Standards Interpretation FAQs

For Hospitals and Academic Medical Centers

Joint Commission International®

Access to Care and Continuity of Care (ACC)			
Standard(s) or Topic	**Subject**	**Question**	**Response**
ACC.01.01	Screening	Do all patients need to be screened for communicable diseases?	Standard ACC.01.01 ME 3 requires the triage process to include early recognition of communicable diseases for all patients. ME 2 and ME 3 are separate requirements. The hospital would identify which screenings or tests need to be done based on the population it serves, but the screening for communicable diseases should also be included.
ACC.04.00-ACC.04.02	Discharge Summary	Does the term "all patients" in standard ACC.04.02 apply to both inpatient and outpatient?	With the 8th edition revision of the standards, standard ACC.04.02 has expanded the discharge summary requirements to include both inpatients and outpatients. The patient discharge summary allows for consistency in care if further referrals are required. It allows the medical chart to contain comprehensive information for inpatient and outpatient services alike. The discharge summary for outpatients may be in the form of an after-visit summary or something similar. In accordance with the intent statement for standard ACC.04.02, it is up to the hospital to determine when a discharge summary is required, including but not limited to when required by hospital policy or laws and regulations, and when the healthcare practitioner who will be responsible for the patient's follow-up care is unknown at the time of discharge or the conclusion of the patient's visit. It should be noted that the requirement for the summary to include the last dose of medication(s) may apply to emergency department patients who received medication, or to outpatient clinic patients who received a medication such as a vaccination.
ACC.04.01	Medication List	Does patient education for medication side effects and food or medication interactions have to be in writing?	Ideally, the medication education should be provided in writing to the patient/family. Not all patients may be able to read, so the education should be provided in a manner that they understand. The education method should be documented in the patient chart for reference.
ACC.04.02	Discharge Summary	In ACC.04.02, would the hospital have to prepare a discharge summary for both inpatients and outpatients?	Yes, with the 8th edition revision of the standards, standard ACC.04.02 has expanded the discharge summary requirements to include both inpatients and outpatients. The patient discharge summary allows for consistency in care if further referrals are required. It allows the medical chart to contain comprehensive information for inpatient and outpatient services alike.
ACC.04.04	Patient Profile	Can you clarify the update to ACC.04.04 in the 8th edition?	Standard ACC.04.04 requires patient profiles for both inpatients and outpatients. This is a change from 7th Edition which required profiles for outpatients with complex diagnoses. The intent of the standard is that patient profiles provide a summary or "snapshot" of a patient's condition, care, and treatments, and are available to all members of the patient's health care team across the continuum of care. All patient medical records contain a patient profile or similar overview. The hospital must identify the necessary information to be included in the profiles in accordance with ME 2, and this should be outlined in policy and procedure. The profile must be easy to access and consistent within care settings, and the process should be evaluated to ensure it is consistently implemented in accordance with the policy. Examples of information to include in patient profiles includes but is not limited to patients' age, weight, height; active problem list, past medical and surgical history, current treatment information, and allergies. The hospital may determine other information should be included based on its patient population and services. The hospital must also follow any applicable laws and regulations, and if these are stricter than the standards, the hospital must follow the stricter standard.
ACC.04.04	Patient Profile	Please clarify the requirements for the patient profile in ACC.04.04	As explained in the intent statement for standard ACC.04.04, the purpose of the patient profile is to provide a "snapshot" of the patient that is easily accessible by the care team and includes necessary information such as age, weight, height, active problem list, past medical and surgical history, current treatment information, and allergies. In accordance with ME 1-4, all patient medical records must contain a patient profile or similar overview; the hospital must identify the necessary information to be included in the profiles; these are easy to access and are consistent within care areas; and the process is evaluated to ensure that the implementation is consistent with the policy and provides clinicians with an accurate overview of the patient.

Assessment of Patients (AOP)			
Standard(s) or Topic	**Subject**	**Question**	**Response**
AOP	Lab	If A lab is ISO certified, does the field staff need to survey the lab?	If a lab is ISO certified, the field staff would still need to survey the organization to the lab standards in the 8th edition manual.
AOP.02.00	Fall-Risk Screening	Should the fall risk screening be an evidenced-based assessment instead?	No, the term “screening tools” is appropriate. When it comes to fall risk tools, they are typically screening tools by nature and not assessment tools.

