outside blood collecting establishment, it must have an agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components. The agreement includes that the blood collecting establishment notify the hospital within the specified timeframes under the following circumstances:
   • Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection
   • Within 45 days of the test for the results of the supplemental (additional, more specific) test for HIV or HCV or other follow-up testing required by the US Food and Drug Administration

   -Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available

   CoP(s): §482.27(b)(3), §482.27(b)(3)(i), §482.27(b)(3)(ii), §482.27(b)(3)(iii)

6. For hospitals that do not use Joint Commission accreditation for deemed status purposes: When using the services of physicians or other licensed practitioners from a Joint Commission–accredited ambulatory care

organization through a telemedical link for interpretive services, the hospital accepts the credentialing and privileging decisions of a Joint Commission–accredited ambulatory provider only after confirming that those decisions are made using the process described in Standards MS.17.01.03 through MS.17.02.03.

LD.13.03.03

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

Element(s) of Performance for LD.13.03.03

1. The hospital maintains a list of all contracted services, including the scope and nature of the services provided.

   CoP(s): §482.12(e), §482.12(e)(2)

2. The governing body is responsible for all services provided in the hospital, including contracted services. The governing body assesses that services are provided in a safe and effective manner and takes action to address issues pertaining to quality and performance.
   Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The governing body makes certain that a contractor of services (including one for shared services and joint ventures) provides services that permit the hospital to comply with applicable Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and standards for contract services.

   CoP(s): §482.12(e), §482.12(e)(1)

3. For hospitals that use Joint Commission accreditation for deemed status purposes: When telemedicine services are furnished to the hospital's patients, the originating site has a written agreement with the distant site that specifies the following:
   • The distant site is a contractor of services to the hospital.
   • The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation.
   • The originating site makes certain through the written agreement that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4).
   Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.
   If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply:
   • The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.17.01.01 through MS.17.04.01).
   • The governing body of the originating site grants privileges to a distant site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site.
   The written agreement includes that it is the responsibility of the governing body of the distant-site hospital to meet the requirements of this element of performance.

   CoP(s): §482.12(a)(9)

5. If the hospital routinely uses the services of an outside blood collecting establishment, it must have an agreement with the blood collecting establishment that governs the procurement, transfer, and availability of

blood and blood components. The agreement includes that the blood collecting establishment notify the hospital within the specified timeframes under the following circumstances:
• Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection
• Within 45 days of the test for the results of the supplemental (additional, more specific) test for HIV or HCV or other follow-up testing required by the US Food and Drug Administration
-Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available

CoP(s): §482.27(b)(3), §482.27(b)(3)(i), §482.27(b)(3)(ii), §482.27(b)(3)(iii)

6. For hospitals that do not use Joint Commission accreditation for deemed status purposes: When using the services of physicians or other licensed practitioners from a Joint Commission–accredited ambulatory care organization through a telemedical link for interpretive services, the hospital accepts the credentialing and privileging decisions of a Joint Commission–accredited ambulatory provider only after confirming that those decisions are made using the process described in Standards MS.17.01.03 through MS.17.02.03.

Medication Management (MM) Chapter

MM.11.01.01

The hospital safely manages pharmaceutical services.

Element(s) of Performance for MM.11.01.01

1. Drugs and biologicals are procured, stored, controlled, and distributed in accordance with federal and state laws and accepted standards of practice.
Note: The hospital stores medications, including sample medications, according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.

CoP(s): §482.25(a), §482.25(b)

MM.11.01.03

The pharmacy is a resource for medication related information.

Element(s) of Performance for MM.11.01.03

1. Information relating to drug interactions, drug therapy, side effects, toxicology, dosage, indications for use, and routes of administration is available to the professional staff.

CoP(s): §482.25(b)(8)

MM.12.01.01

The hospital selects and procures medications.

Element(s) of Performance for MM.12.01.01

1. The hospital maintains a formulary that includes medication strength and dosage. The formulary is readily available to those involved in medication management.
   Note 1: Sample medications are not required to be on the formulary.
   Note 2: In some settings, the term "list of medications available for use" is used instead of “formulary.” The terms are synonymous.

   CoP(s): §482.25(b)(9)

MM.13.01.01

The hospital safely stores medications.

Element(s) of Performance for MM.13.01.01

1. The hospital maintains current and accurate records of the receipt and disposition of all scheduled drugs.

   CoP(s): §482.25(a)(3)

2. The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area and locked when necessary to prevent diversion in accordance with law and regulation.
   Note 1: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970.
   Note 2: This element of performance is also applicable to sample medications.
   Note 3: Only authorized staff have access to locked areas.

   CoP(s): §482.25(b)(2)(i), §482.25(b)(2)(ii), §482.25(b)(2)(iii)

3. The hospital reports abuses and losses of controlled substances, in accordance with federal and state law and regulation, to the individual responsible for the pharmacy department or service and, as appropriate, to the chief executive officer.
   Note: This element of performance is also applicable to sample medications.

   CoP(s): §482.25(b)(7)

4. The hospital removes all expired, damaged, mislabeled, contaminated, or otherwise unusable medications and stores them separately from medications available for patient use.
   Note: This element of performance is also applicable to sample medications.

   CoP(s): §482.25(b)(3)

5. When a pharmacist is not available, only designated staff obtain drugs and biologicals from the pharmacy or storage area in accordance with policies and procedures of medical staff and pharmaceutical service, and applicable federal and state law and regulation.

   CoP(s): §482.25(b)(4)

6. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains records of the receipt and distribution of radiopharmaceuticals.

   CoP(s): §482.53(d)(3)

MM.14.01.01

Medication orders are clear and accurate.

Element(s) of Performance for MM.14.01.01

1. Orders for drugs and biologicals are documented and signed by any practitioner who is authorized to write orders in accordance with state law, hospital policy, and medical staff bylaws, rules, and regulations.
   Note: Influenza and pneumococcal vaccines may be administered per physician-approved hospital policy after an assessment of contraindications.

   CoP(s): §482.23(c)(3), §482.23(c)(3)(iii)

2. The hospital minimizes the use of verbal medication orders.

   CoP(s): §482.23(c)(3)(i)

3. The hospital develops and implements a written policy that defines the following:
   - Specific types of medication orders that it deems acceptable for use
   - Minimum required elements of a complete medication order, which must include medication name, medication dose, medication route, and medication frequency
   - When indication for use is required on a medication order
   - Precautions for ordering medications with look-alike or sound-alike names
   - Actions to take when medication orders are incomplete, illegible, or unclear
   - Required elements for medication titration orders, including the medication name, medication route, initial rate of infusion (dose/unit of time), incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, and the objective clinical measure to be used to guide changes

   Note 1: Examples of objective clinical measures to be used to guide titration changes include blood pressure, Richmond Agitation–Sedation Scale (RASS), and the Confusion Assessment Method (CAM).
   Note 2: Drugs and biologicals not specifically prescribed as to time or number of doses are automatically stopped after a reasonable time that is predetermined by the medical staff.

   CoP(s): §482.25(a), §482.25(b)(5)

4. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home has an electronic prescribing process.

MM.15.01.01

The hospital safely prepares medications.

Element(s) of Performance for MM.15.01.01

1. A pharmacist supervises all compounding, packaging, and dispensing of drugs and biologicals except in urgent situations in which a delay could harm the patient or when the product's stability is short. All compounding, packaging, and dispensing of drugs and biologicals are performed in accordance with state and federal law and regulation.

   CoP(s): §482.25(b)(1)

2. The hospital develops and implements policies and procedures for sterile medication compounding of nonhazardous and hazardous medications in accordance with state and federal law and regulation.
   Note: All compounded medications are prepared in accordance with the orders of a physician or other licensed practitioner.

   CoP(s): §482.25(b)(1)

3. The hospital assesses competency of staff who conduct sterile medication compounding of nonhazardous and hazardous medications in accordance with state and federal law and regulation and hospital policies.

   CoP(s): §482.25(b)(1)

4. The hospital conducts sterile medication compounding of nonhazardous and hazardous medications within a proper environment in accordance with federal law and regulation and hospital policies.
   Note: Aspects of a proper environment include but are not limited to air exchanges and pressures, ISO designations, viable testing, and cleaning/disinfecting.

   CoP(s): §482.25(b)(1)

5. The hospital properly stores compounded sterile preparations of nonhazardous and hazardous medications and labels them with beyond-use dates in accordance with state and federal law and regulation and hospital policies.

   CoP(s): §482.25(b)(1)

6. The hospital conducts quality assurance of compounded sterile preparations of nonhazardous and hazardous medications in accordance with state and federal law and regulation and organization policy.

   CoP(s): §482.25(b)(1)

7. For hospitals that use Joint Commission accreditation for deemed status purposes: An appropriately trained registered pharmacist or doctor of medicine or osteopathy performs or supervises in-house preparation of radiopharmaceuticals.

   CoP(s): §482.25(b)(1), §482.53(b)(1)

MM.16.01.01

The hospital safely administers medications.

Element(s) of Performance for MM.16.01.01

1. Drugs and biologicals are prepared and administered in accordance with federal and state laws, the orders of the licensed practitioner or practitioners responsible for the patient's care, and accepted standards of practice. For hospitals that use Joint Commission Accreditation for deemed status purposes: Drugs and biologicals may be prepared and administered as follows:
   • On the orders of other practitioners not specified under 42 CFR 482.12(c) only if such practitioners are acting in accordance with state law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.
   • On the orders contained within preprinted and electronic standing orders, order sets, and protocols for patient orders only if such orders meet the requirements of 42 CFR 482.24(c)(3).

   CoP(s): §482.23(c)(1), §482.23(c)(1)(i), §482.23(c)(1)(ii)

2. Drugs and biologicals are administered by, or under supervision of, nursing or other staff in accordance with federal and state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.

   CoP(s): §482.23(c)(2)

3. The hospital develops and implements policies and procedures that guide the safe and accurate self-administration of medications by the patient or their caregiver or support person, where appropriate.
   Note 1: This applies to hospital-issued medications and the patient's own medications brought into the hospital.
   Note 2: The term "self-administered medication(s)" may refer to medications administered by a family member.

   CoP(s): §482.23(c)(6)

4. If the hospital allows a patient to self-administer specific hospital-issued medications, the hospital has policies and procedures in place that address the following:
   • Making certain that an order is issued by a licensed practitioner responsible for the patient's care and that it is consistent with the hospital's self-administration policy
   • Determining that the patient or the patient's caregiver or support person is capable of administering the specified medication(s)
   • Instructing the patient or the patient's caregiver or support person, where appropriate, in the safe and accurate administration of the specified medication(s)
   • Addressing the security of the medications for each patient
   Note: The term "self-administered medication(s)" may refer to medications administered by a family member.

   CoP(s): §482.23(c)(6)(i)(A), §482.23(c)(6)(i)(B), §482.23(c)(6)(i)(C), §482.23(c)(6)(i)(D)

5. If the hospital allows a patient to self-administer medications not issued by the hospital, the hospital has policies and procedures in place that address the following:
   • Making certain that an order is issued by a practitioner responsible for the patient's care and that it is consistent with the hospital's self-administration policy
   • Determining that the patient or the patient's caregiver or support person is capable of administering the specified medication(s)
   • Instructing the patient or the patient's caregiver or support person, where appropriate, in the safe and accurate administration of the specified medication(s)
   • Addressing the security of the medications for each patient
   • Identifying the specified medication(s) and visually evaluating the medication(s) for integrity

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

   CoP(s): §482.23(c)(6)(ii)(A), §482.23(c)(6)(ii)(B), §482.23(c)(6)(ii)(C), §482.23(c)(6)(ii)(D)

MM.17.01.01

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

Element(s) of Performance for MM.17.01.01

1. The hospital develops and implements policies and procedures for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs.
   Note: This element of performance is also applicable to sample medications.

   CoP(s): §482.23(c)(5)

2. Medication administration errors, adverse drug reactions, and medication incompatibilities, as defined by the hospital, are immediately reported to the attending physician or other licensed practitioner and, as appropriate, to the hospitalwide quality assessment and performance improvement program.

   CoP(s): §482.25(b)(6)

3. The hospital has a method (such as using established benchmarks for the size and scope of services provided by the hospital or studies on reporting rates published in peer-reviewed journals) by which to measure the effectiveness of its process for identifying and reporting medication errors and adverse drug reactions to the quality assessment and performance improvement program.

   CoP(s): §482.25(b)(6)

MM.18.01.01

The hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.

Element(s) of Performance for MM.18.01.01

1. The antibiotic stewardship program reflects the scope and complexity of the hospital services provided.

   CoP(s): §482.42, §482.42(b)(4)

2. The hospital demonstrates that an individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership.

   CoP(s): §482.42(b)(1)

3. The leader(s) of the antibiotic stewardship program is responsible for the following:
   • Development and implementation a hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics.
   • All documentation, written or electronic, of antibiotic stewardship program activities.
   • Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the hospital's infection prevention and control and QAPI programs, on antibiotic use issues.
   • Competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.

   CoP(s): §482.42, §482.42(c)(3)(i), §482.42(c)(3)(ii), §482.42(c)(3)(iii), §482.42(c)(3)(iv)

4. The governing body ensures all antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the hospital's QAPI leadership.

   CoP(s): §482.42(c)(1)(ii)

5. The hospitalwide antibiotic stewardship program:
   • Demonstrates coordination among all components of the hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services.
   • Documents the evidence-based use of antibiotics in all departments and services of the hospital.
   • Documents any improvements, including sustained improvements, in proper antibiotic use.

   CoP(s): §482.42(b)(2)(i), §482.42(b)(2)(ii), §482.42(b)(2)(iii)

6. The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use.

   CoP(s): §482.42(b)(3)

7. The governing body ensures that systems are in place and operational for the tracking of all antibiotic use activities in order to demonstrate the implementation, success, and sustainability of such activities.

   CoP(s): §482.42(c)(1)(i)

Medical Staff (MS) Chapter

MS.14.01.01

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

Element(s) of Performance for MS.14.01.01

1. The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following:
   - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy)
   - Description of the organization of the medical staff, including those members who are eligible to vote
   - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body
   - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners
   - Process for credentialing and recredentialing physicians and other licensed practitioners
   - List of all the officer positions for the medical staff
   - Process by which the organized medical staff selects and/or elects and removes the medical staff officers
   - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies
   - The qualifications and roles and responsibilities of the department chair, when applicable

   Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4).

   CoP(s): §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)

2. The medical staff bylaws include the qualifications for appointment and reappointment to the medical staff.
   Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff is composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians, as listed at 42 CFR 482.12(c)(1), and other licensed practitioners who the governing body determines are eligible for appointment.
   Note 2: Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership.(See also MS.20.01.01, EP 1)

   CoP(s): §482.22(a)

3. The medical staff bylaws include requirements for the following:
   - Medical history and physical examination for each patient as described in PC.11.02.01, EP 2
   - Updated patient examinations as described in PC.11.02.01, EP 3
   - Assessments in lieu of medical history and physical examinations for patients as described in PC.11.02.01, EP 4

   Note: The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy.

   CoP(s): §482.22(c)(5)(i), §482.22(c)(5)(ii), §482.22(c)(5)(iii)

4. The medical staff bylaws, rules and regulations, and policies; the governing body bylaws; and the hospital policies are compatible with each other and are compliant with law and regulation.

5. The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body.

6. The medical staff bylaws include the following requirements regarding the medical executive committee:
   • The function, size, and composition, as determined by the organized medical staff and approved by the governing body;
   • The authority delegated to the medical executive committee by the organized medical staff to act on the medical staff's behalf and how such authority is delegated or removed. (For more information on the role of the medical executive committee, refer to Standard MS.14.02.01.)
   • The process, as determined by the organized medical staff and approved by the governing body, for selecting and/or electing and removing the medical executive committee members.
   Note: The medical executive committee includes physicians and may include other licensed practitioners.

7. The medical staff bylaws include the following requirements regarding the suspension or termination of a physician's or other licensed practitioner's medical staff membership or privileges:
   • Indications and process for automatic suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges
   • Indications and process for summary suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges
   • Indications and process for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges

8. The medical staff bylaws include requirements for the composition of the fair hearing committee.

MS.14.02.01

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

Element(s) of Performance for MS.14.02.01

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

2. If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the medical executive committee. If the medical executive committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff; when it adopts a policy or an amendment thereto, it communicates this to the medical staff. This element of performance applies only when the organized medical staff, with the approval of the governing body, has delegated authority over such rules, regulations, or policies to the medical executive committee.

3. The organized medical staff has a process that is implemented to manage conflict between the medical staff and the medical executive committee on issues including but not limited to proposals to adopt a rule, regulation, or policy or an amendment thereto. This is not intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the medical executive committee. The governing body determines the method of communication.

4. In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, there is a process by which the medical executive committee, if delegated to do so by the voting members of the organized medical staff, may provisionally adopt and the governing body may provisionally

approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the medical executive committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the medical executive committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the medical executive committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

MS.14.03.01

For hospitals that use Joint Commission accreditation for deemed status purposes: Multihospital systems can choose to establish a unified and integrated medical staff in accordance with state and local laws.

Element(s) of Performance for MS.14.03.01

1. For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, in accordance with state and local laws, the following occurs: Each separately accredited hospital within a multihospital system that elects to have a unified and integrated medical staff demonstrates that the medical staff members of each hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) have voted by majority, in accordance with medical staff bylaws, either to accept the unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their hospital.

   CoP(s): §482.22(b)(4)(i)

2. For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital.

   CoP(s): §482.22(b)(4)(iii)

3. For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff develops and implements policies and procedures and mechanisms to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, regardless of practice or location, are duly considered and addressed.

   CoP(s): §482.22(b)(4)(iv)

4. For hospitals that use Joint Commission accreditation for deemed status purposes: When a multihospital system has a unified and integrated medical staff, the medical staff bylaws include the following requirements: A description of the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective hospital.

   CoP(s): §482.22(b)(4)(ii)

MS.15.01.01

There is a medical staff executive committee.

Element(s) of Performance for MS.15.01.01

1. The structure and function of the medical staff executive committee conforms to the medical staff bylaws.

2. The chief executive officer (CEO) of the hospital or their designee attends each medical staff executive committee meeting on an ex-officio basis, with or without a vote.

3. The majority of voting medical staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the hospital.
Note: All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the medical staff executive committee.

   CoP(s): §482.22(b)(2)

4. The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on all of the following, at a minimum:
   - Organized medical staff's structure
   - Process used to review credentials and delineate privileges
   - Executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups

MS.16.01.01

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

Element(s) of Performance for MS.16.01.01

1. The hospital has an organized medical staff that operates under bylaws approved by the governing body and that is responsible for the quality of medical care provided by the hospital.

   CoP(s): §482.22

2. Physician members of the organized medical staff are designated to perform the oversight activities of the organized medical staff.

3. Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.

4. The organized medical staff, through its designated mechanisms, provides leadership in activities related to patient safety.

5. The organized medical staff provides oversight in the process of analyzing and improving patient satisfaction.

7. The organized medical staff does the following:
   - Defines when a medical history and physical examination must be validated and countersigned by a physician with appropriate privileges
   - Specifies the minimal content and scope of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services, including non-inpatient services

- Monitors the quality of medical histories and physical examinations

8. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The clinical director, service chief, or equivalent for inpatient psychiatric services monitors and evaluates the medical staff's treatment and services for quality and appropriateness.

   CoP(s): §482.62(b)(2)

9. If the hospital provides emergency services, the medical staff establishes and is continually responsible for the policies and procedures governing emergency medical care.

   CoP(s): §482.55(a)(3)

10. If the medical staff chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements would apply in lieu of a comprehensive medical history and physical examination, the policy is based on the following:
    - Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure
    - Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures
    - Applicable state and local health and safety laws

    The hospital demonstrates evidence that the policy applies only to those patients receiving specific outpatient surgical or procedural services.
    Note: For hospitals that use Joint Commission accreditation for deemed status purposes: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii), refer to https://www.ecfr.gov/.

    CoP(s): §482.22(c)(5)(iv), §482.22(c)(5)(v), §482.22(c)(5)(v)(A), §482.22(c)(5)(v)(B), §482.22(c)(5)(v)(C)

11. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures.
    Note: Technologists who perform diagnostic computed tomography exams will, at a minimum, meet the requirements specified at NPG.13.01.01, EP 1.

    CoP(s): §482.26(c)(2)

12. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff approves the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.

    CoP(s): §482.53(a)(2)

13. For hospitals that elect The Joint Commission Primary Care Medical Home option: Through the privileging process, the organized medical staff determines which licensed practitioners are qualified to serve in the role of primary care clinician.