Anesthesia and Surgical Care (ASC)			
Standard(s) or Topic	**Subject**	**Question**	**Response**
ASC.02.01	Training	What type of training is required for practitioners completing procedural sedation?	Joint Commission International (JCI) is not prescriptive regarding specific clinician roles that may perform procedural sedation, only that they are qualified and acting within their scope of practice in accordance with applicable laws and regulations such as licensure. Standard ASC.02.01, ME 1-3 requires authorized clinicians who perform procedural sedation to show evidence of competence in at minimum the techniques used for sedation; pharmacology of sedation drugs and reversal agents; monitoring requirements, response to complications; airway assessment; and recovery criteria. These competencies must be documented in their personnel records, and must include documented verification of competence through direct observation rather than education only.
ASC.04.00	Preoperative Assessment	Does an assessment of psychological, social, or economic needs have to be performed on every surgical patient?	The preoperative assessment is a clinical risk assessment used to determine whether a surgery is safe to proceed with. It must be completed before any surgical procedure. The elements in ME 2 must be included in the assessment.
ASC.04.00	Preoperative Assessment	Can the preoperative assessment be conducted by someone other than a physician?	The initial assessments do not need to be completed by one person. The hospital must have a clearly defined policy on who will be completing which parts of the assessment. The preoperative assessment must be completed by a qualified individual, is within their scope of practice, and it is the hospital’s responsibility to determine who that is.

Care of Patients (COP)			
Standard(s) or Topic	**Subject**	**Question**	**Response**
COP.01.02	Critical Care Services	Can you clarify what constitutes critical care services in COP.01.02 ME2?	It is up to the hospital to define what services they consider to be critical care practice settings. The term “critical care” is generally understood as referring to medical care for people who have acute life-threatening injuries and illnesses, such as that provided in intensive care units and other settings including but not limited to emergency departments, post-anesthesia care units, and other similar settings where patients require specialized intensive monitoring, care, or treatments.
COP.05.00	Suicide Assessment	What expertise or competencies are required for individuals who conduct suicide risk assessments?	Joint Commission International (JCI) is not prescriptive regarding specific qualifications of individuals who perform assessments of patients who have screened positive for suicidality. The intent statement of standard COP.05.00 refers to the importance of individual(s) who conduct these assessments being qualified to do so, and it is understood this must be within the individual(s)’ scope of practice. The standard does not require hospitals to employ psychiatrists and psychologists for this purpose. It is up to the hospital to determine the specifics of those qualifications in accordance with any applicable laws and regulations governing clinical practice, and this should be outlined in policies an procedures as required by ME 5. While JCI does not endorse specific suicide risk assessment tools, there are assessment tools available that can be used by clinicians who are not licensed independent practitioners, such as registered nurses, to perform evidence-based assessments of patients with a positive suicidality screen. The Columbia Suicide Severity Rating Scale (C-SSRS) is one example given in the intent statement that includes both a screening tool as well as an assessment tool that clinicians who are not licensed independent practitioners can be trained to use in any setting, including emergency departments and other clinical settings.

COP.05.00	Suicide Assessment	Do all patients need to be screened for suicide?	Standard COP.05.00, ME 2 does require the hospital to screen all patients for suicidal ideation who are being evaluated or treated for behavioral conditions as their primary reason for care, not just a behavioral diagnosis. If the organization deems further suicide screening for additional patient populations, they may absolutely do so. This is the minimum requirement for organizations to comply with. The hospital must select validated screening tools that are appropriate for the population of the patients it serves, for example, an age-appropriate tool if pediatric populations are served. If adult populations are served, there would need to be a validated tool that is appropriate for that age group as well.
COP.09.00	Transplant Services	Are the standards related to transplantation applicable to all of the examples on the list of organs and tissues on page 98-99? Example: for CABG, do we need to conduct psych evaluation prior to operation especially if it is an emergency procedure? Or if patient is craniectomy due to edematous brain?	Per standard COP.09.00 and the information listed on page 98-99, transplantation refers to exogenous organs and tissues originating from another person or biological source, such as porcine heart valves. In your examples, the transplant standards would not apply to CABG or a craniectomy if there are no tissues being transplanted or donated. If the grafts used for a CABG procedure originate from the same patient, such as a venous graft from that same patient's own leg, the transplant standards would not apply. Donation refers to organs and tissues taken from one patient for another use, such as transplantation into another patient. The hospital should follow all applicable laws and regulations related to use of biological tissues as some tissue products may be classified as medical devices rather than tissues and therefore have separate or different requirements. Any tissues taken from a patient and stored with the intent of grafting back into the same patient later, such as a section of skull bone that was removed during an emergent craniectomy and is intended to be returned to the patient at a future time, is still subject to the same storage requirements such as temperature monitoring in accordance with the transplant standards.
COP.09.00-COP.09.08	Transplant Services	If a hospital is not performing transplants of any kind, do the transplant standards apply?	The standards COP.09.00 through COP.09.08 may or may not apply depending upon the services offered by the hospital. The hospital should review this group of standards for applicability to its services and whether any laws and regulations govern these processes. For example, Standard COP.09.00 refers to educating patients and/or families about donation, which could include tissues such as the donation of corneas after death, which takes place in many hospitals that otherwise do not perform transplants. Standard COP.09.01 refers to the process of obtaining consent for donation, which could also apply to donation of tissues such as corneas after death. The process of obtaining consent from family members for the above can be performed by an organ procurement organization on behalf of the hospital, or by qualified hospital personnel in accordance with its policies and procedures, or laws and regulations. Standard COP.09.05 applies to handling and storage of tissues such as those used in wound care (grafts) or orthopedic surgeries (bone, tendon, etc.) both of which are commonly performed in hospitals that do not otherwise perform transplants. Standard COP.09.06 refers to the consent process for transplantation, which may or may not apply to tissues such as wound grafts or bone grafts depending on the hospital's policies and procedures and any applicable laws and regulations. Therefore, it is up to the hospital to determine applicability of this group of standards and measurable elements to their patient population and scope of services with the understanding that some may still apply to hospitals that do not have an organ transplant program. Any of these standards that do not apply would be considered not applicable.

COP.09.00-COP.09.08	Transplant Services	Would COP transplant standards apply to autographs for bone, veins, and dermis?	The standards that apply to a hospital that performs autografts as in the examples provided include but are not limited to Standards 09.00, 09.01, 09.02 and 09.05. It is generally understood that the other transplant standards in the manual are more relevant to allogenic organ transplant programs such as liver or heart transplants, and living donor programs such as partial liver donation, and do not apply to hospitals that do not have such transplant programs. For example, Standard COP.09.00 refers to educating patients and/or families about donation, which could include tissues such as the donation of corneas after death, which takes place in many hospitals that otherwise do not perform transplants. Standard COP.09.01 refers to the process of obtaining consent for donation, which could also apply to donation of tissues such as corneas after death. The process of obtaining consent from family members for the above can be performed by an organ procurement organization on behalf of the hospital, or by qualified hospital personnel in accordance with its policies and procedures, or laws and regulations. Standard COP.09.02 may still apply to hospitals that do not perform allogenic organ transplants since staff who handle or manage autograft tissues and the related patient care should still be trained and competent for their roles, and the hospital should ensure adequate resources for management of autografts and the care of those patients. Standard COP.09.05 applies to handling and storage of tissues such as those used in wound care or orthopedic surgeries, both of which are commonly performed in hospitals that do not otherwise perform transplants. Standard COP.09.06 refers to the consent process for transplantation, which may or may not apply to tissues such as wound grafts or bone grafts depending on the hospital's policies and procedures and any applicable laws and regulations. Therefore, it is up to the hospital to determine applicability of this group of standards and measurable elements to their patient population and scope of services with the understanding that some may still apply to hospitals that do not have an organ transplant program. Any of these standards that do not apply would be considered not applicable.
COP.09.00-COP.09.08	Tissue transplant	What is the scope of the standards on cell and tissue transplant? Do they apply uniformly regardless of risk profile or origin?	The standards for transplant services would apply uniformly across the listed cells and tissues where there is a donor and a recipient of the cells/tissues. Tissue storage and handling requirements will still apply to autologous tissues such as cranial bone flaps that are removed and stored for later reattachment. If the hospital is performing organ, cell, or tissue donation and transplant, the standards would apply. Hospitals that do not perform organ transplants, i.e., they do not have a transplant program, should carefully evaluate what if any tissue or cells are in use, such as bone or tendons used in orthopedic surgeries, and which standards still apply in those cases. Standards that apply to donors include donation of tissues such as corneas after death, which may still apply to hospitals without an organ transplant program or that otherwise do not use any tissue products or cells. The hospital must also adhere to any local/national laws and regulations.