MS.16.01.03

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

Element(s) of Performance for MS.16.01.03

1. Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the state to admit patients to a hospital.
For hospitals that use Joint Commission accreditation for deemed status purposes: If a Medicare patient is admitted by a practitioner not specified in MS.16.01.03, EP 4, that patient is under the care of a doctor of medicine or osteopathy.

   CoP(s): §482.12(c)(2)

2. A doctor of medicine or osteopathy is on duty or on call at all times.

   CoP(s): §482.12(c)(3)

3. A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization and is not specifically within the scope of practice, as defined by the medical staff and in accordance with state law, of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 12(c)(1)(v); or clinical psychologist.

   CoP(s): §482.12(c)(4), §482.12(c)(4)(i), §482.12(c)(4)(ii), §482.12(c)(4)(ii)(A), §482.12(c)(4)(ii)(B), §482.12(c)(4)(ii)(C)

4. For hospitals that use Joint Commission accreditation for deemed status purposes: Every Medicare patient is under the care of at least one of the following:
   - A doctor of medicine or osteopathy (This requirement does not limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care staff to the extent recognized under state law or a state's regulatory mechanism.)
   - A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the state and who is acting within the scope of their license
   - A doctor of podiatric medicine, but only with respect to functions which they are legally authorized by the state to perform
   - A doctor of optometry who is legally authorized to practice optometry by the state in which they practice
   - A chiropractor who is licensed by the state or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist
   - A clinical psychologist as defined in 42 CFR 410.71, but only with respect to clinical psychologist services as defined in 42 CFR 410.71 and only to the extent permitted by state(See also LD.14.01.03, EP 5)

   CoP(s): §482.12(c)(1)(i), §482.12(c)(1)(ii), §482.12(c)(1)(iii), §482.12(c)(1)(iv), §482.12(c)(1)(v), §482.12(c)(1)(vi)

5. For hospitals that elect The Joint Commission Primary Care Medical Home option: Primary care clinicians have the educational background and broad-based knowledge and experience necessary to handle most medical and

other health care needs of the patients who selected them. This includes resolving conflicting recommendations for care.

MS.16.02.01

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

Element(s) of Performance for MS.16.02.01

1. The organized medical staff has a defined process for supervision of each participant in the program in carrying out patient care responsibilities by a physician with appropriate clinical privileges.

2. The organized medical staff and hospital staff receive written descriptions of the roles, responsibilities, and patient care activities of graduate education program participants.

3. The written descriptions of the roles, responsibilities, and patient care activities of graduate education program participants include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities.

4. Organized medical staff rules and regulations and policies delineate the participants in professional education programs who may write patient care orders, the circumstances under which they may do so, and what entries, if any, must be countersigned by a supervising physician.

5. There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the organized medical staff and the governing body.

6. There is responsibility for effective communication with the medical staff and governing body, whether training occurs at the organization that is responsible for the professional graduate education program or in a participating local or community organization or hospital, as follows:
   • The professional graduate medical education committee(s) (GMEC) communicates with the medical staff and governing body about the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs.
   • If the graduate medical education program uses a community or local participating hospital or organization, the person(s) responsible for overseeing the participants from the program communicates to the organized medical staff and its governing body about the patient care, treatment, and services provided by, and the related educational and supervisory needs of, its participants in the professional graduate education programs.
   Note: The GMEC can represent one or multiple graduate education programs depending on the number of specialty graduate programs within the organization.

7. There is a mechanism for an appropriate person from the community or local hospital or organization to communicate information to the graduate medical education committee about the quality of care, treatment, and services and educational needs of the participants.

8. Information about the quality of care, treatment, and services and educational needs is included in the communication that the graduate medical education committee has with the governing board of the sponsoring hospital.

9. The medical staff demonstrates compliance with residency review committee citations.
   Note: Graduate medical education programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the American Dental Association's Commission on Dental Accreditation are expected to be in compliance with the requirements in this standard;

the hospital should be able to demonstrate compliance with any postgraduate education review committee citations related to this standard.

MS.16.03.01

The organized medical staff leads and participates in organizationwide performance improvement activities to improve quality of care, treatment, and services and patient safety.

Element(s) of Performance for MS.16.03.01

1. The organized medical staff provides leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more physicians or other licensed practitioners credentialed and privileged through the medical staff process.

2. Information used as part of the performance improvement mechanisms, measurement, or assessment includes sentinel event data and patient safety data.

3. The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through the following:
   - Participating in the establishment of protocols and quality metrics
   - Reviewing performance improvement data

4. The organized medical staff completes patient medical records accurately, timely, and legibly.

5. The organized medical staff participates in the following performance improvement activities:
   - Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluation of a physician's or other licensed practitioner's competence.
   - Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.

MS.17.01.01

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

Element(s) of Performance for MS.17.01.01

1. The hospital has a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested privilege.

2. The hospital consistently determines the resources needed for each requested privilege.

MS.17.01.03

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

Element(s) of Performance for MS.17.01.03

1. The governing body approves the credentialing process.

2. The hospital verifies that the physician or other licensed practitioner requesting approval is the same person identified in the credentialing documents by viewing one of the following:
   - Current picture hospital ID card

- Valid picture ID issued by a state or federal agency (for example, a driver's license or passport)

3. The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information for the applicant:
   - Current licensure at the time of initial granting, renewal, and revision of privileges and at the time of license expiration
   - Relevant training
   - Current competence

   CoP(s): §482.11(c)

4. The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations.
   Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a).

   CoP(s): §482.22(a)(2)

5. For hospitals that use Joint Commission accreditation for deemed status purposes: A full-time, part-time, or consulting radiologist, who is a doctor of medicine or osteopathy qualified by education and experience in radiology, supervises ionizing radiology services and interprets radiologic tests that the medical staff determine to require a radiologist’s specialized knowledge.

   CoP(s): §482.26(c)(1)

6. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inpatient psychiatric services are under the direction and supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program and who meets the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. The number and qualifications of doctors of medicine and osteopathy are adequate to provide essential psychiatric services.

   CoP(s): §482.62(b), §482.62(b)(1)

MS.17.02.01

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

Element(s) of Performance for MS.17.02.01

1. The hospital, based on recommendations by the organized medical staff and approval by the governing body, develops and implements criteria that determine if a physician or other licensed practitioner is allowed to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria:

- Current licensure and/or certification, as appropriate, verified with the primary source
- Specific relevant training, verified with the primary source
- Evidence of physical ability to perform the requested privilege
- Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
- Peer and/or faculty recommendation
- When renewing privileges, review of the physician's or other licensed practitioner’s performance within the hospital

2. The hospital has a clearly defined procedure approved by the organized medical staff for processing applications for the granting, renewal, or revision of clinical privileges.

3. An applicant submits a statement that no health problems exist that could affect their ability to perform the privileges requested.

4. The hospital queries the National Practitioner Data Bank (NPDB) in accordance with applicable law and regulation.

5. Completed applications for privileges are acted on within the time period specified in the medical staff bylaws, rules, and regulations, or in policies and procedures.

6. The hospital designates the practitioners who are allowed to perform surgery, in accordance with appropriate policies and procedures and with scope of practice laws and regulations. Surgery is performed only by the following:
   - A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act
   - A doctor of dental surgery or dental medicine
   - A doctor of podiatric medicine

   CoP(s): §482.51(a)(4)

7. The surgical service maintains a current roster listing each practitioner’s surgical privileges.
   Note: The roster may be in paper or electronic format.

   CoP(s): §482.51(a)(4)

9. All physicians and other licensed practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation.

   CoP(s): §482.11(c)

MS.17.02.03

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

Element(s) of Performance for MS.17.02.03

1. Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services.

   CoP(s): §482.51(a)(4)

2. Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of clinical privileges.

3. The hospital completes the credentialing and privileging decision process in a timely manner.

MS.17.03.01

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

Element(s) of Performance for MS.17.03.01

1. The organized medical staff develops and implements criteria for an expedited process for granting privileges. Note: To expedite initial appointments to membership and granting of privileges, reappointment to membership, or renewal or modification of privileges, the governing body may delegate the authority to render those decisions to a committee of at least two voting members of the governing body.

2. The criteria provide that an applicant for privileges is ineligible for the expedited process if any of the following has occurred:
   - The applicant submits an incomplete application.
   - The medical staff executive committee makes a final recommendation that is adverse or has limitations.

3. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:
   - There is a current challenge or a previously successful challenge to licensure or registration.
   - The applicant has received an involuntary termination of medical staff membership at another hospital.
   - The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
   - The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

MS.17.04.01

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

Element(s) of Performance for MS.17.04.01

1. Temporary privileges are granted to meet an important patient care need for a time period defined in the medical staff bylaws.

2. When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence.

3. Temporary privileges may be granted to applicants for new privileges while awaiting review and approval by the organized medical staff upon verification of the following:
   - Current licensure
   - Relevant training or experience
   - Current competence
   - Ability to perform the privileges requested
   - Other criteria required by the medical staff bylaws
   - A query and evaluation of the National Practitioner Data Bank (NPDB) information
   - A complete application
   - No current or previously successful challenge to licensure or registration
   - No subjection to involuntary termination of medical staff membership at another organization
   - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
4. All temporary privileges are granted by the chief executive officer or authorized designee.
5. All temporary privileges are granted on the recommendation of the medical staff president or authorized designee.
6. Temporary privileges for applicants for new privileges are granted for no more than 120 days.

MS.18.01.01

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

Element(s) of Performance for MS.18.01.01

1. Recommendations from peers are obtained and evaluated for all new applicants for privileges.
2. Upon renewal of privileges, when insufficient physician- or other licensed practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations.
3. Peer recommendations include the following information:
   - Medical/clinical knowledge
   - Technical and clinical skills
   - Clinical judgment
   - Interpersonal skills
   - Communication skills
   - Professionalism
4. Peer recommendations are obtained from a physician or other licensed practitioner in the same professional discipline as the applicant with personal knowledge of the applicant’s ability to practice.

MS.18.02.01

The organized medical staff defines the circumstances requiring monitoring and evaluation of a physician's or other licensed practitioner’s professional performance.

Element(s) of Performance for MS.18.02.01

1. The organized medical staff develops and consistently implements criteria to be used for evaluating the performance of physicians or other licensed practitioners when issues affecting the provision of safe, high quality patient care are identified.

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

3. The performance monitoring process is clearly defined and includes each of the following elements:
   - Criteria for conducting performance monitoring
   - Method for establishing a monitoring plan specific to the requested privilege
   - Method for determining the duration of performance monitoring
   - Circumstances under which monitoring by an external source is required

4. The triggers that indicate the need for performance monitoring are clearly defined.
   Note: Triggers can be single incidents or evidence of a clinical practice trend.

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

6. The measures employed to resolve performance issues are clearly defined.

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

MS.18.02.03

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

Element(s) of Performance for MS.18.02.03

1. The medical staff's ongoing professional practice evaluation includes a clearly defined process that facilitates the periodic evaluation of each physician's or other licensed practitioner’s professional practice.
   Note: Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter.

   CoP(s): §482.22(a)(1)

2. The process for the ongoing professional practice evaluation includes the type of data to be collected, which is determined by individual departments and approved by the organized medical staff.

3. The process for the ongoing professional practice evaluation includes the use of information resulting from the ongoing professional practice evaluation to determine whether to continue, limit, or revoke any existing privilege(s).

MS.18.03.01

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

Element(s) of Performance for MS.18.03.01

1. The hospital, based on recommendations by the organized medical staff and approval by the governing body, has a clearly defined process for collecting, investigating, and addressing clinical practice concerns.
   Note: Reported concerns regarding a privileged physician's or other licensed practitioner’s professional practice are uniformly investigated and addressed, as defined by the hospital and applicable law.

MS.18.04.01

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

Element(s) of Performance for MS.18.04.01

1. The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that may differ for members and nonmembers of the medical staff.
2. The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has a mechanism to schedule a hearing of such requests.
3. The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has identified the procedures for the hearing to follow.
4. The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that identifies the composition of the hearing committee as a committee that includes impartial peers.
5. The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that, with the governing body, provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws.

MS.18.05.01

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

Element(s) of Performance for MS.18.05.01

1. The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses the education of physicians or other licensed practitioners and other organization staff about illness and impairment recognition issues specific to practitioners (at-risk criteria).
2. The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses self-referral by a physician or other licensed practitioner.
3. The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses referral by others and maintaining informant confidentiality.
4. The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses referral of the physician or other licensed practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.
5. The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses maintenance of confidentiality of the physician or other licensed practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened.
6. The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses evaluation of the credibility of a complaint, allegation, or concern.
7. The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses monitoring the physician or other licensed practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required.

8. The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses reporting to the organized medical staff leadership instances in which a physician or other licensed practitioner is providing unsafe treatment.

9. The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses initiating appropriate actions when a physician or other licensed practitioner fails to complete the required rehabilitation program.

10. The medical staff implements its process to identify and manage matters of individual health for physicians and other licensed practitioners.

MS.19.01.01

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

Element(s) of Performance for MS.19.01.01

1. The organized medical staff prioritizes hospital-sponsored educational activities that relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital.

2. Education is based on the findings of performance improvement activities.

3. Each individual’s participation in continuing education is documented.

4. Participation in continuing education is considered in decisions about reappointment to membership on the medical staff or renewal or revision of individual clinical privileges.

MS.20.01.01

Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.

Element(s) of Performance for MS.20.01.01

1. When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity:
   - The distant site telemedicine entity provides services in accordance with contract service requirements
   - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the hospital’s process and standards, at a minimum.
   - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.
   - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity.
   - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the hospital whose patients are receiving the telemedicine services is located.
   - For distant-site physicians or other licensed practitioners privileged by the originating hospital, the originating hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the

practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the hospital's patients and complaints the hospital has received about the distant-site physician or other licensed practitioner.
Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).(See also MS.14.01.01, EP 2)

CoP(s): §482.12(a)(8), §482.22(a)(3), §482.22(a)(3)(i), §482.22(a)(3)(ii), §482.22(a)(3)(iii), §482.22(a)(3)(iv), §482.22(a)(4), §482.22(a)(4)(i), §482.22(a)(4)(ii), §482.22(a)(4)(iii), §482.22(a)(4)(iv)

MS.20.01.03

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

Element(s) of Performance for MS.20.01.03

1. The medical staff recommends which clinical services are appropriately delivered by physicians or other licensed practitioners through this medium.

2. The clinical services offered are consistent with commonly accepted quality standards.

National Performance Goals (NPG) Chapter

NPG.01.01.01

The hospital has a process in place to correctly identify patients when providing care, treatment, and services.

Element(s) of Performance for NPG.01.01.01

1. The hospital has a process in place to correctly identify patients when providing care, treatment, and services. This includes using at least two patient identifiers. The hospital does not use the patient's room number or physical location as an identifier.
   Note: Examples of patient identifiers may include but are not limited to the following:
   • Assigned identification number (for example, medical record number)
   • Telephone number or another person-specific identifier
   • Electronic identification technology coding, such as bar coding or RFID, that includes two or more person-specific identifiers

2. The hospital labels containers used for blood and other specimens in the presence of the patient.

3. The hospital uses distinct methods of identification for newborn patients.
   Note: Examples of methods to prevent misidentification may include the following:
   • Distinct naming systems could include using the mother's first and last names and the newborn's gender (for example: "Smith, Judy Girl" or "Smith, Judy Girl A" and "Smith, Judy Girl B" for multiples).
   • Standardized practices for identification banding (for example, using two body sites and/or bar coding for identification).
   • Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).

NPG.01.02.01

The hospital reports critical results of tests and diagnostic procedures on a timely basis.

Element(s) of Performance for NPG.01.02.01

1. The hospital develops and implements written procedures for managing the critical results of tests and diagnostic procedures that address the following:
   - The definition of critical results of tests and diagnostic procedures
   - By whom and to whom critical results of tests and diagnostic procedures are reported
   - The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures
2. The hospital evaluates the timeliness of reporting the critical results of tests and diagnostic procedures.

NPG.01.03.01

The hospital manages the flow of patients throughout the hospital.

Element(s) of Performance for NPG.01.03.01

1. The hospital measures and sets goals for the components of the patient flow process, including the following:
   - Available supply of patient beds
   - Throughput of areas where patients receive care, treatment, and services (such as inpatient units, laboratory, operating rooms, telemetry, radiology, and the postanesthesia care unit)
   - Safety of areas where patients receive care, treatment and services
   - Efficiency of the nonclinical services that support patient care and treatment (such as housekeeping and transportation)
   - Access to support services (such as case management and social work)
2. The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department. (Refer to NPG.8.01.01, EPs 1 and 2; NPG.01.05.02, EP 1)
   Note: Boarding is the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made. The hospital should set its goals with attention to patient acuity and best practice.
3. The individuals who manage patient flow processes review measurement results to determine whether goals were achieved, and leaders take action to improve patient flow processes when goals are not achieved.
   Note: At a minimum, leaders include members of the medical staff and governing body, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization. (See the Glossary for the definition of leader.)

NPG.01.04.01

The hospital has a process for hand-off communication.

Element(s) of Performance for NPG.01.04.01

1. The hospital follows a process to receive or share patient information when the patient is referred to internal providers of care, treatment, and services.
2. The hospital's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information.
   Note: Such information may include the patient’s condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.

NPG.01.05.01

The hospital improves the safety of clinical alarm systems.

Element(s) of Performance for NPG.01.05.01

1. Identify the most important alarm signals to manage based on the following:
   - Input from the medical staff and clinical departments
   - Risk to patients if the alarm signal is not attended to or if it malfunctions
   - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
   - Potential for patient harm based on internal incident history
   - Published best practices and guidelines

2. Establish policies and procedures for managing the alarms identified in NPG.01.05.01, EP 1 that, at a minimum, address the following:
   - Clinically appropriate settings for alarm signals
   - When alarm signals can be disabled
   - When alarm parameters can be changed
   - Who in the organization has the authority to set alarm parameters
   - Who in the organization has the authority to change alarm parameters
   - Who in the organization has the authority to set alarm parameters to “off”
   - Monitoring and responding to alarm signals
   - Checking individual alarm signals for accurate settings, proper operation, and detectability.

NPG.01.05.02

The hospital recognizes and responds to changes in a patient’s condition.
Note: Hospitals are not required to create rapid response teams or medical emergency teams in order to meet this standard. The existence of these types of teams does not mean that all of the elements of performance are automatically achieved.

Element(s) of Performance for NPG.01.05.02

1. The hospital develops and implements written criteria describing early warning signs of a change or deterioration in a patient’s condition and the appropriate action to take.

NPG.01.05.03

Resuscitative services are available throughout the hospital.

Element(s) of Performance for NPG.01.05.03

1. The hospital provides resuscitative services based on national standards of care, guidelines, and the hospital’s policies, procedures, or protocols.

2. Resuscitation equipment is available for use based on the needs of the population served.
   Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available.

3. The hospital provides education and training to staff involved in the provision of resuscitative services. The hospital determines which staff complete this education and training based on their job responsibilities and hospital policies and procedures. The education and training are provided at the following intervals:
   - At orientation
   - A periodic basis thereafter, as determined by the hospital
   - When staff responsibilities change

Note 1: Topics may cover resuscitation procedures or protocols; use of cardiopulmonary resuscitation techniques, devices, or equipment; and roles and responsibilities during resuscitation events.
Note 2: The hospital determines the format and content of education and training (for example, a skills day, a mock code).

NPG.01.05.04

The hospital develops and implements processes for post-resuscitation care.

Element(s) of Performance for NPG.01.05.04

1. The hospital develops and implements policies, procedures, or protocols based on current scientific literature for interdisciplinary post–cardiac arrest care.
   Note 1: Post–cardiac arrest care is aimed at identifying, treating, and mitigating acute pathophysiological processes after cardiac arrest and includes evaluation for targeted temperature management and other aspects of critical care management.
   Note 2: This requirement does not apply to hospitals that do not provide post–cardiac arrest care.

2. The hospital develops and implements policies, procedures, or protocols based on current scientific literature to determine the neurological prognosis for patients who remain comatose after cardiac arrest.
   Note 1: Because any single method of neuroprognostication has an intrinsic error rate, current guidelines recommend that multiple testing modalities be incorporated into the hospital's routine procedures and protocols to improve decision-making accuracy.
   Note 2: This requirement does not apply to hospitals that do not provide post–cardiac arrest care.

NPG.01.05.05

The hospital reviews resuscitation cases to identify opportunities for improvement.

Element(s) of Performance for NPG.01.05.05

1. An interdisciplinary committee reviews cases and data to identify and suggest practice and system improvements in resuscitation performance.
   Note 1: Review examples could include the following:
   - How often early warning signs of clinical deterioration were present prior to in-hospital cardiac arrest in patients in nonmonitored or non–critical care units
   - Timeliness of staff's response to a cardiac arrest
   - Quality of cardiopulmonary resuscitation (CPR)
   - Post–cardiac arrest care processes
   - Outcomes following cardiac arrest

   Note 2: The review functions may be designated to an existing interdisciplinary committee.