International Patient Safety Goals (IPSG)			
Standard(s) or Topic	**Subject**	**Question**	**Response**
IPSG.01.00	Patient Identifiers	Are two patient identifiers required to be labeled on each page of the medical record?	Standard IPSG.01.00, ME 2, applies to the patient themself being identified. Two identifiers must be used to identify the patient before any procedure or treatment. IPSG.01.00, ME 1 requires two patient identifiers for labeling all components of patient care, which would include the patient medical record. Standard MOI.03.00, ME 1 requires the medical record to have two unique identifiers for each item. Each page of physical paper medical record should have a patient I label or other identifier. When using an EHR, the patient identifiers should be evident when viewing each page and also when the pages are printed out. All pages and components of the patient record should indicate who the patient is.

IPSG.02.00	Critical Values	What constitutes critical results in pathology?	Joint Commission International (JCI) is not prescriptive regarding specific pathology values that qualify as critical results. It is up to the hospital to define its critical values based upon professional practice standards, the potential clinical impact to patients, and its services and patient population. As explained in the intent statement for IPSG.02.00, a critical result is defined as “a variance from normal range that represents a pathophysiologic state that is high risk or life-threatening, is considered urgent or emergent, and in which immediate medical action is likely necessary to preserve life or prevent a catastrophic event”. The intent differentiates critical results from other abnormal test results. To comply with ME 1, the hospital must define what diagnostic test results qualify as critical results based on the definition above. Pathologists and clinicians should agree on what diagnoses are critical, and the hospital should establish a policy that includes effective communication and documentation, as well as time frames for reporting and acting upon those results.
IPSG.02.01	Handover	Would a completed progress note from a physician or a post-anesthesia care sheet be acceptable as a handover tool?	Standard IPSG.02.01, ME 2 requires the hospital to use standardized forms, tools, or methods to support a consistent and complete handover process. The content of the handover communication and the respective form, tool, or method used are standardized and consistent for this specific type of handover throughout the hospital. During the handover process, there should be time for the persons completing the process to clarify the information provided. This would allow the insignificant information to be noted at that time. If this is the processes being used, it is important that the information conveyed with the progress reports and/or care sheet be complete and provide all necessary information.
IPSG.04.00	Site Marking	Is the "line" considered an ambiguous mark along with an "X" marking? Is there a source for this?	Per the WHO’s Implementation Manual WHO Surgical Safety Checklist from 2009, “the checklist coordinator should confirm that the surgeon performing the operation has marked the site of surgery (usually with a permanent felt-tip marker) in cases involving laterality (a left or right distinction) or multiple structures or levels (e.g. a particular finger, toe, skin lesion, vertebra). Site-marking for midline structures (e.g. thyroid) or single structures (e.g. spleen) should follow local practice. Consistent site marking in all cases, however, can provide a backup check confirming the correct site and procedure.” In the following article, there is a recommendation for physician initials to be used. Ragusa PS, et al. Effectiveness of surgical safety checklists in improving patient safety. Orthopedics. 2016 Mar–Apr;39(2):e307–e310 https://doi.org/10.3928/01477447-20160301-02.
IPSG.04.00	Site Marking	Is the "line" suitable for site marking?	JCI is not prescriptive in the exact mark that a hospital uses for site marking. Standard IPSG.04.00, ME 2 states “the hospital uses an instantly recognizable and unambiguous mark for identifying the surgical/invasive site that is consistent throughout the hospital.” The intent serves to offer guidance. Site marking is done with an instantly recognizable and unambiguous mark. As in the intent, an “X” is ideally not used as the mark, as it may be interpreted as “not here” or “wrong side” and could potentially lead to errors in patient care, nor should other ambiguous marks such as a line or a dot be used. Whichever site marking the hospital chooses to use, it should be consistent throughout the hospital. The document noting the policy or procedure for site marking is a required document at the time of survey.
IPSG.04.01	Time Out/Sign Out	In situations where there are two surgeons, would it be ok to have a single sign out at the final closure, even when one of the surgeons is not physically present?	The standard IPSG.04.01, ME 2 does not specifically require all staff and practitioners, such as both surgeons when there is more than one surgeon, to participate in the sign-out process. This is a different requirement than that of ME 4, in which a handover to the second surgeon for the next procedure must include components of a time-out which must be documented. Ideally all personnel involved should participate in the sign-out process, but this is not always possible in all circumstances. The intent of the standard requires the labeling of specimens to be verified when these are present during the sign-out process. When specimens are not present, such as when another practitioner has taken them to pathology before the surgery's completion, they would be exempt from the sign-out process. However, in accordance with IPSG.01.00, ME 1, specimens must still be labeled and verified using two unique identifiers in accordance with the hospital’s policy whether or not these are present during the sign-out process. Regarding surgical equipment, the intent of the standard is to address any issues that may have occurred with equipment and to perform an instrument count when applicable. It is up to the hospital to determine the best way to address this in accordance with laws and regulations, evidence-based guidelines, or industry standards of practice when there is more than one surgeon involved and more than one procedure during the same surgery. However, this must always be completed before the patient leaves the area where the surgery was performed in accordance with ME 2 when applicable.

IPSG.04.01, ME 4	Time Out	Should a second time-out be done if the same surgeon is doing two different procedures involving repositioning?	No, In the case of surgeries that involve repositioning as part of one or more procedures performed by the same surgeon during the same episode of surgery, a second time-out is not required. IPSG.04.01, ME 4 requires the team to perform another time-out when two or more separate procedures are being performed on the same patient by different surgeons. However, it is up to the hospital to determine its time-out process and policy in accordance with the standard, and a risk assessment is a valuable tool to identify and mitigate potential risks associated with the types of surgeries performed. In addition, the hospital must adhere to all applicable laws and regulations, and where requirements conflict the hospital must follow the stricter requirement.
IPSG.08.02	BLS	How should an organization address senior physicians and BLS training when physical limitations related to age impact ability to take the course?	In accordance with the standard SQE.01.08, ME 1, all clinical staff including physicians who provide patient care, treatment, and services must be trained in basic life support (BLS) at minimum. In the case of clinicians with a disability or a physical limitation that affects their ability to perform the physical actions of BLS, it is up to the hospital to determine how to best address this and still ensure that all patients have access to BLS in accordance with COP.04.00, which requires hospitals to provide resuscitation services to all patients in the hospital 24 hours a day every day, and immediately upon recognition of cardiac or respiratory arrest. When addressing BLS training for clinicians with a disability, the hospital should do its due diligence to develop alternatives in accordance with applicable laws and regulations and healthcare industry standards of care, while still ensuring compliance with COP.04.00 as detailed in the preceding paragraph. For example, as an alternative the American Heart Association has developed BLS resources for inclusion of clinicians with disabilities that may affect their ability to perform BLS: https://newsroom.heart.org/news/new-program-developed-for-persons-with-disabilities-to-advise-others-on-cpr . However, it is important to note that in the case of clinicians who are physically or otherwise unable to perform BLS, the hospital must still ensure that someone physically able is immediately available to assist the clinician with a disability in the event of an emergency.