NPG.01.06.01

The hospital conducts a preprocedure verification process.

Element(s) of Performance for NPG.01.06.01

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

2. The hospital identifies the items that must be available for the procedure and uses a standardized list to verify their availability. At a minimum, these items include the following:

- Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)
- Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
- Any required blood products, implants, devices, and/or special equipment for the procedure

Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.

NPG.01.06.01

The hospital conducts a preprocedure verification process.

Element(s) of Performance for NPG.01.06.01

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

2. The hospital identifies the items that must be available for the procedure and uses a standardized list to verify their availability. At a minimum, these items include the following:
   - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)
   - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
   - Any required blood products, implants, devices, and/or special equipment for the procedure

   Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.

NPG.01.06.02

The hospital marks the procedure site.

Element(s) of Performance for NPG.01.06.02

1. The hospital identifies those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.
   Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.

2. The procedure site is marked before the procedure is performed and, if possible, with the patient involved.

3. The procedure site is marked by a licensed practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications:
   - An individual in a medical postgraduate education program who is being supervised by the licensed practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed
   - A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed practitioner performing the procedure (that is, an advanced practice registered nurse [APRN]

or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed.
Note: The hospital's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications.

4. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital.
Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site.

5. A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).
Note: Examples of other situations that involve alternative processes include the following:
- Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice
- Teeth
- Premature infants, for whom the mark may cause a permanent tattoo

NPG.01.06.03

The hospital performs a time-out before the procedure.

Element(s) of Performance for NPG.01.06.03

1. The hospital conducts a time-out immediately before starting the invasive procedure or making the incision.

2. The time-out has the following characteristics:
- It is standardized, as defined by the hospital.
- It is initiated by a designated member of the team.
- It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.

3. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, the hospital performs a time-out before each procedure is initiated.

4. During the time-out, the team members agree, at a minimum, on the following:
- Correct patient identity
- The correct site
- The procedure to be done

5. The hospital documents the completion of the time-out.
Note: The hospital determines the amount and type of documentation.

NPG.02.01.01

The mission, vision, and goals guide the hospital’s actions.

Element(s) of Performance for NPG.02.01.01

1. The governing body, senior managers, and leaders of the organized medical staff work together to create the hospital’s mission, vision, and goals, which guide the leaders’ actions. The mission, vision, and goals are communicated to staff and the population(s) served.

NPG.02.02.01

The hospital addresses conflicts of interest and ethics.

Element(s) of Performance for NPG.02.02.01

1. The governing body, senior managers, and leaders of the organized medical staff work together to define in writing conflicts of interest that could affect safety and quality of care, treatment, and services.

2. The governing body, senior managers, and leaders of the organized medical staff work together to develop a written policy that defines how conflicts of interest will be addressed.

3. Conflicts of interest are disclosed as defined by the hospital.

4. Senior managers and leaders of the organized medical staff work with the governing body to develop and implement an ongoing process for managing conflict among leadership groups that has the potential to adversely affect patient safety or quality of care.

5. The hospital develops and implements a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.

NPG.02.03.01

The hospital's leaders design work processes to focus individuals on safety and quality issues.

Element(s) of Performance for NPG.02.03.01

1. The leaders implement a hospitalwide patient safety program as follows:
   - One or more qualified individuals or an interdisciplinary group manage the safety program.
   - All departments, programs, and services within the hospital participate in the safety program.
   - The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls ["near misses"] or good catches) to hazardous conditions and sentinel events.

2. The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.
   Note: Examples of voluntary programs include The Joint Commission Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch.

3. As part of the safety program, the leaders create procedures for responding to system or process failures.
   Note: Responses might include continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.

4. The leaders provide and encourage the use of systems for internal reporting of a system or process failure, or the results of a proactive risk assessment, without the risk of retaliation.
   Note: This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for errors due to negligence.

5. The hospital conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the "Sentinel Event Policy" (SE) chapter of this manual.

6. The leaders make support systems available for staff who have been involved in an adverse or sentinel event.
   Note: Support systems recognize that health care workers who are involved in sentinel events may be negatively affected by the event and require support. Support systems provide staff with help and support as well as

additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals.

7. At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment. Note: For suggested components, refer to the Proactive Risk Assessment section at the beginning of this chapter.

8. To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and the results of proactive risk assessments.

9. Communication processes are effective in doing the following:
   - Fostering the safety of the patient and their quality of care
   - Supporting a culture of safety and quality
   - Meeting the needs of internal and external users
   - Informing those who work in the hospital of changes in the environment
   - Disseminating lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and proactive risk assessments to all affected staff

10. Leaders evaluate the effectiveness of communication methods.

11. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools. Possible issues are identified by the culture of safety evaluation. Proposed improvements are prioritized and implemented.

12. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.

13. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

NPG.02.04.01

The hospital has a workplace violence prevention program.

Element(s) of Performance for NPG.02.04.01

1. The hospital has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team that includes the following:
   - Policies and procedures to prevent and respond to workplace violence
   - A process to report incidents in order to analyze incidents and trends
   - A process for follow up and support to victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary
   - Reporting of workplace violence incidents to the governing body

2. As part of its workplace violence prevention program, the hospital provides training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention program) to leaders, staff, and licensed practitioners. The hospital determines what aspects of training are appropriate for individuals based on their roles and responsibilities. The training, education, and resources address prevention, recognition, response, and reporting of workplace violence as follows:
   - What constitutes workplace violence
   - Education on the roles and responsibilities of leaders, clinical staff, security personnel, and external law enforcement
   - Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents
   - The reporting process for workplace violence incidents

3. The hospital conducts an annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based on findings from the analysis.
   Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.

NPG.03.01.01

Hospital leadership provides oversight and support of the emergency management program.

Element(s) of Performance for NPG.03.01.01

1. The hospital's senior leaders provide oversight and support for the following emergency management program activities:
   - Allocation of resources for the emergency management program
   - Review of the emergency management program documents
   - Review of the emergency operations plan, policies and procedures, and training and education that support the emergency management program
   - Review of after-action reports (AAR) and improvement plans

   Note 1: The hospital defines who the members of the senior leadership group are as well as their roles and responsibilities for emergency management–related activities.
   Note 2: An AAR provides a detailed critical summary or analysis of a planned exercise or actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and identifies areas needing improvement.

2. The hospital's senior leaders identify a qualified individual to lead the emergency management program who has defined responsibilities that include, but are not limited to, the following:
   - Developing and maintaining the emergency operations plan and policies and procedures
   - Implementing the four phases of emergency management (mitigation, preparedness, response, and recovery)
   - Implementing emergency management activities across the six critical areas (communications, staffing, patient clinical and support services, safety and security, resources and assets, and utilities)
   - Coordinating the emergency management exercises and developing after-action reports
   - Collaborating across clinical and operational areas to implement organizationwide emergency management
   - Identifying and collaborating with community response partners

   Note: Education, training, and experience in emergency management should be taken into account when considering the qualifications of the individual(s) who lead the program.

3. The hospital has a multidisciplinary committee that oversees the emergency management program. The committee includes the emergency program lead and other participants identified by the hospital; meeting frequency, goals, and responsibilities are defined by the committee.
   Note 1: Other multidisciplinary committee participants may include representatives from senior leadership, nursing services, medical staff, pharmacy services, infection prevention and control, facilities engineering, security, and information technology.
   Note 2: The multidisciplinary committee that oversees the emergency management program may be incorporated into an existing committee.

4. The multidisciplinary committee provides input and assists in the coordination of the preparation, development, implementation, evaluation, and maintenance of the hospital's emergency management program. The activities include, but are not limited to, the following:
   - Hazard vulnerability analysis
   - Emergency operations plan, policies, and procedures

- Continuity of operations plan
- Training and education
- Planning and coordinating incident response exercises (seminars; workshops; tabletop exercises; functional exercises; full-scale, community-based exercises)
- After-action reports and improvement plans

Note: An after-action report (AAR) provides a detailed critical summary or analysis of a planned exercise or actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and specifies areas needing improvement.

NPG.03.02.01

The hospital develops an emergency operations plan based on an all-hazards approach.
Note: The hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.

Element(s) of Performance for NPG.03.02.01

1. The hospital's incident command structure describes the overall incident command operations, including specific incident command roles and responsibilities. The incident command structure is flexible and scalable to respond to varying types and degrees of emergencies or disaster incidents.
   Note: The incident command structure may include facilities, equipment, staff, procedures, and communications within a defined organizational structure.

2. The hospital identifies the individual(s) who has the authority to activate the hospital's emergency operations plan and/or the hospital's incident command.

3. The hospital identifies its primary and alternate sites for incident command operations and determines how it will maintain and support operations at these sites.
   Note 1: Alternate command center sites may include the use of virtual command centers.
   Note 2: Maintaining and supporting operations at alternate sites include having appropriate supplies, resources, communications, and information technology capabilities.

NPG.03.02.02

The hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency.
Note: The hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.

Element(s) of Performance for NPG.03.02.02

1. The hospital's communications plan describes how it will establish and maintain communications in order to deliver coordinated messages and information during an emergency or disaster incident to the following individuals:
   - Staff and volunteers (including individuals providing care at alternate sites)
   - Patients and family members, including people with disabilities and other access and functional needs
   - Community partners (such as fire department, emergency medical services, police, public health department)
   - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff)
   - Media and other stakeholders

   Note: Examples of means of communication include text messaging, phone system alerts, email, social media, and augmentative and alternative communication (AAC) for those with difficulties communicating using speech.

2. The emergency response communications plan identifies the hospital's warning and notification alerts specific to emergency and disaster events and the procedures to follow when an emergency or disaster incident occurs.

NPG.03.02.03

The hospital has a staffing plan for managing all staff and volunteers during an emergency or disaster incident.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a staffing plan.

Element(s) of Performance for NPG.03.02.03

1. The hospital's staffing plan describes in writing how it will manage volunteer licensed practitioners when the emergency operations plan has been activated and the hospital is unable to meet its patient needs. The hospital does the following:
   - Verifies and documents the identity of all volunteer licensed practitioners
   - Completes primary source verification of licensure as soon as the immediate situation is under control or within 72 hours from the time the volunteer licensed practitioner presents to the organization
   - Provides oversight of the care, treatment, and services provided by volunteer licensed practitioners

   Note: If primary source verification of licensure cannot be completed within 72 hours, the hospital documents the reason(s) it could not be performed.

2. The hospital identifies the individual(s) responsible for granting disaster privileges to volunteer physicians and other licensed practitioners and has a process for granting these privileges. This is documented in the medical staff bylaws, rules and regulations, or policies and procedures.

3. The emergency response staffing plan describes how it will provide employee assistance and support, which includes the following:
   - Staff support needs (for example, housing, transportation)
   - Family support needs of staff (for example, child care, elder care)
   - Mental health and wellness needs

NPG.03.02.04

The hospital has a plan for providing patient care and clinical support during an emergency or disaster incident.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for patient care and clinical support.

Element(s) of Performance for NPG.03.02.04

1. The hospital's plan for providing patient care and clinical support includes written procedures for managing individuals that may present during a disaster or emergency that are not in need of medical care (such as visitors).

2. The hospital coordinates with the local medical examiner's office, local mortuary services, and other local, regional, or state services when there is a surge of unidentified or deceased patients.

NPG.03.02.05

The hospital has a plan for safety and security measures to take during an emergency or disaster incident.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for safety and security.

Element(s) of Performance for NPG.03.02.05

1. The hospital has a plan for safety and security measures. The plan describes the roles that community security agencies (for example, police, sheriff, National Guard) will have in the event of an emergency and how the hospital will coordinate security activities with these agencies.

NPG.03.02.06

The hospital has a plan for managing resources and assets during an emergency or disaster incident.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for resources and assets.

Element(s) of Performance for NPG.03.02.06

1. The hospital's plan for managing its resources and assets describes in writing the actions the hospital will take to sustain the needs of the hospital for up to 96 hours based on calculations of current resource consumptions.
   Note 1: Hospitals are not required to remain fully functional for 96 hours or stockpile 96 hours' worth of supplies.
   Note 2: The 96-hour time frame provides a framework for hospitals to evaluate their capability to be self-sufficient for at least 96 hours. For example, if a hospital loses electricity and has backup generators, the emergency response plan for resources and assets establishes how much fuel is on hand and how long those generators can be operated before determining next steps. The plan may also address conservation of resources and assets, such as rationing existing resources, canceling noncritical procedures, or redirecting resources.

NPG.03.03.01

The hospital has a disaster recovery plan.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a disaster recovery plan.

Element(s) of Performance for NPG.03.03.01

1. The hospital has a disaster recovery plan that describes in writing its strategies for when and how it will do the following:
   - Conduct hospitalwide damage assessments
   - Restore critical systems and essential services
   - Return to full operations

2. The hospital's disaster recovery plan describes in writing how the hospital will address family reunification and coordinate with its local community partners to help locate and assist with the identification of adults and unaccompanied children.

NPG.03.04.01

The hospital has an emergency management education and training program.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.

Element(s) of Performance for NPG.03.04.01

1. The hospital requires that incident command staff participate in education and training specific to their duties and responsibilities in the incident command structure.
   Note: The hospital may choose to develop its own training, or it may require incident command staff to take an incident command–related course(s) such as those offered by the Federal Emergency Management Agency.

NPG.03.05.01

The hospital plans and conducts exercises to test its emergency operations plan and response procedures.
Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.

Element(s) of Performance for NPG.03.05.01

1. Each accredited freestanding outpatient care building that provides patient care, treatment, and services is required to conduct at least one operations-based or discussion-based exercise per year to test its emergency response procedures, if not conducted in conjunction with the hospital's emergency exercises. Exercises and actual emergency or disaster incidents are documented.

NPG.03.06.01

The hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.

Element(s) of Performance for NPG.03.06.01

1. The after-action reports, identified opportunities for improvement, and recommended actions to improve the emergency management program are forwarded to senior hospital leaders for review.

NPG.04.01.01

Improving health care equity for the hospital's patients is a quality and safety priority.

Element(s) of Performance for NPG.04.01.01

1. The hospital designates an individual(s) to lead activities to improve health care equity for the hospital's patients.
   Note: Leading the hospital's activities to improve health care equity may be an individual's primary role or part of a broader set of responsibilities.

2. The hospital assesses the patient's health-related social needs (HRSNs) and provides information about community resources and support services.
   Note 1: Hospitals determine which HRSNs to include in the patient assessment. Examples of a patient's HRSNs may include the following:
   - Access to transportation
   - Difficulty paying for prescriptions or medical bills
   - Education and literacy
   - Food insecurity
   - Housing insecurity

Note 2: HRSNs may be identified for a representative sample of the hospital's patients or for all the hospital's patients.

3. The hospital identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the hospital's patients.
   Note 1: Hospitals may focus on areas with known health care disparities identified in the scientific literature (for example, organ transplantation, maternal care, diabetes management) or select measures that affect all patients (for example, experience of care and communication).
   Note 2: Hospitals determine which sociodemographic characteristics to use for stratification analyses. Examples of sociodemographic characteristics may include the following:
   - Age
   - Gender
   - Preferred language
   - Race and ethnicity
   - Veterans
   - Patients in rural communities
   - Physical, mental, and cognitive disabilities

4. The hospital develops a written action plan that describes how it will improve health care equity by addressing at least one of the health care disparities identified in its patient population.

5. The hospital acts when it does not achieve or sustain the goal(s) in its action plan to improve health care equity.

6. At least annually, the hospital informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health care equity.

NPG.05.01.01

The hospital implements its infection prevention and control program through surveillance, prevention, and control activities.

Element(s) of Performance for NPG.05.01.01

1. To prioritize the program's activities, the hospital identifies risks for infection, contamination, and exposure that pose a risk to patients and staff based on the following:
   - Its geographic location, community, and population served
   - The care, treatment, and services it provides
   - The analysis of surveillance activities and other infection control data
   - Relevant infection control issues identified by the local, state, or federal public health authorities that could impact the hospital

   Note: Risks may include organisms with a propensity for transmission within health care facilities based on published reports and the occurrence of clusters of patients (for example, norovirus, respiratory syncytial virus, influenza, measles, organisms with antimicrobial resistance such as Carbapenem-resistant Enterobacterales [CRE] and Candida auris).

2. The hospital reviews identified risks at least annually or whenever significant changes in risk occur.

NPG.05.02.01

The hospital implements processes to support preparedness for high-consequence infectious diseases or special pathogens.

Element(s) of Performance for NPG.05.02.01

1. The hospital develops and implements protocols for high-consequence infectious diseases or special pathogens. The protocols are readily available for use at the point of care and address the following:
   • Identify: Procedures for screening at the points of entry to the hospital for respiratory symptoms, fever, rash, and travel history to identify or initiate evaluation for high-consequence infectious diseases or special pathogens
   • Isolate: Procedures for transmission-based precautions
   • Inform: Procedures for informing public health authorities and key hospital staff
   • Required personal protective equipment and proper donning and doffing techniques
   • Infection control procedures to support continued and safe provision of care while the patient is in isolation and to reduce exposure among staff, patients, and visitors using the hierarchy of controls
   • Procedures for managing waste and cleaning and disinfecting patient care spaces, surfaces, and equipment
   Note 1: Points of entry may include the emergency department, urgent care, and ambulatory clinics.
   Note 2: See the Glossary for a definition of hierarchy of controls.

2. The hospital develops and implements education and training and assesses competencies for staff who will implement protocols for high-consequence infectious diseases or special pathogens.

NPG.05.03.01

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

Element(s) of Performance for NPG.05.03.01

1. The hospital implements a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines. The program sets goals for improving compliance with hand hygiene based on established goals.

NPG.06.01.01

Pain assessment and pain management, including safe opioid prescribing, are identified as an organizational priority.

Element(s) of Performance for NPG.06.01.01

1. The hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing, as well as developing and monitoring performance improvement activities.

2. The hospital provides nonpharmacologic pain treatment modalities.

3. The hospital provides staff with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population.

4. The hospital provides information to staff on available services for consultation and referral of patients with complex pain management needs.

5. The hospital identifies opioid treatment programs that can be used for patient referrals.

6. The hospital facilitates licensed practitioner and pharmacist access to the Prescription Drug Monitoring Program databases.

Note: This element of performance is applicable in any state that has a Prescription Drug Monitoring Program database, whether querying is voluntary or is mandated by state regulations for all patients prescribed opioids.

7. Hospital leadership works with its clinical staff to identify and acquire the equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment.

NPG.06.02.01

The hospital assesses and manages the patient's pain and minimizes the risks associated with treatment.

Element(s) of Performance for NPG.06.02.01

1. The hospital has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand.

2. The hospital screens patients for pain during emergency department visits and at the time of admission.

3. The hospital treats the patient's pain or refers the patient for treatment.
Note: Treatment strategies for pain may include nonpharmacologic, pharmacologic, or a combination of approaches.

4. The hospital develops a pain treatment plan based on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals.

5. The hospital involves the patient in the pain management treatment planning process through the following:
   - Developing realistic expectations and measurable goals that the patient understands for the degree, duration, and reduction of pain
   - Discussing the objectives used to evaluate treatment progress (for example, relief of pain and improved physical and psychosocial function)
   - Providing education on pain management, treatment options, and safe use of opioid and nonopioid medications when prescribed

6. The hospital monitors patients identified as being high risk for adverse outcomes related to opioid treatment.

7. The hospital reassesses and responds to the patient's pain through the following:
   - Evaluation and documentation of response(s) to pain intervention(s)
   - Progress toward pain management goals, including functional ability (for example, ability to take a deep breath, turn in bed, walk with improved pain control)
   - Side effects of treatment
   - Risk factors for adverse events caused by the treatment

8. The hospital educates the patient and family on discharge plans related to pain management, including the following:
   - Pain management plan of care
   - Side effects of pain management treatment
   - Daily living activities, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care and strategies to address these issues
   - Safe use, storage, and disposal of opioids when prescribed

NPG.06.03.01

The hospital collects data on pain assessment and management.

Element(s) of Performance for NPG.06.03.01

1. The hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.

NPG.07.01.01

The hospital respects the patient's right to receive information in a manner the patient understands.

Element(s) of Performance for NPG.07.01.01

1. The hospital respects the patient’s right to and need for effective communication.

2. The hospital provides interpreting and translation services, as necessary.
Note: For hospitals that elect The Joint Commission Primary Care Medical Home option: Language interpreting options may include trained bilingual staff, contract interpreting services, or employed language interpreters. These options may be provided in person or via telephone or video. The documents translated, and the languages into which they are translated, are dependent on the primary care medical home's patient population.