Medication Management and Use (MMU)			
Standard(s) or Topic	**Subject**	**Question**	**Response**
MMU.04.01	Titration	May we have a default maximum dose for titration orders as part of our policy instead of requiring physicians to indicate maximum dose?	Based on standard MMU.04.01, ME 4, the hospital may have a default maximum dose for titration orders as part of the policy, but only if those titration parameters are explicitly defined and outlined in the protocol for each medication. This may also be done only if each medication order specifically orders dosing in accordance with the existing protocol. There must still be a medication order written for each individual patient by a qualified, authorized practitioner, such as a physician, for the mediation to be titrated in accordance with the protocol. It would not be compliant with the standard to omit the maximum dose from the medication order without referring to the protocol each time.
MMU.05.01	Radiopharmaceuticals	The hospital's process for radiopharmaceuticals is in accordance with laws, regulations, and guidelines. Measurable Element #3: Sterile radiopharmaceutical facilities are designed and controlled to minimize airborne contamination and provide an appropriately lighted and comfortable working environment. May we know if this is applicable to a Hot Laboratory (area inside the preparation room where radioactive materials are unpacked, tested for radiation level and prepared for administration)? Local laws do not require a Hot Laboratory to be sterile since it is equipped with a Fume Hood following the recommended average face velocity to ensure that no radioactive material contaminate would escape.	Standard MMU.05.01, ME 3 applies to any facility that compounds sterile radiopharmaceuticals for intravenous use in hospitals. A hot lab in the hospital where these radiopharmaceuticals are received from the compounding pharmacy and prepped for administration to patients would not be subject to this ME. However, the hospital must still follow all applicable laws and regulations, professional practice standards, and safe handling and disposal of radiopharmaceuticals.

Patient-Centered Care (PCC)			
Standard(s) or Topic	**Subject**	**Question**	**Response**
PCC.03.00	Informed Consent	Must the informed consent be a written document or can informed consent be done verbally?	It is up to the hospital to define what information must be documented as part of the consent process in its policy. The informed consent should then be obtained according to the hospital policy. It also must be completed in a manner/language that the patient and family can understand.
PCC.03.00	Informed Consent	What information must be documented in the medical record regarding the informed consent?	The hospital must establish a policy surrounding the informed consent and whatever the policy determines, that should be documented accordingly. The intent provides some examples of elements that are commonly use in their informed consent policy. They are: Name of the hospital, Name of the test, procedure, or treatment covered by the informed consent, Name of the responsible practitioner(s) performing the procedures(s), Signature of the patient or designee if the hospital or laws and regulations require a signed consent form, Date and time consent is granted by the patient, Statement that the procedure was explained to the patient or designee, including benefits, risks, and alternatives, The likelihood of success, potential complications, the recovery process, and possible results of nontreatment, Name, signature, and role of the person who explained the procedure to the patient or surrogate, Name, signature, and role of the clinical staff member witnessing the consent if required

Facility Management and Safety (FMS)			
Standard(s) or Topic	**Subject**	**Question**	**Response**
FMS.05.00	SDS	Do all medications, including prepared cytotoxic medications, require an SDS file?	Cytotoxic medications are considered to be a category of hazardous materials as reflected in the intent statement of Standard FMS.05.00 even though they are also categorized as medications, and the safety data sheet (SDS) requirement still applies. The rationale for this is that the hospital must have access to information such as how to proceed in the event of a spill or other accidental exposures. The SDS also provides important information such as safe handling and storage, safe disposal of waste, and whether special hazards may exist. Standard FMS.05.00, ME 3 requires the hazardous materials and waste program to establish and implement procedures for clear labeling, safe handling, storage, and use of hazardous materials that is consistent with the safety data sheets. To comply with the standard and ME, the hospital must have the SDS for all hazardous medications in use including cytotoxic medications.
FMS.08.03	Water Testing	FMS.08.03, ME 2 requires water quality testing to be done prior to and during dialysis. Please clarify how the collection and testing can be done during testing.	FMS.08.03 requires hospitals to follow industry standards and professional guidelines for water quality and infection prevention and control measures. One of those is AAMI, or the Association for the Advancement of Medical Instrumentation. For example, AAMI guidelines specify that water used for treatment must be monitored continuously during patient treatment via resistivity or conductivity meters as applicable. Alarm set points must be relevant to the expected quality of the product water and alarms for reading outside of the target range must be able to be seen/heard in the direct treatment area.