3. The hospital communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.

NPG.07.02.01

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

Element(s) of Performance for NPG.07.02.01

1. The hospital develops and implements a written policy on informed consent that describes the following:
   - Specific care, treatment, and services that require informed consent
   - Circumstances that would allow for exceptions to obtaining informed consent
   - Process used to obtain informed consent
   - Physicians or other licensed practitioners permitted to conduct the informed consent discussion in accordance with law and regulation
   - How informed consent is documented in the patient record

   Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record.
   - When a surrogate decision-maker may give informed consent

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

NPG.07.03.01

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

Element(s) of Performance for NPG.07.03.01

1. The hospital uses written criteria to identify those patients who may be victims of physical assault, sexual assault, sexual molestation, domestic abuse, elder or child abuse, neglect, and exploitation. Patients are evaluated upon entry into the hospital and on an ongoing basis.
   Note: Criteria can be based on age, sex, and circumstance.
2. To assist with referrals of possible victims of abuse, neglect, and exploitation, the hospital maintains a list of private and public community agencies that can provide or arrange for assessment and care.
3. The hospital educates staff about how to recognize signs of possible abuse, neglect, and exploitation and about their roles in follow-up.
4. The hospital internally reports cases of possible abuse, neglect, and exploitation.
5. When the hospital serves a population of patients that need protective services (for example, guardianship or advocacy services, conservatorship, or child or adult protective services), it provides resources to help the family and the courts determine the patient's needs for such services.

NPG.07.04.01

The hospital treats the patient in a dignified and respectful manner.

Element(s) of Performance for NPG.07.04.01

1. The hospital respects the patient's cultural and personal values, beliefs, and preferences.
2. The hospital accommodates the patient's right to religious and other spiritual services.

NPG.08.01.01

The hospital reduces the risk for suicide.
Note: EPs 2–7 apply to patients in psychiatric distinct part units in hospitals or patients being evaluated or treated for behavioral health conditions as their primary reason for care in hospitals. In addition, EPs 3–7 apply to all patients who express suicidal ideation during the course of care.

Element(s) of Performance for NPG.08.01.01

1. For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).
   For nonpsychiatric units in hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital.
   Note: Nonpsychiatric units in hospitals do not need to be ligature resistant. Nevertheless, these facilities should routinely assess clinical areas to identify objects that could be used for self-harm and remove those objects, when possible, from the area around a patient who has been identified as high risk for suicide. This information

can be used for training staff who monitor high-risk patients (for example, developing checklists to help staff remember which equipment should be removed when possible).

CoP(s): §482.13(c)(2)

2. The hospital screens all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool.
Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.

CoP(s): §482.13(c)(2)

3. The hospital uses an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.
Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation.

CoP(s): §482.13(c)(2)

4. The hospital documents patients' overall level of risk for suicide and the plan to mitigate the risk for suicide.

CoP(s): §482.13(c)(2)

5. The hospital follows written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following:
   - Training and competence assessment of staff who care for patients at risk for suicide
   - Guidelines for reassessment
   - Monitoring patients who are at high risk for suicide

CoP(s): §482.13(c)(2)

6. The hospital follows written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide.

7. The hospital monitors implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and takes action as needed to improve compliance.

CoP(s): §482.13(c)(2)

NPG.09.01.01

The hospital uses standardized procedures for managing tissues.

Element(s) of Performance for NPG.09.01.01

1. The hospital develops and implements standardized written procedures for the acquisition, receipt, storage, and issuance of tissues.

2. The hospital confirms that tissue suppliers are registered with the US Food and Drug Administration (FDA) as a tissue establishment and maintain a state license when required.
Note 1: This element of performance does not apply to autologous tissue- or cellular-based products considered tissue for the purposes of these standards but classified as medical devices by the FDA.
Note 2: The supplier's FDA registration status may also be checked annually by using the FDA's online database: https://www.fda.gov/vaccines-blood-biologics/biologics-establishment-registration/find-tissue-establishment.

3. The hospital follows the tissue suppliers' or manufacturers' written directions for transporting, handling, storing, and using tissue.

4. The hospital maintains daily records to demonstrate that tissues requiring a controlled environment are stored at the required temperatures.
Note 1: Types of tissue storage include room temperature, refrigerated, frozen (for example, deep freezing colder than -40°C), and liquid nitrogen storage.
Note 2: Tissues requiring no greater control than "ambient temperature" (defined as the temperature of the immediate environment) for storage would not require temperature monitoring.

5. The hospital continuously monitors the temperature of refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues.
Note 1: Continuous temperature recording is not required but may be available with some continuous temperature monitoring systems.
Note 2: For tissue stored at room temperature, continuous temperature monitoring is not required.

6. Refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues at a controlled temperature have functional alarms and an emergency backup plan.
Note: For tissue stored at room temperature, alarm systems are not required.

7. In Department of Defense hospitals, Veterans Affairs medical centers, and other federally administered health care agencies, notification to the organ procurement organization of patients who have died or whose death is imminent is done according to procedures approved by the respective agency.

NPG.09.02.01

The hospital traces all tissues bi-directionally.

Element(s) of Performance for NPG.09.02.01

1. The hospital's records allow any tissue to be traced from the donor or tissue supplier to the recipient(s) or other final disposition, including discard, and from the recipient(s) or other final disposition back to the donor or tissue supplier.

2. The hospital identifies, in writing, the materials and related instructions used to prepare or process tissues.

NPG.09.03.01

The hospital investigates adverse events related to tissue use or donor infections.

Element(s) of Performance for NPG.09.03.01

1. The hospital has a written procedure to investigate tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue. The procedure includes the following at a minimum:
   - Investigating disease transmission or other complications that are suspected of being directly related to the use of tissue
   - Reporting of a post-transplant infection or adverse event related to the use of tissue to the tissue supplier as soon as the hospital becomes aware
   - Sequestering of tissue whose integrity may have been compromised or that is reported by the tissue supplier as a suspected cause of infection
   - Identifying and informing tissue recipients of infection risk when donors are subsequently found to have human immunodeficiency virus (HIV), human T-lymphotropic virus-I/II (HTLV-I/II), viral hepatitis, or other infectious agents known to be transmitted through tissue

NPG.10.01.01

Policies and procedures for waived tests are established, current, approved, and readily available.

Element(s) of Performance for NPG.10.01.01

1. The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, establishes written policies and procedures for waived testing that address the following:
   - Clinical usage and limitations of the test methodology
   - Need for confirmatory testing (for example, recommendations made by the manufacturer for rapid tests) and result follow-up recommendations (for example, a recommendation to repeat the test when results are higher or lower than the reportable range of the test)
   - Specimen type, collection, and identification, and required labeling
   - Specimen preservation, if applicable
   - Instrument maintenance and function checks, such as calibration
   - Storage conditions for test components
   - Reagent use, including not using a reagent after its expiration date
   - Quality control (including frequency and type) and corrective action when quality control is unacceptable
   - Test performance
   - Result reporting, including not reporting individual patient results unless quality control is acceptable
   - Equipment performance evaluation

   Note 1: Policies and procedures for waived testing are made available to testing personnel.
   Note 2: The designee should be knowledgeable by virtue of training, experience, and competence about the waived testing performed.

2. Policies or procedures for each waived test are consistent with manufacturers' instructions for use and include specific operational policies (that is, detailed quality control protocols and any other institution-specific procedures regarding the test or instrument).

NPG.10.02.01

Staff performing waived tests are competent.

Element(s) of Performance for NPG.10.02.01

1. Staff who perform waived testing have been trained for each test that they are authorized to perform. The training for each waived test is documented.
   Note: This includes training on the use and maintenance of instruments.

2. Competence for waived testing is assessed according to hospital policy at defined intervals, but at least at the time of orientation and annually thereafter. Competency is assessed using at least two of the following methods per person per test:
   - Performance of a test on a blind specimen
   - Periodic observation of routine work by the supervisor or qualified designee
   - Monitoring of each user's quality control performance
   - Use of a written test specific to the test assessed

   This competency is documented.
   Note 1: When a licensed practitioner performs waived testing that does not involve an instrument and the test falls within their specialty, the hospital may use the medical staff credentialing and privileging process to document evidence of training and competency in lieu of annual competency assessment. In this circumstance, individual privileges include the specific waived tests appropriate to the scope of practice that they are authorized to perform. At the discretion of the person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate or according to hospital policy, more stringent competency requirements may be implemented.
   Note 2: Provider-performed microscopy (PPM) procedures are not waived tests.

NPG.11.01.01

The hospital manages security risks.

Element(s) of Performance for NPG.11.01.01

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

2. The hospital develops and implements written policies and procedures to follow in the event of a security incident, including an infant or pediatric abduction.

3. The hospital develops and implements a process(es) for continually monitoring, internally reporting, and investigating the following:
   - Injuries to patients or others within the hospital's facilities and grounds
   - Occupational illnesses and staff injuries
   - Incidents of damage to its property or the property of others
   - Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence
   - Hazardous materials and waste spills and exposures
   - Fire safety management problems, deficiencies, and failures
   - Medical or laboratory equipment management problems, failures, and use errors
   - Utility systems management problems, failures, or use errors

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

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

4. The hospital coordinates administrative and clinical decisions for patients under legal or correctional restrictions on the following:
   - Use of seclusion and restraint for nonclinical purposes
   - Imposition of disciplinary restrictions
   - Restriction of rights
   - Plan for discharge and continuing care, treatment, and services
   - Length of stay

NPG.11.02.01

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

Element(s) of Performance for NPG.11.02.01

1. The hospital implements fall risk reduction interventions based on the patient population, setting, and individual patient's assessed risks.

NPG.11.03.01

The hospital manages utility systems.

Element(s) of Performance for NPG.11.03.01

1. The hospital develops and implements written procedures for responding to utility system disruptions. The procedures include but are not limited to shutting off a malfunctioning system and notifying staff in the affected areas.

2. The hospital develops and implements a policy to provide emergency backup for essential medication dispensing equipment identified by the hospital, such as automatic dispensing cabinets, medication carousels, and central medication robots.
   Note: Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how dispensing and administration of medications will continue when emergency backup is needed.

3. The hospital develops and implements a policy to provide emergency backup for essential refrigeration for medications identified by the hospital, such as designated refrigerators and freezers.
   Note: Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how refrigeration of medications will continue when emergency backup is needed.

NPG.12.01.01

The hospital’s leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determines how staff function within the organization.

Element(s) of Performance for NPG.12.01.01

1. Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services.

Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following:
- Rehabilitation services
- Emergency services
- Outpatient services
- Respiratory services
- Pharmaceutical services, including emergency pharmaceutical services
- Diagnostic and therapeutic radiology services

Note 2: Emergency services staff are qualified in emergency care.

CoP(s): §482.25(a)(2), §482.26, §482.26(a), §482.54(b)(2), §482.55(b)(2), §482.57(a)(2)

6. The hospital has a medical record service that has administrative responsibility for medical records. The hospital employs adequate staff to support the prompt completion, filing, and retrieval of records.

   CoP(s): §482.24(a)

7. The hospital has dietetic services that are directed and adequately staffed by qualified personnel.
   Note: For hospitals that provide dietetic services through contracted services, the contracted service has a dietician who serves the hospital full-time, part-time, or on a consultant basis and acts as a liaison to hospital medical staff for recommendations on dietetic policies that affect patient care, treatment, and services.

   CoP(s): §482.28

8. The hospital has a full-time employee, qualified through education, training, or experience, who serves as director to oversee the daily management of food and dietetic services.

   CoP(s): §482.28(a)(1)(i), §482.28(a)(1)(ii), §482.28(a)(1)(iii)

9. The hospital has a qualified dietitian on a full-time, part-time, or consultative basis.

   CoP(s): §482.28(a)(2)

10. The hospital has a pharmacy that is directed by a registered pharmacist. If the hospital does not have a pharmacy, it has a drug storage area under competent supervision, as defined by the hospital.
    Note: The pharmacy or drug storage area is administered in accordance with accepted professional principles.

    CoP(s): §482.25

11. The hospital has a full-time, part-time, or consulting pharmacist who is responsible for developing, supervising, and coordinating all pharmacy services activities.

    CoP(s): §482.25(a)(1)

12. The hospital's governing body, based on the recommendation of the medical staff and nursing leaders, appoints an infection preventionist(s) or infection control professional(s) qualified through education, training, experience, or certification in infection prevention to be responsible for the infection prevention and control program.

    CoP(s): §482.42(a)(1)

13. The surgical services include but are not limited to the following staff:
    - An experienced registered nurse or doctor of medicine or osteopathy who supervises the operating rooms
    - Licensed practical nurses (LPNs) and surgical technologists (operating room technicians) who serve as scrub nurses, if under the supervision of a registered nurse
    - Qualified registered nurses who perform circulating duties in the operating room

    Note: In accordance with applicable state laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies.

    CoP(s): §482.51(a)(1), §482.51(a)(2), §482.51(a)(3)

NPG.12.02.01

The nurse executive directs the implementation of a nurse staffing plan(s).

Element(s) of Performance for NPG.12.02.01

1. The nurse executive, who is a licensed registered nurse, is responsible for the operation of nursing services, including determining the following:
    - Nursing policies and procedures
    - Types and numbers of nursing and other staff necessary to provide nursing care for all areas of the hospital

    CoP(s): §482.23(a)

2. The nurse executive assumes an active leadership role with the hospital’s governing body, senior leadership, medical staff, management, and other clinical leaders in the hospital’s decision-making structure and process.
    Note 1: The nurse executive possesses a postgraduate degree in nursing or a related field, the knowledge and skills associated with an advanced degree, or a written plan to obtain these qualifications.
    Note 2: A related field may include health care administration or business administration.

4. A registered nurse directly provides or supervises the nursing services provided by other staff to patients 24 hours a day, 7 days a week. The hospital has a licensed practical nurse or registered nurse on duty at all times.
    Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse is immediately available for the provision of care of any patient.
    Note 2: For hospitals that use The Joint Commission for deemed-status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services.

    CoP(s): §482.23, §482.23(b)(1)

5. There must be an adequate number of licensed registered nurses, licensed practical (vocational) nurses, and other staff to provide nursing care to all patients, as needed.

Note: There are supervisors and staff for each department or nursing unit to make certain a registered nurse is immediate availability for the care of any patient.

CoP(s): §482.23(b)

7. The hospital has policies and procedures that establish which outpatient departments, if any, are not required to have a registered nurse present. The policies and procedures meet the following requirements:
   • Establish criteria that such outpatient departments need to meet, taking into account the types of services delivered, the general level of acuity of patients served by the department, and established standards of practice for the services delivered
   • Describe alternative staffing plans
   • Are approved by the director of nursing
   • Are reviewed at least once every three years

   CoP(s): §482.23(b)(7), §482.23(b)(7)(i), §482.23(b)(7)(ii), §482.23(b)(7)(iii), §482.23(b)(7)(iv)

NPG.12.03.01

For psychiatric hospitals that use Joint Commission for accreditation for deemed purposes: The psychiatric hospital develops and implements staffing plans according to law and regulation.

Element(s) of Performance for NPG.12.03.01

1. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital does the following:
   • Is primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons.
   • Meets the Medicare Conditions of Participation specified in 42 CFR 482.1 through 482.23, and 42 CFR 482.25 through 482.57.
   • Meets the staffing requirements specified in 42 CFR 482.62.

   CoP(s): §482.60(a), §482.60(b), §482.60(d)

2. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital makes certain a registered professional nurse is available 24 hours a day.

   CoP(s): §482.62(d)(2)

3. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The number of qualified therapists, support personnel, and consultants is adequate to provide therapeutic activities consistent with each patient's active treatment program.

   CoP(s): §482.62(g)(2)

4. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following:

- Evaluate patients
- Formulate written individualized, comprehensive treatment plans
- Provide active treatment measures
- Engage in discharge planning
- Provide the nursing care necessary under each patient's active treatment program
- Maintain progress notes on each patient
- Provide essential psychiatric services

CoP(s): §482.62, §482.62(a)(1), §482.62(a)(2), §482.62(a)(3), §482.62(a)(4), §482.62(d), §482.62(d)(2)

5. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Doctors of medicine or osteopathy and other appropriate professional staff are available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the hospital, the hospital has an agreement with an outside source for these services to ensure that they are immediately available, or the hospital establishes an agreement for transferring patients to a general hospital that participates in the Medicare program.

   CoP(s): §482.62(c)

6. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a director of social services who monitors and evaluates the quality and appropriateness of social services. Note: Social services are provided in accordance with accepted standards of practice and established policies and procedures.

   CoP(s): §482.62(f)

NPG.12.04.01

The hospital verifies that staff complete all requirements for employment and practice within their scope of practice.

Element(s) of Performance for NPG.12.04.01

1. The hospital obtains a criminal background check on the applicant as required by law and regulation or hospital policy. Criminal background checks are documented.
2. Staff comply with applicable health screening as required by law and regulation or hospital policy. Health screening compliance is documented.
3. Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration, in accordance with law and regulation.

NPG.12.05.01

The hospital provides education and training and evaluates staff competence.

Element(s) of Performance for NPG.12.05.01

1. The hospital orients staff on the following:
   - Relevant hospitalwide and unit-specific policies and procedures
   - Their specific job duties, including those related to infection prevention and control and assessing and managing pain

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

Completion of this orientation is documented.

2. The hospital evaluates staff performance once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. Staff are evaluated based on performance expectations that reflect their job responsibilities. This evaluation is documented.

NPG.12.06.01

The hospital evaluates staffing during performance improvement activities.

Element(s) of Performance for NPG.12.06.01

1. When the hospital identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes.
   Note 1: Adequacy of staffing includes the number, skill mix, and competency of all staff. In their analysis, hospitals may also wish to examine issues such as processes related to workflow; competency assessment; credentialing; supervision of staff; and orientation, training, and education.
   Note 2: Hospitals may find value in using the staffing effectiveness indicators (which include National Quality Forum Nursing Sensitive Measures) to help identify potential staffing issues.

2. When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the hospitalwide patient safety program (as addressed at NPG.02.03.01, EP 1) are informed, in a manner determined by the safety program, of the results of this analysis and actions taken to resolve the identified problem(s).

3. At least once a year, the leaders responsible for the hospitalwide patient safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.

4. At least once a year, the leaders provide governance with written reports that include results of the analyses related to the adequacy of staffing.

NPG.13.01.01

The hospital defines and verifies qualifications and education requirements for imaging services staff.

Element(s) of Performance for NPG.13.01.01

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

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

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

2. The hospital verifies and documents that diagnostic medical physicists who support computed tomography (CT) services have board certification in diagnostic radiologic physics or radiologic physics by the American Board of Radiology, or in diagnostic imaging physics by the American Board of Medical Physics, or in diagnostic radiological physics by the Canadian College of Physicists in Medicine, or meet all of the following requirements:
   - A graduate degree in physics, medical physics, biophysics, radiologic physics, medical health physics, or a closely related science or engineering discipline from an accredited college or university
   - College coursework in the biological sciences with at least one course in biology or radiation biology and one course in anatomy, physiology, or a similar topic related to the practice of medical physics
   - Documented experience in a clinical CT environment conducting at least 10 CT performance evaluations under the direct supervision of a board-certified medical physicist

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

3. The hospital verifies and documents that individuals who perform diagnostic computed tomography (CT) examinations participate in ongoing education that includes annual training on the following:
   - Radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently® and Image Wisely® campaigns
   - Safe procedures for operation of the types of CT equipment they will use

   Note 1: Information on the Image Gently and Image Wisely initiatives can be found online at https://www.imagegently.org and https://www.imagewisely.org, respectively.
   Note 2: This element of performance does not apply to CT systems used for therapeutic radiation treatment planning or delivery or for calculating attenuation coefficients for nuclear medicine studies.
   Note 3: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

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

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

NPG.13.02.01

The hospital's imaging services have a designated leader and follow current safe imaging practices.

Element(s) of Performance for NPG.13.02.01

1. The hospital designates an individual to serve as the radiation safety officer who is responsible for making certain that radiologic services are provided in accordance with law, regulation, and hospital policy. This individual has the necessary authority and leadership support to do the following:
   - Monitor and verify compliance with established radiation safety practices (including oversight of dosimetry monitoring)
   - Provide recommendations for improved radiation safety
   - Intervene as needed to stop unsafe practices
   - Implement corrective action

2. The hospital provides radiology services that meet safety standards approved by nationally recognized professional organizations. At a minimum, diagnostic radiology services are maintained and available at all times the hospital provides services, including emergency services.
   Note: If the hospital also provides other radiology services, such as therapeutic radiology, the requirements of this element of performance also apply to those services.

3. The hospital establishes or adopts diagnostic computed tomography (CT) imaging protocols based on current standards of practice, which address key criteria including the following:
   - Clinical indication
   - Contrast administration
   - Age (to indicate whether the patient is pediatric or an adult)
   - Patient size and body habitus
   - Expected radiation dose index range

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

4. Diagnostic computed tomography (CT) imaging protocols are reviewed and kept current with input from an interpreting physician, medical physicist, and lead imaging technologist to make certain that they adhere to current standards of practice and account for changes in CT imaging equipment. These reviews are conducted at time frames identified by the hospital. (For rehabilitation and psychiatric distinct part units in hospitals, refer to MS.17.01.03, EP 5 for supervision of radiologic services)
   Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

NPG.13.03.01

The hospital manages imaging safety risks.

Element(s) of Performance for NPG.13.03.01

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

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

3. For hospitals that provide computed tomography (CT), positron emission tomography (PET), nuclear medicine (NM), or fluoroscopy services: The radiation safety officer, diagnostic medical physicist, or health physicist reviews the results of dosimetry monitoring at least quarterly to assess whether staff radiation exposure levels are “as low as reasonably achievable” (ALARA) and below regulatory limits.
   Note 1: For the definition of ALARA, please refer to US Nuclear Regulatory Commission federal regulation 10 CFR 20.1003.
   Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

4. For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist does the following:
   • Measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol]) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted.
   • Verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results, and verifications of these measurements are documented.
   Note 1: This element of performance is only applicable for systems capable of calculating and displaying radiation doses.
   Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
   Note 3: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3)

5. For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics:
   • Image uniformity
   • Scout prescription accuracy
   • Alignment light accuracy
   • Table travel accuracy
   • Radiation beam width
   • High-contrast resolution
   • Low-contrast detectability
   • Geometric or distance accuracy
   • CT number accuracy and uniformity
   • Artifact evaluation

Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3)

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

   Note: Medical physicists or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or MRI scientist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3)

NPG.13.04.01

The hospital monitors quality improvement projects related to imaging safety.

Element(s) of Performance for NPG.13.04.01

1. The hospital collects data on the following:
   - Patient thermal injuries that occur during magnetic resonance imaging (MRI) exams
   - Incidents where ferromagnetic object unintentionally entered the MRI scanner room
   - Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room

2. The hospital reviews and analyzes incidents where the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) from diagnostic CT examinations exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks.
   Note 1: While the CTDIvol, DLP, and SSDE are useful indicators for monitoring radiation dose indices from the CT machine, they do not represent the patient's radiation dose.
   Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

NPG.14.01.01

The hospital safely manages pharmaceutical services.

Element(s) of Performance for NPG.14.01.01

1. When an on-site pharmacy is not open 24 hours a day, 7 days a week, the following occurs:
   • A health care professional, who the hospital determines is qualified, reviews the medication order in the pharmacist's absence
   • A pharmacist conducts a retrospective review of all medication orders during this period as soon as a pharmacist is available or the pharmacy opens
2. When automatic dispensing cabinets (ADCs) are used, the hospital develops and implements a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews. A 100% review of overrides is not required.

NPG.14.02.01

The hospital selects and procures medications.

Element(s) of Performance for NPG.14.02.01

1. The hospital standardizes and limits the number of drug concentrations available to meet patient care needs.
2. The hospital follows a process to communicate medication shortages and outages to staff who participate in medication management.
3. The hospital follows written medication substitution protocols to be used in the event of a medication shortage or outage and communicates the medication substitution protocols for shortages or outages to all affected staff.

NPG.14.03.01

The hospital labels all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.
Note: Medication containers include syringes, medicine cups, and basins.

Element(s) of Performance for NPG.14.03.01

1. In perioperative and other procedural settings both on and off the sterile field, the hospital labels medications and solutions that are not immediately administered. This applies even if there is only one medication being used.
   Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.
2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.
3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:
   • Medication or solution name
   • Strength

- Amount of medication or solution containing medication (if not apparent from the container)
- Diluent name and volume (if not apparent from the container)
- Expiration date and time

Note: The date and time are not necessary for short procedures, as defined by the hospital.

4. The hospital verifies all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.

5. The hospital labels each medication or solution as soon as it is prepared, unless it is immediately administered.
Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.

NPG.14.04.01

The hospital reduces the likelihood of patient harm associated with the use of anticoagulant therapy.
Note: This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for preventing venous thromboembolism (for example, related to procedures or hospitalization).

Element(s) of Performance for NPG.14.04.01

1. The hospital uses approved protocols and evidence-based practice guidelines for reversal of anticoagulation and management of bleeding events related to each anticoagulant medication.

2. The hospital uses approved protocols and evidence-based practice guidelines for perioperative management of all patients on oral anticoagulants.
Note: Perioperative management may address the use of bridging medications, timing for stopping an anticoagulant, and timing and dosing for restarting an anticoagulant.

3. The hospital uses only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.
Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.

NPG.14.05.01

The hospital maintains and communicates accurate patient medication information.

Element(s) of Performance for NPG.14.05.01

1. The hospital obtains information on the medications the patient is currently taking when they are admitted to the hospital or are seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.
Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications.
Note 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.

2. Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in non-24-hour settings.
Note: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.

3. Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.
Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison.

4. Provide the patient (or family, caregiver, or support person as needed) with written information on the medications the patient should be taking when they are discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).

5. Explain the importance of managing medication information to the patient when they are discharged from the hospital or at the end of an outpatient encounter.
Note: Examples include instructing the patient to give a list to their primary care provider; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on patient education on medications, refer to Standards MM.16.01.01, PC.12.02.01, and PC.14.01.01.)

NPG.14.06.01

The hospital has an active antibiotic stewardship program.

Element(s) of Performance for NPG.14.06.01

1. The hospital has a multidisciplinary committee that oversees the antibiotic stewardship program.
Note 1: The committee may be composed of representatives from the medical staff, pharmaceutical services, the infection prevention and control program, nursing services, microbiology, information technology, and the quality assessment and performance improvement program.
Note 2: The committee may include part-time or consultant staff. Participation may occur on site or remotely.

2. The antibiotic stewardship program monitors the hospital's antibiotic use by analyzing data on days of therapy per 1,000 days present or 1,000 patient days or by reporting antibiotic use data to the National Healthcare Safety Network's Antimicrobial Use Option of the Antimicrobial Use and Resistance Module.

Nursing (NR) Chapter

NR.11.01.01

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

Element(s) of Performance for NR.11.01.01

1. A registered nurse assigns the nursing care for each patient to other nursing staff in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available.

   CoP(s): §482.23(b)(5)

2. All licensed nurses who provide services in the hospital adhere to its policies and procedures.
Note: This applies to all nursing staff providing services (that is, hospital employee, contract, lease, other agreement, or volunteer).

   CoP(s): §482.23(b)(6)

3. The nurse executive provides for the supervision and evaluation of the clinical activities of all nursing staff in accordance with nursing policies and procedures.
Note: This applies to all nursing staff who are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer).

   CoP(s): §482.23(b)(6)

4. A registered nurse supervises and evaluates the nursing care for each patient.

   CoP(s): §482.23(b)(3)

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

PC.11.01.01

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

Element(s) of Performance for PC.11.01.01

1. The hospital develops and implements a written process for accepting a patient that addresses admission criteria and procedures for accepting referrals.

PC.11.02.01

The hospital assesses and reassesses the patient and the patient's condition according to defined time frames.

Element(s) of Performance for PC.11.02.01

1. The hospital conducts the patient's initial assessment within the written time frames it defines and in accordance with law and regulation.

2. A medical history and physical examination is completed and documented no more than 30 days prior to, or within 24 hours after, registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services.
Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except prior to any specific outpatient surgical or procedural services for which an assessment is performed instead as provided under 42 CFR 482.24(c)(4)(i)(C).
Note 2: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii), refer to https://www.ecfr.gov/.

   CoP(s): §482.24(c)(4)(i)(A), §482.51(b)(1)(i)

3. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.
Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except prior to any specific outpatient surgical or procedural services for which an assessment is performed instead as provided under 42 CFR 482.24(c)(4)(i)(C).

Note 2: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii), refer to https://www.ecfr.gov/.

CoP(s): §482.24(c)(4)(i)(B), §482.51(b)(1)(ii)

4. When the medical staff allows an assessment (in lieu of a comprehensive medical history and physical examination) for patients receiving specific outpatient surgical or procedural services, the patient assessment is completed and documented after registration but prior to the surgery or procedure requiring anesthesia services.
Note: For further regulatory guidance at 42 CFR 482.24(c)(4)(i)(A) and (B), 482.51(b)(1)(i) and (ii), and 482.22(c)(5)(v), refer to https://www.ecfr.gov/.

   CoP(s): §482.51(b)(1)(iii)

9. The hospital defines, in writing, the scope and content of screening, assessment, and reassessment. Patient information is collected according to these requirements.
Note 1: In defining the scope and content of the information it collects, the hospital may want to consider information that it can obtain, with the patient's consent, from the patient's family and the patient's other care providers, as well as information conveyed on any medical jewelry.
Note 2: Assessment and reassessment information includes the patient's perception of the effectiveness of, and any side effects related to, their medication(s).

10. The hospital defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed.
Note: Examples may include criteria that identify when a nutritional, functional, or pain assessment should be performed.

PC.11.02.03

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

Element(s) of Performance for PC.11.02.03

1. The assessment for patients who receive treatment for emotional and behavioral disorders includes the following, based on their age and needs:
   - Psychiatric evaluation
   - Psychological assessments, including intellectual, projective, neuropsychological, and personality testing
   - For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Complete neurological examination at the time of the admission physical examination, when indicated (For more information on physical examination, see PC.11.02.01, EP 2)

   CoP(s): §482.61(a)(5)

2. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following:
   - Medical history
   - Record of mental status
   - Description of the onset of illness and the circumstances leading to admission
   - Description of attitudes and behavior
   - Estimation of intellectual functioning, memory functioning, and orientation

- Inventory of the patient's assets in descriptive, not interpretative, fashion

CoP(s): §482.61(b), §482.61(b)(1), §482.61(b)(2), §482.61(b)(3), §482.61(b)(4), §482.61(b)(5), §482.61(b)(6), §482.61(b)(7)

PC.11.02.05

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

Element(s) of Performance for PC.11.02.05

1. Patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders receive an assessment that includes the following:
   - History of each substance use, including age of onset, duration, intensity, patterns of use, consequences of use, types of previous treatments, and responses to such treatment
   - History of mental, emotional, and behavioral problems; their co-occurrence with substance use disorders; and their treatment
   - History of biomedical complications associated with substance use disorders and the patient's level of awareness of the relationships between their behavioral conditions and pattern of substance use

2. Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following:
   - Acceptance of treatment or motivation for change, as well as recovery environment features that serve as resources or obstacles to recovery, including family members' use of alcohol or other substances
   - Family circumstances, including the composition of the family group and the need for their participation in the patient's care

3. Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following:
   - Religion and spiritual beliefs, values, and preferences
   - Living situation
   - Leisure and recreational activities
   - Military service history
   - Peer-group
   - Social factors
   - Ethnic and cultural factors
   - Financial status
   - Vocational or educational background
   - Legal history
   - Communication skills

4. Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following:
   - History of any physical or sexual abuse, as either the abuser or the abused
   - Sexual history and identification
   - Childhood history
   - Emotional and health issues
   - Visual-motor functioning
   - Self care

PC.11.02.07

The hospital assesses the patient’s communication needs.

Element(s) of Performance for PC.11.02.07

1. The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care.
   Note: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.

PC.11.03.01

The hospital plans the patient’s care.

Element(s) of Performance for PC.11.03.01

1. The hospital develops, implements, and revises a written individualized plan of care based on the following:
   - Needs identified by the patient’s assessment, reassessment, and results of diagnostic testing
   - The patient’s goals and the time frames, settings, and services required to meet those goals

   Note 1: Nursing staff develops and keeps current a nursing plan of care plan, which may be a part of an interdisciplinary plan of care, for each patient.
   Note 2: The hospital evaluates the patient’s progress and revises the plan of care based on the patient’s progress.
   Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient’s goals include both short- and long-term goals.

   CoP(s): §482.23(b)(4)

2. The hospital involves the patient in the development and implementation of their plan of care.
   Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to be informed, in advance, of changes to their plan of care.

   CoP(s): §482.13(b)(1), §482.58(b)(1), §483.10(c)(2)(iii)

3. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Each patient has an individual comprehensive treatment plan that is based on an inventory of the patient's strengths and disabilities. The written plan includes the following:
   - Substantiated diagnosis
   - Short-term and long-term goals
   - Specific treatment modalities utilized
   - Responsibilities of each member of the treatment team
   - Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out

   CoP(s): §482.61(c)(1), §482.61(c)(1)(i), §482.61(c)(1)(ii), §482.61(c)(1)(iii), §482.61(c)(1)(iv), §482.61(c)(1)(v)

4. For hospitals that elect The Joint Commission Primary Care Medical Home option: Patient self-management goals are developed in partnership with patients, based on criteria established by the organization, and incorporated into the patient’s treatment plan.

Note: Examples of criteria include the patient's disease process or condition and specific patient populations, such as those with multiple comorbidities or a chronic disease. It is not expected that self-management goals be developed for every patient.

5. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses clinical decision support tools to guide decision making.

PC.12.01.01

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

Element(s) of Performance for PC.12.01.01

1. Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.
Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietetic services, if provided.
Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals.

   CoP(s): §482.26(b)(4), §482.28(b)(2), §482.53(d)(4), §482.56(b), §482.57(b)(3), §482.58(b)(6), §483.65(b)

2. Any physician or other licensed practitioner who orders outpatient services meets the following conditions:
   - Responsible for the care of the patient
   - Licensed in the state where they provide care to the patient
   - Acting within their scope of practice under state law
   - Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services

   Note: This applies to physicians or other licensed practitioners who are appointed to the hospital's medical staff or have been granted privileges, as well as practitioners not appointed to the medical staff who satisfy the above criteria.

   CoP(s): §482.54(c)(1), §482.54(c)(2), §482.54(c)(3), §482.54(c)(4), §482.54(c)(4)(i), §482.54(c)(4)(ii)

3. The hospital administers blood transfusions and intravenous medications in accordance with state law and approved medical staff policies and procedures.

   CoP(s): §482.23(c)(4)

4. If the hospital provides rehabilitation, physical therapy, occupational therapy, speech-language pathology, or audiology services, the services are organized and provided in accordance with national accepted standards of practice.
Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The provision of rehabilitation services is in accordance with 42 CFR 409.17.

   CoP(s): §482.56, §482.56(a), §482.56(b)(2)

5. For hospitals that elect The Joint Commission Primary Care Medical Home option: Each patient has a designated primary care clinician.

PC.12.01.05

Resuscitative services are available throughout the hospital.

Element(s) of Performance for PC.12.01.05

1. For hospitals that use Joint Commission accreditation for deemed status purposes: At a minimum, operating room suites have the following equipment available:
   - Call-in system (process to communicate with or summon staff outside of the operating room when needed)
   - Cardiac monitor
   - Resuscitator (hand-held or mechanical device that provides positive airway pressure)
   - Defibrillator
   - Aspirator (hand-held or mechanical device used to suction out fluids or secretions)
   - Tracheotomy set

   CoP(s): §482.51(b)(3)

PC.12.01.09

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

Element(s) of Performance for PC.12.01.09

1. The nutritional needs of the individual patient are met in accordance with clinical practice guidelines and recognized dietary practices.
   Note: Diet menus meet the needs of the patients.

   CoP(s): §482.28(b), §482.28(b)(1)

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The dietitian and medical staff approve a therapeutic diet manual that is current and available to all medical, nursing, and food service staff.
   Note: For the purposes of this element of performance, current is defined as having a publication or revision date no more than five years old.

   CoP(s): §482.28(b)(3)

PC.12.02.01

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

Element(s) of Performance for PC.12.02.01

1. The hospital performs a learning needs assessment for each patient, which includes the following:
   - Cultural and religious beliefs

- Emotional barriers
- Desire and motivation to learn
- Physical or cognitive limitations
- Barriers to communication

2. The hospital coordinates the patient education and training provided by all disciplines involved in the patient's care, treatment, and services.

3. Based on the patient's condition and assessed needs, the education and training provided to the patient by the hospital include any of the following:
   - An explanation of the plan for care, treatment, and services
   - Basic health practices and safety
   - Information on the safe and effective use of medications
   - Nutrition interventions (for example, supplements) and modified diets
   - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
   - Information on oral health
   - Information on the safe and effective use of medical equipment or supplies provided by the hospital
   - Habilitation or rehabilitation techniques to help the patient reach maximum independence
   - Fall reduction strategies

4. The hospital evaluates the patient's understanding of the education and training it provided.

5. The hospital provides the patient education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.

6. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient's individual needs. (Refer to PC.11.03.01, EP 7)

7. For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team identifies the patient's health literacy needs.
   Note: Typically this is an interactive process. For example, patients may be asked to demonstrate their understanding of information provided by explaining it in their own words.

8. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team incorporate the patient's health literacy needs into the patient's education.

PC.12.03.01

For hospitals that elect The Joint Commission Primary Care Medical Home option: The patient has access to the primary care medical home 24 hours a day, 7 days a week.
Note: Access may be provided through a number of methods, including telephone, e-mail, websites, portals, and flexible hours.

Element(s) of Performance for PC.12.03.01

1. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides patients with access to the following 24 hours a day, 7 days a week:
   - Appointment availability/scheduling
   - Requests for prescription renewal
   - Test results
   - Clinical advice for urgent health needs

2. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home offers flexible scheduling to accommodate patient care needs.
   Note: This may include open scheduling, same-day appointments, group visits, expanded hours, and arrangements with other organizations.

3. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home has a process to address patient urgent care needs 24 hours a day, 7 days a week.

PC.12.03.03

For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home is accountable for providing patient care. (Refer to Standard PC.12.03.05)

Element(s) of Performance for PC.12.03.03

1. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home manages transitions in care and provides or facilitates patient access to care, treatment, or services, including the following:
   - Acute care
   - Management of chronic care
   - Preventive services that are age- and gender-specific
   - Behavioral health needs
   - Oral health care
   - Urgent and emergent care
   - Substance abuse treatment

   Note: Some of these services may be obtained through the use of community resources, as available, or in collaboration with other organizations.

2. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides care that addresses various phases of a patient's lifespan, including end-of-life care.

3. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides disease and chronic care management services to its patients.

4. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides population-based care.

5. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses health information technology to do the following:
   - Support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services
   - Document and track care, treatment, or services
   - Support disease management, including providing patient education
   - Support preventive care, treatment, or services
   - Create reports for internal use and external reporting
   - Facilitate electronic exchange of information among providers
   - Support performance improvement

PC.12.03.05

For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.

Element(s) of Performance for PC.12.03.05

1. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home identifies the composition of the interdisciplinary team, based on individual patient needs.

2. For hospitals that elect The Joint Commission Primary Care Medical Home option: The members of the interdisciplinary team provide comprehensive and coordinated care, treatment, or services and maintain the continuity of care.
   Note: The provision of care may include making internal and external referrals.

3. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team provide care for a designated group of patients.

4. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician is responsible for making certain that the interdisciplinary team provides comprehensive and coordinated care, treatment, or services and maintains the continuity of care as described in EPs 6–10.
   Note: Coordination of care may include making internal and external referrals, developing and evaluating treatment plans, and resolving conflicts in the provision of care.

5. For hospitals that elect The Joint Commission Primary Care Medical Home option: When a patient is referred internally or externally, the interdisciplinary team reviews and tracks the care provided to the patient and, as needed, acts on recommendations for additional care, treatment, and services.
   Note: Internal referrals include orders for laboratory tests and imaging.

6. For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team participates in the development of the patient’s treatment plan.

7. For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team works in partnership with the patient to achieve planned outcomes.

8. For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team monitors the patient’s progress toward achieving treatment goals.

9. For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team involves the patient in the development of the patient's treatment plan.

10. For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team assesses patients for health risk behaviors.

PC.13.01.01

The hospital plans operative or other high-risk procedures.
Note: Equipment identified in the elements of performance is available to the operating room suites

Element(s) of Performance for PC.13.01.01

1. For hospitals that use Joint Commission accreditation for deemed status purposes: General anesthesia, regional anesthesia, and monitored anesthesia, including deep sedation/analgesia, is administered only by the following individuals:

- A qualified anesthesiologist
- A doctor of medicine or osteopathy other than an anesthesiologist
- A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law
- A doctor of podiatric medicine, who is qualified to administer anesthesia under state law
- A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b), supervised by the operating practitioner, except as provided in 42 CFR 482.52(c) regarding the state exemption for this supervision
- An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist who is immediately available if needed

Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law or, if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission.
Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant.
Note 3: The CoP at 42 CFR 482.52(c) for state exemption states: A hospital may be exempt from the requirement for doctors of medicine or osteopathy to supervise CRNAs if the state in which the hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor attests that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.

CoP(s): §482.52(a)(1), §482.52(a)(2), §482.52(a)(3), §482.52(a)(4), §482.52(a)(5), §482.52(c)(1), §482.52(c)(2)

PC.13.01.03

The hospital provides the patient with care before and after operative or other high-risk procedures.

Element(s) of Performance for PC.13.01.03

1. Before operative or other high-risk procedures are initiated or before anesthesia is administered, the hospital conducts a preanesthesia patient assessment.

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements policies and procedures for anesthesia that include the delineation of preanesthesia and postanesthesia responsibilities. The policies require the following for each patient:
   - A preanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in 42 CFR 482.52(a), within 48 hours prior to surgery or a procedure requiring anesthesia services.
   - An intraoperative anesthesia record.
   - A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in 42 CFR 482.52(a), no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery is completed in accordance with state law and

hospital policies and procedures that have been approved by the medical staff and reflect current standards of anesthesia care.

CoP(s): §482.52(b), §482.52(b)(1), §482.52(b)(2), §482.52(b)(3)

4. Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered, the hospital provides the patient with preprocedural education, according to the plan for care.

5. The hospital has adequate provisions for immediate postoperative care.

   CoP(s): §482.51(b)(4)

6. A qualified physician or other licensed practitioner discharges the patient from the recovery area or from the hospital. In the absence of a qualified individual, patients are discharged according to criteria approved by clinical leaders.

PC.13.01.05

The laboratory has written policies and procedures for the handling of tissue specimens removed during a surgical procedure.

Element(s) of Performance for PC.13.01.05

1. The laboratory develops and implements written policies and procedures for collecting, preserving, transporting, receiving, and reporting examination results for tissue specimens.

   CoP(s): §482.27(a)(3)

2. The laboratory develops and implements a written policy, approved by the medical staff and a pathologist, that establishes which tissue specimens require only a macroscopic examination and which require both a macroscopic and microscopic examination.

   CoP(s): §482.27(a)(4)

PC.13.02.01

The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.
Note: See Glossary for the definitions of restraint and seclusion.

Element(s) of Performance for PC.13.02.01

1. The hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order.

   CoP(s): §482.13(e), §482.13(e)(2), §482.13(e)(9), §482.58(b)(3)

2. The hospital uses the least restrictive form of restraint or seclusion that will be effective to protect the patient, a staff member, or others from harm.

   CoP(s): §482.13(e)(3), §482.58(b)(3)

3. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital does not use physical or chemical restraints that are imposed for purposes of discipline or convenience and are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the hospital uses the least restrictive alternative for the least amount of time and documents ongoing reevaluation of the need for restraints.

   CoP(s): §483.12(a)(2)

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

   CoP(s): §482.13(e)(1)(i)(A), §482.13(e)(1)(i)(B), §482.13(e)(1)(i)(C)

5. The hospital seclusion policies are followed when a patient is involuntarily confined alone in a room or area from which the patient is physically prevented from leaving.
   Note: Seclusion is only used for the management of violent or self-destructive behavior.

   CoP(s): §482.13(e)(1)(ii)

PC.13.02.03

The hospital uses restraint or seclusion safely.

Element(s) of Performance for PC.13.02.03

1. The hospital's use of restraint or seclusion meets the following requirements:
   - In accordance with a written modification to the patient's plan of care.
   - Implemented by trained staff using safe techniques identified by the hospital's policies and procedures in accordance with law and regulation

   CoP(s): §482.13(e)(4)(i), §482.13(e)(4)(ii), §482.13(f)

PC.13.02.05

The hospital initiates restraint or seclusion based on an individual order.

Element(s) of Performance for PC.13.02.05

1. The hospital uses restraint or seclusion as ordered by a physician or other authorized licensed practitioner responsible for the patient's care in accordance with hospital policy and state law and regulation.

   CoP(s): §482.13(e)(5)

2. The hospital does not use standing orders or PRN (also known as "as needed") orders for restraint or seclusion.

   CoP(s): §482.13(e)(6)

3. The attending physician is consulted as soon as possible, in accordance with hospital policy, if they did not order the restraint or seclusion.
   Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

   CoP(s): §482.13(e)(7)

4. Unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others may be renewed within the following time limits:
   - 4 hours for adults 18 years of age or older
   - 2 hours for children and adolescents 9 to 17 years of age
   - 1 hour for children under 9 years of age

   Orders may be renewed according to the time limits for a maximum of 24 consecutive hours.

   CoP(s): §482.13(e)(8)(i), §482.13(e)(8)(i)(A), §482.13(e)(8)(i)(B), §482.13(e)(8)(i)(C)

5. Unless state law is more restrictive, every 24 hours, a physician or other authorized licensed practitioner responsible for the patient's care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others, in accordance with hospital policy and law and regulation.

   CoP(s): §482.13(e)(8)(ii)

6. Orders for restraint used to protect the physical safety of a nonviolent or non-self-destructive patient are renewed in accordance with hospital policy.

   CoP(s): §482.13(e)(8)(iii)

PC.13.02.07

The hospital monitors patients who are restrained or secluded.

Element(s) of Performance for PC.13.02.07

1. Physicians, other licensed practitioners, or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion.

   CoP(s): §482.13(e)(10)

PC.13.02.09

The hospital has written policies and procedures that guide the use of restraint or seclusion.

Element(s) of Performance for PC.13.02.09

1. The hospital's policies and procedures regarding the use of restraint or seclusion include the following:
   - Definitions for restraint and seclusion that are consistent with state and federal law and regulation
   - Physician and other licensed practitioner training requirements
   - Staff training requirements
   - Who has authority to order restraint or seclusion
   - Who has authority to discontinue the use of restraint or seclusion
   - Who can initiate the use of restraint or seclusion
   - Circumstances under which restraint or seclusion is discontinued
   - Requirement that restraint or seclusion is discontinued as soon as is safely possible
   - Who can assess and monitor patients in restraint or seclusion
   - Time frames for assessing and monitoring patients in restraint or seclusion

   CoP(s): §482.13(e)(11)

2. Physicians and other licensed practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working knowledge of the hospital policy regarding the use of restraint or seclusion.

   CoP(s): §482.13(e)(11)

PC.13.02.11

The hospital evaluates and reevaluates the patient who is restrained or secluded.

Element(s) of Performance for PC.13.02.11

1. A physician or other licensed practitioner responsible for the patient's care evaluates the patient in person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion if they are trained in accordance with the requirements in PC.13.02.17, EP 3.
   Note: The hospital also follows any state statute or regulation that may be more stringent than the requirements in this element of performance.

   CoP(s): §482.13(e)(12)(i)(A), §482.13(e)(12)(i)(B), §482.13(e)(13)

2. The in-person evaluation is conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. The evaluation includes the following:
   - An evaluation of the patient's immediate situation
   - The patient's reaction to the intervention
   - The patient's medical and behavioral condition
   - The need to continue or terminate the restraint or seclusion

   CoP(s): §482.13(e)(12)(ii)(A), §482.13(e)(12)(ii)(B), §482.13(e)(12)(ii)(C), §482.13(e)(12)(ii)(D)

3. When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse, they consult with the attending physician or other licensed practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy.

   CoP(s): §482.13(e)(14)

PC.13.02.13

The hospital continually monitors patients who are simultaneously restrained and secluded.

Element(s) of Performance for PC.13.02.13

1. The patient who is simultaneously restrained and secluded is continually monitored by trained staff, either in person or through the use of both video and audio equipment that is in close proximity to the patient.
   Note: In this element of performance, continually means ongoing without interruption.

   CoP(s): §482.13(e)(15)(i), §482.13(e)(15)(ii)

PC.13.02.15

The hospital documents the use of restraint or seclusion.

Element(s) of Performance for PC.13.02.15

1. Documentation of restraint or seclusion in the medical record includes the following:
   - The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior
   - Description of the patient's behavior and the intervention used
   - Alternatives or other less restrictive interventions attempted (as applicable)
   - Patient's condition or symptom(s) that warranted the use of the restraint or seclusion
   - Patient's response to the intervention(s) used, including the rationale for continued use of the intervention

   CoP(s): §482.13(e)(16)(i), §482.13(e)(16)(ii), §482.13(e)(16)(iii), §482.13(e)(16)(iv), §482.13(e)(16)(v)

PC.13.02.17

The hospital trains staff to safely implement the use of restraint or seclusion.

Element(s) of Performance for PC.13.02.17

1. The hospital trains staff on the use of restraint and seclusion and assesses their competence at the following intervals:
   - At orientation
   - Before participating in the use of restraint or seclusion
   - On a periodic basis thereafter, as determined by hospital policy

   CoP(s): §482.13(f)(1)(i), §482.13(f)(1)(ii), §482.13(f)(1)(iii)

3. Based on the population served, staff education, training, and demonstrated knowledge focus on the following:
   - Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion
   - Use of nonphysical intervention skills
   - Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition
   - Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia)
   - Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary
   - Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion
   - Use of first aid techniques and certification in the use of cardiopulmonary resuscitation (CPR), including required periodic recertification

   CoP(s): §482.13(f)(2)(i), §482.13(f)(2)(ii), §482.13(f)(2)(iii), §482.13(f)(2)(iv), §482.13(f)(2)(v), §482.13(f)(2)(vi), §482.13(f)(2)(vii)

4. Individuals providing staff training in restraint or seclusion are qualified as evidenced by education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion.

   CoP(s): §482.13(f)(3)

5. The hospital documents in staff records that they have completed restraint and seclusion training and demonstrated competence.

   CoP(s): §482.13(f)(4)

PC.13.02.19

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

Element(s) of Performance for PC.13.02.19

1. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports the following information to the Centers for Medicare & Medicaid Services regarding deaths related to restraint or seclusion:
   - Each death that occurs while a patient is in restraint or seclusion
   - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
   - Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death

   Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard.
   Note 2: In this element of performance "reasonable to assume" includes but is not limited to deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.

   CoP(s): §482.13(g), §482.13(g)(1)(i), §482.13(g)(1)(ii), §482.13(g)(1)(iii)

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The deaths addressed in PC.13.02.19, EP 1, are reported to the Centers for Medicare & Medicaid Services by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.

   CoP(s): §482.13(g)(1), §482.13(g)(3)(i)

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

   CoP(s): §482.13(g)(2)(i), §482.13(g)(2)(ii), §482.13(g)(3)(ii), §482.13(g)(4)(i), §482.13(g)(4)(ii), §482.13(g)(4)(iii)

PC.14.01.01

The hospital follows its process for discharging or transferring patients.

Element(s) of Performance for PC.14.01.01

1. The hospital has an effective discharge planning process that focuses on, and is consistent with, the patient's goals and treatment preferences; makes certain there is an effective transition of the patient from the hospital to postdischarge care; and reduces the factors leading to preventable critical access hospital and hospital readmissions.
   Note: The hospital's discharge planning process requires regular reevaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan is updated as needed to reflect these changes.

   CoP(s): §482.43, §482.43(a)(6)

2. The hospital begins the discharge planning process early in the patient's episode of care, treatment, and services.

   CoP(s): §482.43(a)

3. As part of the discharge planning evaluation, the hospital evaluates the patient's need for appropriate posthospital services, including but not limited to hospice care services, extended care services, home health services, and non–health care services and community-based care providers. The hospital also evaluates the availability of the appropriate services and the patient's access to those services as part of the discharge planning evaluation.

   CoP(s): §482.43(a)(2)

4. The patient, the patient's caregiver(s) or support person(s), physicians, other licensed practitioners, clinical psychologists, and staff who are involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. The patient and their caregiver(s) or support person(s) are included as active partners when planning for postdischarge care.
   Note 1: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (refer to the Glossary).
   Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move. The notice is in writing, in a language and manner they understand, and includes the items described in 42 CFR 483.15(c)(5). The hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the hospital is safe and orderly. The hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman.

   CoP(s): §482.43, §482.58(b)(2), §482.62(f)(2), §483.15(c)(3)(i), §483.15(c)(3)(iii), §483.15(c)(7)

5. The hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge

in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician.
Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided.
Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person.

CoP(s): §482.43(a), §482.43(a)(1), §482.43(a)(4), §482.43(a)(5)

6. The hospital discusses the results of the discharge planning evaluation with the patient or their representative, including any reevaluations performed and any arrangements made.

   CoP(s): §482.43(a)(3)

7. The hospital assists the patient, their family, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes but is not limited to home health agency, skilled nursing facility, inpatient rehabilitation facility, and long-term care hospital data on quality measures and resource-use measures. The hospital makes certain that the post–acute care data on quality measures and resource-use measures is relevant and applicable to the patient's goals of care and treatment preferences.

   CoP(s): §482.43(a)(8)

8. For hospitals that use Joint Commission accreditation for deemed status purposes: The patient's discharge plan includes a list of home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, or long-term care hospitals that are available to the patient, participating in the Medicare program, and serving the geographic area in which the patient resides (as defined by the home health agency or, in the case of a skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital, in the geographic area requested by the patient). The hospital documents in the medical record that this list was presented to the patient or the patient's representative.
   Note 1: Home health agencies must request to be listed by the hospital.
   Note 2: This list is only presented to patients for whom home health care, posthospital extended care services, skilled nursing, inpatient rehabilitation, or long-term care hospital services are identified as needed.

   CoP(s): §482.43(c)(1), §482.43(c)(1)(i), §482.43(c)(1)(iii)

9. For hospitals that use Joint Commission accreditation for deemed status purposes: For patients enrolled in managed care organizations, the hospital makes patients aware of the need to verify with their managed care organization which practitioners, providers, or certified suppliers are in the managed care organization's network. If the hospital has information on which practitioners, providers, or certified suppliers are in the network of the patient's managed care organization, it shares this information with the patient or the patient's representative.

   CoP(s): §482.43(c)(1)(ii)

10. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of postdischarge services and, when possible, respects the patient's or their representative's goals of care and treatment preferences, as well as other preferences when they are expressed. The hospital does not limit the qualified providers or suppliers that are available to the patient.

    CoP(s): §482.43(c)(2)

11. For hospitals that use Joint Commission accreditation for deemed status purposes: The discharge plan identifies any home health agency or skilled nursing facility in which the hospital has a disclosable financial interest and any home health agency or skilled nursing facility that has a disclosable financial interest in a hospital.
    Note: Disclosure of financial interest is determined in accordance with the provisions in 42 CFR 420, subpart C, and section 1861 of the Social Security Act (42 U.S.C. 1395x).

    CoP(s): §482.43(c)(3)

12. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged.
    Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days.

    CoP(s): §482.58(b)(2), §483.15(c)(4)(i), §483.15(c)(4)(ii)(A), §483.15(c)(4)(ii)(B), §483.15(c)(4)(ii)(C), §483.15(c)(4)(ii)(D), §483.15(c)(4)(ii)(E)

13. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in 42 CFR 483.15(c)(3) includes the following:
    - Reason for transfer or discharge
    - Effective date of transfer or discharge
    - Location to which the resident is transferred or discharged
    - Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request
    - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman
    - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000

• For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act

CoP(s): §482.58(b)(2), §483.15(c)(5)(i), §483.15(c)(5)(ii), §483.15(c)(5)(iii), §483.15(c)(5)(iv), §483.15(c)(5)(v), §483.15(c)(5)(vi), §483.15(c)(5)(vii)

14. The hospital assesses its discharge planning process on a regular basis, as defined by the hospital. The assessment includes an ongoing, periodic review of a representative sample of discharge plans, including plans for patients who were readmitted within 30 days of a previous admission, to make certain that the plans are responsive to patient postdischarge needs.

CoP(s): §482.43(a)(7)

PC.14.01.03

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Residents are not transferred or discharged from the hospital unless they meet specific criteria, in accordance with law and regulation.

Element(s) of Performance for PC.14.01.03

1. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only under at least one of the following conditions:
   • The resident's health has improved to the point where they no longer need the hospital's services.
   • The transfer or discharge is necessary for the resident's welfare, and the hospital cannot meet the resident's needs.
   • The safety of the individuals in the hospital is endangered due to the resident's clinical or behavioral status.
   • The health of individuals in the hospital would otherwise be endangered.
   • The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid.
   • The hospital ceases operation.

   Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose.

   CoP(s): §482.58(b)(2), §483.15(c)(1)(i)(A), §483.15(c)(1)(i)(B), §483.15(c)(1)(i)(C), §483.15(c)(1)(i)(D), §483.15(c)(1)(i)(E), §483.15(c)(1)(i)(F), §483.15(c)(1)(ii)

PC.14.02.01

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

Element(s) of Performance for PC.14.02.01

2. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides medically related social services to attain or maintain the optimal physical, mental, and psychosocial well-being of each resident.

   CoP(s): §482.58(b)(4), §483.40(d)

3. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The hospital may charge a Medicare resident an additional amount for routine and emergency dental services.

   CoP(s): §482.58(b)(7), §483.55(a)(2), §483.55(b)(5)

4. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements a policy identifying circumstances when loss of or damage to a resident's dentures is the hospital's responsibility, and it may not charge a resident for the loss or damage of dentures.

   CoP(s): §482.58(b)(7), §483.55(a)(3), §483.55(b)(4)

5. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If necessary or requested, the hospital assists residents in making dental appointments and arranging for transportation to and from the dental services location.

   CoP(s): §482.58(b)(7), §483.55(a)(4)(i), §483.55(a)(4)(ii), §483.55(b)(2)(i), §483.55(b)(2)(ii)

6. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay.

   CoP(s): §482.58(b)(7), §483.55(a)(5), §483.55(b)(3)

7. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides or obtains from an outside resource routine (to the extent covered under the state plan) and emergency dental services.

   CoP(s): §482.58(b)(7), §483.55(b)(1)(i)

8. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident's comprehensive plan of care requires specialized rehabilitative services, including but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity, the hospital provides

or obtains the required services from a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Social Security Act.

CoP(s): §482.58(b)(6), §483.65(a)(1), §483.65(a)(2)

PC.14.02.03

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

Element(s) of Performance for PC.14.02.03

1. The hospital provides or transmits necessary medical information when discharging, transferring, or referring the patient to post–acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners who are responsible for the patient's follow-up or ancillary care. Necessary medical information includes, at a minimum, the following:
   - Current course of illness and treatment
   - Postdischarge goals of care
   - Treatment preferences at the time of discharge

   CoP(s): §482.43(b)

PC.15.01.01

The hospital safely provides blood and blood components.

Element(s) of Performance for PC.15.01.01

1. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements written policies and procedures, including documentation and notification procedures, addressing potentially infectious blood and blood components, consistent with Centers for Medicare & Medicaid Services requirements at 42 CFR 482.27.
   Note 1: The procedures for notification and documentation conform to federal, state, and local laws, including requirements for the confidentiality of medical records and other patient information.
   Note 2: See Glossary for the definition of potentially infectious blood and blood components.

   CoP(s): §482.27(b)(1)(i), §482.27(b)(1)(ii), §482.27(b)(1)(iii), §482.27(b)(2), §482.27(b)(9)

2. For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification of blood that is reactive to the human immunodeficiency virus (HIV) or hepatitis C virus (HCV) screening test, the hospital determines the disposition of the blood or blood components and quarantines all previously donated blood and blood components in inventory.

   CoP(s): §482.27(b)(4)

3. For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification that the result of the supplemental (additional, more specific) test for potentially infectious blood or blood components or other follow-up testing required by the US Food and Drug Administration is negative

and there are no other informative test results, the hospital may release the blood and blood components from quarantine.

CoP(s): §482.27(b)(4)(i)

4. For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification that the result of the supplemental (additional, more specific) test for potentially infectious blood or blood components or other follow-up testing required by the US Food and Drug Administration is positive, the hospital does the following:
   - Disposes of the blood and blood components
   - Notifies the transfusion recipients as set forth in 42 CFR 482.27(b)(6)

   CoP(s): §482.27(b)(4)(ii)(A), §482.27(b)(4)(ii)(B)

5. For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification that the result of the supplemental (additional, more specific) test for potentially infectious blood or blood components or other follow-up testing required by the US Food and Drug Administration (FDA) is indeterminate, the hospital destroys or labels prior collections of blood or blood components held in quarantine, consistent with FDA requirements 21 CFR 610.46(b)(2) and 610.47(b)(2).

   CoP(s): §482.27(b)(4)(iii)

6. For hospitals that use Joint Commission accreditation for deemed status purposes: When potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood or blood components are administered (either directly through the hospital's own blood collecting establishment or under an agreement) or released to another entity or individual, the hospital takes the following actions:
   - Makes reasonable attempts to notify the patient, the attending physician or other licensed practitioner, or the physician or other licensed practitioner who ordered the blood or blood component and ask the practitioner to notify the patient, or other individuals as permitted under 42 CFR 482.27, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling
   - Attempts to notify to the patient, legal guardian, or relative if the practitioner is unavailable or declines to make the notification
   - Documents in the patient's medical record the notification or attempts to give the required notification

   CoP(s): §482.27(b)(6)(i), §482.27(b)(6)(ii), §482.27(b)(6)(iii)

7. If the hospital receives notification that it received potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood and blood components, the hospital makes reasonable attempts to give notification over a period of 12 weeks unless one of the following occurs:
   - The patient is located and notified.
   - The hospital is unable to locate the patient and documents in the patient's medical record the extenuating circumstances beyond the hospital's control that caused the notification timeframe to exceed 12 weeks.

   Note: For notifications resulting from donors tested on or after February 20, 2008 as set forth at 21 CFR 610.46 and 610.47, the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HIV or HCV infectious blood and blood components.

   CoP(s): §482.27(b)(7), §482.27(b)(7)(i), §482.27(b)(7)(ii)

8. When notifying patients who have received potentially human immune deficiency virus (HIV) or hepatitis C virus (HCV) infectious blood or blood components, the notification includes the following:
   • Oral or written information explaining the need for HIV or HCV testing and counseling, so that the patient can make an informed decision about whether to obtain HIV or HCV testing and counseling
   • A list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose

   CoP(s): §482.27(b)(8)(i), §482.27(b)(8)(ii), §482.27(b)(8)(iii)

9. If a patient has received an infectious blood or blood component, the hospital notifies the specified individual(s) under the following circumstances:
   • A legal representative designated in accordance with state law if the patient has been adjudged incompetent by a state court
   • The patient or his or her legal representative or relative if the patient is competent but state law permits a legal representative or relative to receive the information on the patient's behalf
   • The patient's legal representative or relative if the beneficiary of the potentially human immunodeficiency virus infectious transfusion is deceased
   • The parents or legal guardian if the patient is a minor

   CoP(s): §482.27(b)(10)

10. The hospital complies with US Food and Drug Administration regulations pertaining to blood safety issues in the following areas:
   • Appropriate testing and quarantining of infectious blood and blood components
   • Notification and counseling of potential recipients of infectious blood and blood components
   Note: This applies to lookback activities only related to new blood safety issues that are identified after August 24, 2007.

   CoP(s): §482.27(c)(1), §482.27(c)(2)

Physical Environment (PE) Chapter

PE.01.01.01

The hospital has a safe and adequate physical environment.

Element(s) of Performance for PE.01.01.01

1. The hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients.
   Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided.
   Note 2: When planning for new, altered, or renovated space, the hospital uses state rules and regulations or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria.

   CoP(s): §482.41, §482.41(a), §482.41(d), §482.41(d)(1), §482.42(a)(3)

2. The hospital has adequate space and facilities for the services it provides, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the needs of the community served.
Note: The extent and complexity of facilities is determined by the services offered.

   CoP(s): §482.41, §482.41(a), §482.41(d), §482.41(d)(3)

3. The hospital's premises are clean and orderly.
Note: Clean and orderly means an uncluttered physical environment where patients and staff can function. This includes but is not limited to storing equipment and supplies in their proper spaces, attending to spills, and keeping areas neat.

   CoP(s): §482.41(a)

PE.02.01.01

The hospital manages risks related to hazardous materials and waste.

Element(s) of Performance for PE.02.01.01

1. The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation.

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

3. The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings.
Note: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements.

4. The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following:
   - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors
   - Disposal of hazardous medications
   - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding
   - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection
   - Precautions to follow and personal protective equipment to wear in response to hazardous material and waste spills or exposure

   Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs).
   Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)

   CoP(s): §482.26(b), §482.26(b)(1), §482.26(b)(2), §482.53(b), §482.53(b)(2)

5. Radiation workers are checked periodically, using exposure meters or badge tests, for the amount of radiation exposure.

   CoP(s): §482.26(b)(3)

6. The hospital has procedures for the proper routine storage and prompt disposal of trash and regulated medical waste.

   CoP(s): §482.41(b)(4)

PE.03.01.01

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

Element(s) of Performance for PE.03.01.01

1. The hospital maintains current and accurate drawings denoting features of fire safety and related square footage. Fire safety features include the following:
   - Areas of the building that are fully sprinklered (if the building is partially sprinklered)
   - Locations of all hazardous storage areas
   - Locations of all fire-rated barriers
   - Locations of all smoke-rated barriers
   - Sleeping and non-sleeping suite boundaries, including the size of the identified suites
   - Locations of designated smoke compartments
   - Locations of chutes and shafts
   - Any approved equivalencies or waivers

2. The hospital maintains current Basic Building Information (BBI) within the Statement of Conditions (SOC).

3. The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).
   Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served.
   Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in hospitals.
   Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients.
   Note 4: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

   CoP(s): §482.15(e)(1), §482.15(h)(1)(ix), §482.15(h)(1)(vii), §482.15(h)(1)(viii), §482.15(h)(1)(x), §482.15(h)(1)(xi), §482.41(b), §482.41(b)(1)(i), §482.41(b)(2), §482.41(b)(3), §482.41(e)(1)(ix), §482.41(e)(1)(vii), §482.41(e)(1)(viii), §482.41(e)(1)(x), §482.41(e)(1)(xi)

4. The hospital has written fire control plans that include provisions for prompt reporting of fires; extinguishing fires; protection of patients, staff, and guests; evacuation; and cooperation with firefighting authorities.

   CoP(s): §482.15(b)(1)(ii)(C), §482.41(b)(5)

5. The hospital maintains written evidence of regular inspection and approval by state or local fire control agencies.

   CoP(s): §482.41(b)(6)

6. For hospitals that use Joint Commission accreditation for deemed status purposes: Regardless of the provisions of the Life Safety Code, corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited on these doors.

   CoP(s): §482.41(b)(1)(ii)

7. When the hospital installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access.

   CoP(s): §482.41(b)(7)

8. When a sprinkler system is shut down for more than 10 hours, the hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service, or the hospital establishes a fire watch until the system is back in service.

   CoP(s): §482.41(b)(8)(i), §482.41(b)(8)(ii)

9. Buildings have an outside window or outside door in every sleeping room. For any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor.
   Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement.
   Note 2: The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours.
   Note 3: The sill height in special nursing care areas of new occupancies does not exceed 60 inches.

   CoP(s): §482.41(b)(9), §482.41(b)(9)(i), §482.41(b)(9)(ii)

PE.03.02.01

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

Element(s) of Performance for PE.03.02.01

1. The hospital has a written interim life safety measures (ILSM) policy that covers situations when Life Safety Code deficiencies cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent the hospital implements PE.03.02.01, EPs 2–15, to compensate for increased life safety risk. The criteria include the assessment process to determine when interim life safety measures are implemented.
   Note: For any Life Safety Code (LSC) deficiency that cannot be immediately corrected during survey, the hospital identifies which ILSMs in its policy will be implemented until the issue is corrected.

2. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2)

3. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital posts signage identifying the location of alternative exits to everyone affected.

4. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital inspects exits in affected areas on a daily basis. The need for these inspections is based on criteria in the hospital's interim life safety measures (ILSM) policy.

5. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital provides temporary but equivalent fire alarm and detection systems for use when a fire system is impaired. The need for equivalent systems is based on criteria in the hospital's interim life safety measures (ILSM) policy.

6. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital provides additional firefighting equipment. The need for this equipment is based on criteria in the hospital's interim life safety measures (ILSM) policy.

7. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital uses temporary construction partitions that are smoke-tight or made of noncombustible or limited-combustible material that will not contribute to the development or spread of fire. The need for these partitions is based on criteria in the hospital's interim life safety measures (ILSM) policy.

8. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas and storage, excavation, and field offices. The need for increased surveillance is based on criteria in the hospital's interim life safety measures (ILSM) policy.

9. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital enforces storage, housekeeping, and debris-removal practices that reduce the building’s flammable and combustible fire load to the lowest feasible level. The need for these practices is based on criteria in the hospital's interim life safety measures (ILSM) policy.

10. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital provides additional training to those who work in the hospital on the use of firefighting equipment. The need for additional training is based on criteria in the hospital's interim life safety measures (ILSM) policy.

11. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital conducts one additional fire drill per shift per quarter. The need for additional drills is based on criteria in the hospital's interim life safety measures (ILSM) policy.

12. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital inspects and tests temporary systems monthly. The completion date of the

tests is documented. The need for these inspections and tests is based on criteria in the hospital's interim life safety measures (ILSM) policy.

13. The hospital conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety. The need for education is based on criteria in the hospital's interim life safety measures (ILSM) policy.

14. The hospital trains those who work in the hospital to compensate for impaired structural or compartmental fire safety features. The need for training is based on criteria in the hospital's interim life safety measures (ILSM) policy.
Note: Compartmentalization is the concept of using various building components (for example, fire-rated walls and doors, smoke barriers, fire-rated floor slabs) to prevent the spread of fire and the products of combustion so as to provide a safe means of egress to an approved exit. The presence of these features varies, depending on the building occupancy classification.

15. The hospital's policy allows the use of other interim life safety measures (ILSMs) not addressed in EPs 3–14.
Note: The other ILSMs used are documented by selecting “other” and annotating the associated text box in the hospital's Survey-Related Plan for Improvement (SPFI) within the Statement of Conditions™ (SOC).

PE.04.01.01

The hospital addresses building safety and facility management.

Element(s) of Performance for PE.04.01.01

1. The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6).
Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.
Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.
Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

   CoP(s): §482.15(e)(1), §482.15(h)(1)(i), §482.15(h)(1)(ii), §482.15(h)(1)(iii), §482.15(h)(1)(iv), §482.15(h)(1)(v), §482.15(h)(1)(vi), §482.41(c), §482.41(c)(1), §482.41(c)(2), §482.41(e)(1)(i), §482.41(e)(1)(ii), §482.41(e)(1)(iii), §482.41(e)(1)(iv), §482.41(e)(1)(v), §482.41(e)(1)(vi), §482.42

2. The hospital maintains essential equipment in safe operating condition.

   CoP(s): §482.41(d)(2)

3. The hospital has proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.

   CoP(s): §482.41(d)(4)

4. The hospital maintains equipment and supplies appropriate for the types of nuclear medicine services offered. The equipment is maintained for safe operation and efficient performance.

   CoP(s): §482.53(c), §482.53(c)(1)

5. The hospital maintains supplies to ensure an acceptable level of safety and quality.
   Note: Supplies are stored in a manner to ensure the safety of the stored supplies and to not violate fire codes or otherwise endanger patients.

   CoP(s): §482.41(d)(2)

PE.04.01.03

The hospital manages utility systems.

Element(s) of Performance for PE.04.01.03

1. The hospital has emergency power and lighting in the following areas, at a minimum:
   - Operating rooms
   - Recovery rooms
   - Intensive care
   - Emergency rooms
   - Stairwells

   Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source.

   CoP(s): §482.41(a)(1)

2. The hospital has a system to provide emergency gas and water supply.
   Note 1: The system includes making arrangements with local utility companies and others for the provision of emergency sources of water and gas.
   Note 2: Emergency gas includes fuels such as propane, natural gas, fuel oil, or liquefied natural gas, as well as any gases the hospital uses in the care of patients, such as oxygen, nitrogen, or nitrous oxide.

   CoP(s): §482.41(a)(2)

3. The hospital meets the emergency power system and generator requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.

   CoP(s): §482.15(e)(1), §482.15(e)(2), §482.15(h)(1)(xii)

4. When performing repairs or maintenance activities, the hospital has a process to manage risks associated with air-quality requirements; infection control; utility requirements; noise, odor, dust, and vibration; and other hazards that affect care, treatment, or services for patients, staff, and visitors.

PE.04.01.05

The hospital has a water management program that addresses Legionella and other waterborne pathogens.
Note: The water management program is in accordance with law and regulation.

Element(s) of Performance for PE.04.01.05

1. The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities.

   CoP(s): §482.41(d)(2), §482.42(a)(3)

2. The individual or team responsible for the water management program develops the following:
   • A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points
   Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth.
   • A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water)
   Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment.
   • A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas)
   • An evaluation of the patient populations served to identify patients who are immunocompromised
   • Monitoring protocols and acceptable ranges for control measures
   Note: Hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range.(See also IC.04.01.01, EP 2)

   CoP(s): §482.41(d)(2), §482.42(a)(3)

3. The individual or team responsible for the water management program manages the following:
   • Documenting results of all monitoring activities
   • Corrective actions and procedures to follow if a test result outside of acceptable limits is obtained, including when a probable or confirmed waterborne pathogen(s) indicates action is necessary
   • Documenting corrective actions taken when control limits are not maintained
   Note: See PE.07.01.01, EP 1 for the process of monitoring, reporting, and investigating utility system issues.

   CoP(s): §482.41(d)(2)

4. The individual or team responsible for the water management program reviews the program annually and when the following occurs:
   • Changes have been made to the water system that would add additional risk.
   • New equipment or an at-risk water system(s) has been added that could generate aerosols or be a potential source for Legionella. This includes the commissioning of a new wing or building.
   Note 1: The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) do not require culturing for Legionella or other waterborne pathogens. Testing protocols are at the discretion of the hospital unless required by law or regulation.

Note 2: Refer to ASHRAE Standard 188-2018 “Legionellosis: Risk Management for Building Water Systems” and the Centers for Disease Control and Prevention Toolkit "Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings" for guidance on creating a water management plan. For additional guidance, consult ANSI/ASHRAE Guideline 12-2020 “Managing the Risk of Legionellosis Associated with Building Water Systems.”

CoP(s): §482.41(d)(2)

PE.05.01.01

The hospital manages imaging safety risks.

Element(s) of Performance for PE.05.01.01

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

   Note 1: The following test is recommended but not required: Low-contrast resolution or detectability for non-planar acquisitions.
   Note 2: The medical physicist or nuclear medicine physicist is accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or nuclear medicine physicist. (For more information, refer to HR.11.01.03, EPs 1 and 2; HR.11.02.01, EP 2)

   CoP(s): §482.53(c)(2)

2. At least annually, a diagnostic medical physicist conducts a performance evaluation of all positron emission tomography (PET) imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluations are conducted for all of the image types produced clinically by each PET scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics:
   - Image uniformity/system uniformity
   - High-contrast resolution/system spatial resolution
   - Low-contrast resolution or detectability (not applicable for planar acquisitions)
   - Artifact evaluation

   Note 1: The following tests are recommended but not required for PET scanner testing: sensitivity, energy resolution, and count-rate performance.
   Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist. (For more information, refer to HR.11.01.03, EPs 1 and 2; HR.11.02.01, EP 2)

3. For computed tomography (CT), positron emission tomography (PET), nuclear medicine (NM), or magnetic resonance imaging (MRI) services: The annual performance evaluation conducted by the diagnostic medical physicist or MRI scientist (for MRI only) includes testing of image acquisition display monitors for maximum and minimum luminance, luminance uniformity, resolution, and spatial accuracy.
Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
Note 2: Medical physicists or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist or MRI scientist. (For more information, refer to HR.11.01.03, EPs 1 and 2; HR.11.02.01, EP 2)

4. For hospitals that provide fluoroscopic services: At least annually, a diagnostic medical physicist conducts a performance evaluation of fluoroscopic imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes an assessment of the following:
   - Beam alignment and collimation
   - Tube potential/kilovolt peak (kV/kVp) accuracy
   - Beam filtration (half-value layer)
   - High-contrast resolution
   - Low-contrast detectability
   - Maximum exposure rate in fluoroscopic mode
   - Displayed air-kerma rate and cumulative-air kerma accuracy (when applicable)

   Note 1: Medical physicists conducting performance evaluations may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist.
   Note 2: This element of performance does not apply to fluoroscopy equipment used for therapeutic radiation treatment planning or delivery.

Performance Improvement (PI) Chapter

PI.11.01.01

The hospital has an ongoing quality assessment and performance improvement program.

Element(s) of Performance for PI.11.01.01

2. The hospital has an ongoing quality assessment and performance improvement program that shows measurable improvement for indicators that are selected based on evidence that they will improve health outcomes and aid in the identification and reduction of medical errors. The program incorporates quality indicator data, including patient care data and other relevant data to achieve the goals of the program.

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Relevant data includes data submitted to or received from Medicare quality reporting and quality performance programs including but not limited to data related to hospital readmissions and hospital-acquired conditions.

CoP(s): §482.21(a)(1), §482.21(b)(1)

3. The hospital conducts performance improvement projects as part of its quality assessment and performance improvement program. The number and scope of distinct improvement projects conducted annually is proportional to the scope and complexity of the hospital's services and operations.
Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. In the initial stage of development, this project does not need to demonstrate measurable improvement in indicators related to health outcomes.
Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital is not required to participate in a quality improvement organization cooperative project, but its own projects are required to be of comparable effort.

   CoP(s): §482.21(d), §482.21(d)(1), §482.21(d)(2), §482.21(d)(4)

PI.12.01.01

The hospital collects data.

Element(s) of Performance for PI.12.01.01

1. The hospital tracks medical errors and adverse patient events, analyzes their causes, and implements preventive actions and mechanisms that include feedback and learning throughout the hospital. Medical errors and adverse patient events include but are not limited to the following:
   - Medication administration errors
   - Surgical errors
   - Equipment failure
   - Infection control errors
   - Blood transfusion–related errors
   - Diagnostic errors

   CoP(s): §482.21(c)(2)

2. The hospital documents what quality improvement projects it is conducting, the reasons for conducting these projects, and the measurable progress achieved on these projects.

   CoP(s): §482.21(d)(3)

3. The hospital measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service, and operations.

   CoP(s): §482.21(a)(2)

4. The hospital takes action to improve its performance. After implementing changes, the hospital measures its success and tracks performance to ensure that improvements are sustained.

   CoP(s): §482.21(c)(3)

5. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home collects data on the following:
   - Disease management outcomes
   - Patient access to care within time frames established by the hospital
   - Patient experience and satisfaction related to access to care, treatment, or services and communication
   - Patient perception of the comprehensiveness of care, treatment, or services
   - Patient perception of the coordination of care, treatment, or services
   - Patient perception of the continuity of care, treatment, or services

PI.13.01.01

The hospital compiles, analyzes, and uses data.

Element(s) of Performance for PI.13.01.01

1. The hospital analyzes and compares internal data over time and uses the results of data analysis to do the following:
   - Monitor the effectiveness and safety of services
   - Monitor the quality of care
   - Identify opportunities for improvement and changes that will lead to improvement

   CoP(s): §482.21(b)(2)(i), §482.21(b)(2)(ii)

PI.14.01.01

The hospital improves performance.

Element(s) of Performance for PI.14.01.01

1. The hospital acts on improvement priorities.

   CoP(s): §482.21, §482.21(c)(3), §482.21(d)(4), §482.21(e)(1)

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

Record of Care, Treatment, and Services (RC) Chapter

RC.11.01.01

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

Element(s) of Performance for RC.11.01.01

1. The hospital maintains a medical record for every inpatient and outpatient in the hospital.

   CoP(s): §482.24, §482.24(b)

2. The medical record includes the following:
   - Information needed to justify the patient's admission and continued care, treatment, and services
   - Information needed to support the patient's diagnosis and condition
   - Information about the patient's care, treatment, and services that promotes continuity of care among staff and providers

   Note: For hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers.

   CoP(s): §482.24(c)

3. The medical record of a patient who receives urgent or immediate care, treatment, and services contains all of the following:
   - Time and means of arrival
   - Indication that the patient left against medical advice, when applicable
   - Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services
   - A copy of any information made available to the provider furnishing follow-up care, treatment, or services

4. The hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, and timed medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. The medical records are promptly completed, properly filed and retained, and readily accessible.

   CoP(s): §482.24(b), §482.24(c)(1), §482.53(d), §482.53(d)(2)

5. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital maintains clinical records on all patients to determine the degree and intensity of treatments, as specified in 42 CFR 482.61.

   CoP(s): §482.60(c), §482.61

6. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The medical record contains the following information:
   - History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized
   - Identification data, including the patient's legal status
   - Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses
   - Reasons for admission, as stated by the patient and/or others significantly involved
   - Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history
   - When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination
   - Documentation of treatment received, including all active therapeutic efforts
   - Discharge summary of the patient's hospitalization that includes recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge

   CoP(s): §482.61(a), §482.61(a)(1), §482.61(a)(2), §482.61(a)(3), §482.61(a)(4), §482.61(a)(5), §482.61(c)(2), §482.61(e)

9. For hospitals that elect The Joint Commission Primary Care Medical Home option: The medical record includes the patient's self-management goals and their progress toward achieving those goals. (Refer to PC.11.03.01, EP 7)

RC.11.02.01

Entries in the medical record are authenticated.

Element(s) of Performance for RC.11.02.01

1. All orders, including verbal orders, are dated, timed, and authenticated by the ordering physician or other licensed practitioner who is responsible for the patient's care and who is authorized to write orders, in accordance with hospital policy, law and regulation, and medical staff bylaws, rules, and regulations.

   CoP(s): §482.24(c)(2)

2. The hospital uses a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

   CoP(s): §482.24(b)

RC.11.03.01

The hospital retains its medical records.

Element(s) of Performance for RC.11.03.01

1. The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation.

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical records are retained in their original or legally reproduced form for at least five years. This includes nuclear medicine reports; radiological reports, printouts, films, and scans; and other applicable image records.

CoP(s): §482.24(b)(1), §482.26(d)(2), §482.26(d)(2)(i), §482.26(d)(2)(ii), §482.53(d)(1)

RC.12.01.01

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

Element(s) of Performance for RC.12.01.01

1. The medical record contains the following demographic information for the patient:
   - Name, address, and date of birth and the name of any legally authorized representative
   - Sex
   - Legal status of any patient receiving behavioral health care services
   - Communication needs, including preferred language for discussing health care
   - Race and ethnicity

   Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative are documented in the medical record.

2. The medical record contains the following clinical information:
   - Admitting diagnosis
   - Any emergency care, treatment, and services provided to the patient before their arrival
   - Any allergies to food and medications
   - Any findings of assessments and reassessments
   - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient
   - Treatment goals, plan of care, and revisions to the plan of care
   - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia
   - All practitioners' orders
   - Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition
   - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration

   Note: When rapid titration of a medication is necessary, the hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary.
   - Administration of each self-administered medication, as reported by the patient (or the patient’s caregiver or support person where appropriate)
   - Records of radiology and nuclear medicine services, including signed interpretation reports
   - All care, treatment, and services provided to the patient
   - Patient’s response to care, treatment, and services
   - Medical history and physical examination, including any conclusions or impressions drawn from the information
   - Discharge plan and discharge planning evaluation
   - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge
   - Any diagnoses or conditions established during the patient’s course of care, treatment, and services

Note: Medical records are completed within 30 days following discharge, including final diagnosis.

CoP(s): §482.23(c)(6)(i)(E), §482.23(c)(6)(ii)(E), §482.24(c), §482.24(c)(4)(ii), §482.24(c)(4)(iii), §482.24(c)(4)(iv), §482.24(c)(4)(vi), §482.24(c)(4)(vii), §482.24(c)(4)(viii), §482.26(d), §482.26(d)(1), §482.43(a)(3), §482.53(d), §482.56(b)(1), §482.57(b)(4)

3. The medical record contains any informed consent, when required by hospital policy or federal or state law or regulation.
Note: The properly executed informed consent is placed in the patient's medical record prior to surgery, except in emergencies. A properly executed informed consent contains documentation of a patient's mutual understanding of and agreement for care, treatment, and services through written signature; electronic signature; or, when a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision-maker.

   CoP(s): §482.24(c)(4)(v), §482.51(b)(2)

4. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Progress notes are documented in accordance with applicable state scope-of-practice laws and hospital policies by the following qualified practitioners:
   - Doctor(s) of medicine or osteopathy or other licensed practitioner(s) who is responsible for the care of the patient
   - Nurse(s)
   - Social worker(s) or social service staff involved in the care of the patient
   - When appropriate, others significantly involved in the patient's active treatment modalities

   The patient's condition determines the frequency of progress notes, but they must be recorded at least weekly for the first 2 months and at least once a month thereafter. The progress notes must contain recommendations for revisions in the treatment plan as indicated, as well as a precise assessment of the patient's progress in accordance with the original or revised treatment plan.

   CoP(s): §482.61(d)

5. The hospital uses preprinted and electronic standing orders, order sets, and protocols for patient orders only if the following occurs:
   - Orders and protocols are reviewed and approved by the medical staff and the hospital's nursing and pharmacy leadership.
   - Orders and protocols are consistent with nationally recognized and evidence-based guidelines.
   - Orders and protocols are periodically and regularly reviewed by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the orders and protocols.
   - Orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or by another practitioner responsible for the care of the patient only if such a practitioner is acting in accordance with state law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

   CoP(s): §482.24(c)(3)(i), §482.24(c)(3)(ii), §482.24(c)(3)(iii), §482.24(c)(3)(iv)

6. The medical history and physical examination or updates to the medical history and physical examination are placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

   CoP(s): §482.24(c)(4)(i)(A), §482.24(c)(4)(i)(B)

7. An assessment of the patient (in lieu of a medical history and physical examination as described in 42 CFR 482.24(c)(4)(i)(A) and (B)) is completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the following conditions are met:
   - The patient is receiving specific outpatient surgical or procedural services.
   - The medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at §482.22(c)(5)(v), specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.

   CoP(s): §482.24(c)(4)(i)(C)

RC.12.01.03

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

Element(s) of Performance for RC.12.01.03

1. The hospital has a complete and up-to-date operating room register or equivalent record that includes the following:
   - Patient's name
   - Patient's hospital identification number
   - Date of operation
   - Inclusive or total time of operation
   - Name of surgeon and any assistants
   - Name of nursing staff
   - Type of anesthesia used and name of person administering it
   - Operation performed
   - Pre- and postoperative diagnosis
   - Age of patient

   CoP(s): §482.51(b)(5)

2. An operative report is written or dictated immediately following surgery and signed by the surgeon. The report includes the following:
   - Name and hospital identification number of the patient
   - Date and times of the surgery
   - Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues)

- Preoperative and postoperative diagnosis
- Name of the specific surgical procedure(s) performed
- Type of anesthesia administered
- Complications, if any
- Description of techniques, findings, and tissues removed or altered
- Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any
- Any estimated blood loss

Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital.
Note 2: If the physician or other licensed practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

CoP(s): §482.51(b)(6)

RC.12.02.01

Qualified staff receive and record verbal orders.

Element(s) of Performance for RC.12.02.01

1. Only staff authorized by hospital policies and procedures consistent with federal and state law accept and record verbal orders.

   CoP(s): §482.23(c)(3)(ii)

RC.12.03.01

The patient’s medical record contains discharge information.

Element(s) of Performance for RC.12.03.01

1. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. A physician documents in the resident’s medical record when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. The resident’s physician documents in the medical record when the transfer is due to the resident improving and no longer needing long term care services or when the transfer is due to the resident’s welfare and resident’s needs cannot be met in the hospital’s swing bed.

   CoP(s): §482.58(b)(2), §483.15(c)(2), §483.15(c)(2)(ii)(A), §483.15(c)(2)(ii)(B)

2. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident’s discharge information includes the following:
   - Reason for transfer, discharge, or referral
   - Treatment provided, diet, medication orders, and orders for the resident’s immediate care
   - Referrals provided to the resident, the referring physician's or other licensed practitioner’s name, and the name of the physician or other licensed practitioner who has agreed to be responsible for the resident’s medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner

- Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals
- Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation
- Nursing information that is useful in the resident's care
- Any advance directives
- Instructions given to the resident before discharge

CoP(s): §482.58(b)(2), §483.15(c)(2)(i)(A)

3. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: When the resident is transferred or discharged because the hospital cannot meet their needs, the hospital documents which needs could not be met, the hospital's attempts to meet the resident's needs, and the services available at the receiving organization that will meet the resident's needs.

   CoP(s): §482.58(b)(2), §483.15(c)(2)(i)(B)

4. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital records the reasons for the transfer or discharge in the resident's medical record in accordance with 42 CFR 483.15(c)(2).

   CoP(s): §482.58(b)(2), §483.15(c)(3)(ii)

5. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: When the hospital anticipates the discharge of a resident, the discharge summary includes but is not limited to the following:
   - A summary of the resident's stay that includes at a minimum the resident's diagnosis, course of illness/ treatment or therapy, and pertinent laboratory, radiology, and consultation results
   - A final summary of the resident's status to include items in 42 CFR 483.20 (b)(1) at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
   - Reconciliation of all predischarge medications with the resident's postdischarge medications (both prescribed and over-the-counter).
   - A postdischarge plan of care, which will assist the resident to adjust to his or her new living environment, that is developed with the participation of the resident and, with the resident's consent, the resident representative(s). The postdischarge plan of care indicates where the individual plans to reside, any arrangements that have been made for the resident's follow up care, and any postdischarge medical and nonmedical services

   CoP(s): §482.58(b)(5), §483.21(c)(2)(i), §483.21(c)(2)(ii), §483.21(c)(2)(iii), §483.21(c)(2)(iv)

Rights and Responsibilities of the Individual (RI) Chapter

RI.11.01.01

The hospital respects, protects, and promotes patient rights.

Element(s) of Performance for RI.11.01.01

1. The hospital develops and implements written policies to protect and promote patient rights.

   CoP(s): §482.13, §482.58(b)(1)

2. The hospital informs each patient, or when appropriate, the patient's representative (as allowed, under state law) of the patient's rights in advance of providing or discontinuing patient care whenever possible.

   CoP(s): §482.13(a)(1)

3. The patient has the right to receive care in a safe setting.

   CoP(s): §482.13(c)(2)

4. The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.
   Note: This includes prohibiting discrimination through restricting, limiting, or otherwise denying visitation privileges. The hospital allows all visitors to have full and equal visitation privileges consistent with patient preferences.

   CoP(s): §482.13(h)(3), §482.13(h)(4)

5. The hospital respects the patient's right to personal privacy.
   Note 1: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a patient's health information, refer to Standard IM.12.01.01.
   Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

   CoP(s): §482.13(c)(1), §482.58(b)(1), §483.10(h)(1), §483.10(h)(2)

6. The hospital provides the patient, upon an oral or written request, with access to medical records, including past and current records, in the form and format requested (including in electronic form or format when available). If electronic is unavailable, the medical record is provided in hard copy or another form agreed to by the hospital and patient. The hospital does not impede the legitimate efforts of individuals to gain access to their own medical records and fulfills these electronic or hard-copy requests within a reasonable time frame (that is, as quickly as its recordkeeping system permits).

   CoP(s): §482.13(d)(2)

7. The hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive visitors designated by the patient, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient also has the right to withdraw or deny consent for visitors at any time.
Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies and procedures include any restrictions or limitations that are clinically necessary or reasonable that need to be placed on visitation rights and the reasons for the restriction or limitation.
Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient (or support person, where appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights.

   CoP(s): §482.13(h), §482.13(h)(1), §482.13(h)(2)

8. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides immediate family and other relatives immediate access to the resident, except when the resident denies or withdraws consent. The hospital provides others who are visiting immediate access to the resident, except when reasonable clinical or safety restrictions apply or when the resident denies or withdraws consent.

   CoP(s): §482.58(b)(1), §483.10(f)(4)(ii), §483.10(f)(4)(iii)

RI.11.02.01

The hospital respects the patient's right to receive information in a manner the patient understands.

Element(s) of Performance for RI.11.02.01

1. The hospital provides information, including but not limited to the patient’s total health status, in a manner tailored to the patient's age, language, and ability to understand.
Note: The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs.

   CoP(s): §482.58(b)(1), §483.10(c)(1)

RI.12.01.01

The hospital respects the patient's right to participate in decisions about their care, treatment, and services.
Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

Element(s) of Performance for RI.12.01.01

1. The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

   CoP(s): §482.13(b)(2), §482.58(b)(1), §483.10(c)

2. The hospital asks the patient whether they want a family member, representative, or physician or other licensed practitioner notified of their admission to the hospital. The hospital promptly notifies the identified individual(s).
Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care service providers and suppliers. The hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations.

   CoP(s): §482.13(b)(4)

3. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law.
Note 1: If a resident representative's decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority.
Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights.
Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process.

   CoP(s): §482.58(b)(1), §483.10(b)(7), §483.10(b)(7)(i), §483.10(b)(7)(ii), §483.10(b)(7)(iii)

4. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to request, refuse, and/or discontinue treatment; to participate in or refuse to participate in experimental research; and to formulate an advance directive.

   CoP(s): §482.58(b)(1), §483.10(c)(6)

5. Staff and licensed practitioners who provide care, treatment, or services in the hospital honor the patient's right to formulate advance directives and comply with these directives, in accordance with law and regulation.
Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Law and regulation includes, at a minimum, 42 CFR 489.100, 489.102, and 489.104.

   CoP(s): §482.13(b)(3)

6. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose a licensed attending physician.
Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending physicians at 42 CFR 483, the hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also

discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.

CoP(s): §482.58(b)(1), §483.10(d), §483.10(d)(1), §483.10(d)(2), §483.10(d)(4), §483.10(d)(5)

7. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home allows the patient to select their primary care clinician.

8. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home respects the patient's right to make decisions about the management of the patient's care.

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

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

RI.12.02.01

The hospital respects the patient's right to receive information about the individual(s) responsible for, as well as those providing, the patient's care, treatment, and services.

Element(s) of Performance for RI.12.02.01

1. The hospital informs the patient of the following:
   - Name of the physician, clinical psychologist, or other licensed practitioner who has primary responsibility for the patient's care, treatment, and services
   - Name of the physician(s), clinical psychologist(s), or other licensed practitioner(s) who will provide the patient's care, treatment, and services

   Note 1: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
   Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also provides the resident and the resident's family with the specialty of the physician or other licensed practitioner primarily responsible for the resident's care and a method to contact them.

   CoP(s): §483.10(d)(3)

RI.12.02.03

For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides patients with information about its functions and services.

Element(s) of Performance for RI.12.02.03

1. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about its mission, vision, and goals.
   Note: This may include how it provides for patient-centered and team-based comprehensive care, a systems-based approach to quality and safety, and enhanced patient access.

2. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about the scope of care and types of services it provides.

3. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about how it functions, including the following:
   - Processes supporting patient selection of a primary care clinician
   - Involving the patient in their treatment plan
   - Obtaining and tracking referrals
   - Coordinating care
   - Collaborating with patient-selected clinicians who provide specialty care or second opinions

   Note: Supporting patients in selecting a primary care clinician may include providing patients with information regarding the clinician's credentials, area(s) of specialty, interests, languages spoken, and gender.

4. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about how to access the organization for care or information.

5. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about patient responsibilities, including providing health history and current medications, and participating in self-management activities. (Refer to RI.15.01.01, EP 2)

6. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about the patient's right to obtain care from other clinicians within the primary care medical home, to seek a second opinion, and to seek specialty care. (Refer to RI.11.02.01, EPs 1 and 3)

RI.13.01.01

The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.

Element(s) of Performance for RI.13.01.01

1. The hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental, sexual, or physical abuse that could occur while the patient is receiving care, treatment, and services.
   For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also protects the resident from misappropriation of property.

   CoP(s): §482.13(c)(3), §482.13(e), §482.58(b)(3), §483.12, §483.12(a)(1)

2. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff.

   CoP(s): §482.58(b)(3), §483.12(a)(4)

3. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements written policies and procedures that prohibit and prevent mistreatment,

neglect, and abuse of residents and misappropriation of resident property. The policies and procedures also address investigation of allegations related to these issues.

CoP(s): §482.58(b)(3), §483.12(b)(1), §483.12(b)(2)

4. The hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events or as required by law.
Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law and established procedures. The alleged violations are reported in the following time frames:
• No later than 2 hours after the allegation is made if the allegation involves abuse or serious bodily injury
• No later than 24 hours after the allegation is made if the allegation does not involve abuse or serious bodily injury

CoP(s): §482.58(b)(3), §483.12(c)(1)

5. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations of abuse, neglect, exploitation, or mistreatment are thoroughly investigated and that it prevents further abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, including the state survey agency, within five working days of the incident. If the alleged violation is verified, appropriate corrective action is taken.

CoP(s): §482.58(b)(3), §483.12(c)(2), §483.12(c)(3), §483.12(c)(4)

RI.13.01.03

The patient has the right to an environment that preserves respect and dignity.

Element(s) of Performance for RI.13.01.03

1. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows the patient to keep and use personal clothing and possessions, unless this infringes on others' rights or is medically or therapeutically contraindicated, based on the setting or service.

CoP(s): §482.58(b)(1), §483.10(e)(2)

2. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows the resident to share a room with their spouse when married residents are living in the same hospital and when both individuals consent to the arrangement.

CoP(s): §482.58(b)(1), §483.10(e)(4)

3. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to send and promptly receive unopened mail through the postal service and

to receive letters, packages, and other materials delivered to the hospital for the resident through a means other than a postal service. The hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's expense.

CoP(s): §482.58(b)(1), §483.10(g)(8), §483.10(g)(8)(i), §483.10(g)(8)(ii), §483.10(h)(2)

RI.14.01.01

The patient and their family have the right to have grievances reviewed by the hospital.

Element(s) of Performance for RI.14.01.01

1. For hospitals that use Joint Commission accreditation for deemed status purposes: The process for resolving grievances includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization.

   CoP(s): §482.13(a)(2)

2. The hospital develops and implements policies and procedures for the prompt resolution of patient grievances. The policies clearly explain the procedure for patients to submit written or verbal grievances and specify timeframes for the review of and response to the grievance.

   CoP(s): §482.13(a)(2), §482.13(a)(2)(i), §482.13(a)(2)(ii)

3. For hospitals that use Joint Commission accreditation for deemed status purposes: In its resolution of grievances, the hospital provides the patient with a written notice of its decision, which contains the following:
   - Name of the hospital contact person
   - Steps taken on behalf of the individual to investigate the grievances
   - Results of the process
   - Date of completion of the grievance process

   CoP(s): §482.13(a)(2)(iii)

RI.15.01.01

The hospital informs the patient about the patient's responsibilities related to their care, treatment, and services.

Element(s) of Performance for RI.15.01.01

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

2. The hospital informs the patient about the patient's responsibilities in accordance with its policy.

Note: Information about patient responsibilities can be shared verbally, in writing, or both.

Transplant Safety (TS) Chapter

TS.11.01.01

The hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs, tissues, and eyes.

Element(s) of Performance for TS.11.01.01

1. The hospital develops and implements written policies and procedures that include the following:
   - A written agreement with an organ procurement organization (OPO) that requires the hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital, and that includes the OPO's responsibility to determine medical suitability for organ donation
   - A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement
   - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes.
   - Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO
   - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations

   Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has an agreement with an OPO designated under 42 CFR part 486.
   Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the hospital.
   Note 3: A designated requestor is an individual who has completed a course offered or approved by the organ procurement organization. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation.
   Note 4: The term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).
   Note 5: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https://n.neurology.org/content/early/2023/09/13/WNL.0000000000207740, the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines/Home/GuidelineDetail/1085, and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC.

   CoP(s): §482.45(a)(1), §482.45(a)(2), §482.45(a)(3), §482.45(a)(4), §482.45(b)(2)

2. The hospital develops and implements policies and procedures for working with the organ procurement organization (OPO) and tissue and eye banks to do the following:
   - Review death records in order to improve identification of potential donors
   - Maintain potential donors while the necessary testing and placement of potential donated organs, tissues, and eyes takes place in order to maximize the viability of donor organs for transplant

- Educate staff about issues surrounding donation

CoP(s): §482.45(a)(5)

3. The individual designated by the hospital documents that the patient or family accepts or declines the opportunity for the patient to become an organ, tissue, or eye donor.

TS.12.01.01

The hospital complies with organ transplantation responsibilities.

Element(s) of Performance for TS.12.01.01

1. The hospital performing organ transplants belongs to and abides by the rules of the Organ Procurement and Transplantation Network (OPTN) established under section 372 of the Public Health Service (PHS) Act. Note: The term “rules of the OPTN” means those rules provided for in regulations issued by the Secretary of the US Department of Health & Human Services in accordance with section 372 of the PHS Act which are enforceable under 42 CFR 121.10. No hospital is considered to be out of compliance with section 1138(a)(1)(B) of the Act, or with the requirements of this element of performance, unless the Secretary has given the OPTN formal notice that the Secretary approves the decision to exclude the hospital from the OPTN and has notified the hospital in writing.

   CoP(s): §482.45(b)(1)

2. If requested, the hospital provides all data related to organ transplant to the Organ Procurement and Transplantation Network (OPTN), the Scientific Registry of Transplant Recipients (SRTR), the hospital’s designated organ procurement organization (OPO), and, when requested by the Office of the Secretary, directly to the US Department of Health & Human Services.

   CoP(s): §482.45(b)(3)