Governance, Leadership, and Direction (GLD)			
Standard(s) or Topic	**Subject**	**Question**	**Response**
GLD.01.00	Governing Body Evaluation	Is a governing body evaluation still required for Hospital 8th Edition?	This ME was removed with the 8th edition. This could be a point of discussion during the survey, but there is not scorable element for evaluating the governing entity. This would be a best practice however, there is not specific requirement any longer.

GLD.04.02	Diagnostic Error	What does the term diagnostic error mean in the context of GLD.04.02?	As per the intent in GLD.04.02, diagnostic errors are defined as diagnoses that are missed, wrong, or delayed, as detected by subsequent definitive test findings, according to the Society to Improve Diagnosis in Medicine. A diagnostic error is considered an incorrect diagnosis, whether obtained by a practitioner, testing results, or communication/coordination issues. Within ME 3, there is guidance as to what element to choose to focus on as the category of the diagnostic error. You would be completing some kind of risk-focused assessment targeting one of the areas listed in ME 3 to reduce the occurrence of diagnostic errors. Causes of diagnostic errors are complex, and rarely the fault of an individual clinician or staff member. Factors leading to diagnostic errors include diagnostic complexity, breakdowns in communication or care coordination, lost test results, equipment malfunctions, availability of specialty clinicians, and cognitive errors or bias. Closed-loop communication is an essential method to reduce diagnostic errors, and it means every test result is always sent, received, acknowledged, and acted on.
GLD.05.01	Credentialing	Should credentialing and privileging for independent practitioners who are not hospital employees be conducted by our hospital, or can we accept the credentialing from the hiring organization?	The intent for GLD.05.01 states that credentialing and privileging for independent practitioners must be completed through primary source verification. Any independent practitioner would need to be credentialed and privileged in the organization receiving their services. Obtaining copies of primary source verification and credentials would meet the requirement for credential verification per SQE.05.00-SQE.05.02. The hospital may also choose to do this itself. Whichever method is used, any relevant laws and regulations would need to be adhered to.
GLD.07.01	Culture of Safety	Is data collection and analysis required for assessing culture of safety?	The standard/MEs of GLD.07.01 do not specifically state that data is required, however, hospital leaders must have a basis for establishing and supporting a culture of safety. In the intent of GLD.07.01, it states that hospital leaders evaluate the culture on a regular basis using a variety of methods, such as formal surveys, focus groups, staff interviews, and data analysis. Data could be helpful in determining what is working well and what improvements need to be made.

Health Care Technology (HCT)			
Standard(s) or Topic	**Subject**	**Question**	**Response**
HCT.01.03	AI Tools	An EMR system incorporates features that suggest appropriate medication doses of prescribed orders and assist in decision-making during the prescription review process. These suggestions are based on predefined rules about patient-specific factors, including weight, age, gender, abnormal laboratory results relevant to the patient's condition and other relevant factors. Would this be considered an AI tool and would HCT.01.03 apply?	If your electronic health record system is using a predictive support tool for medication dosing, it would fall under the category of clinical decision support tool and would be scorable under the HCT.01.03 measurable elements. The intent for standard HCT.01.03 states that AI clinical decision support tools include diagnostic decision support tools, treatment decision support tools, predictive analytics tools, and population health management tools. Examples of commonly used types of clinical decision support tools used in the hospital setting include but are not limited to the following: sepsis triggers, wound management, medication reconciliation, medication dosing, diagnostic code selection, aide in rapid response procedures, creation of treatment guideliens for urgent conditions, interpretation of lab and testing results.
HCT.02.00	Laser Safety	Do the laser safety standards require organizations to have a full time laser safety officer present 24 hours per day, sevem days per week, or can there be one officer providing oversight?	Joint Commission International (JCI) does not require hospitals to create a full time, stand-alone position for laser safety oversight, and does not require this role to be present in the hospital 24 hours per day seven days per week. The role can be assigned to a person who has one or more other positions in the hospital. The only requirement is that an individual with the appropriate training and experience in laser safety provideds oversight of the laser, electrosurgical, and optical radiation safety program in accordance with HCT.02.00, ME 1.

Management of Information (MOI)			
Standard(s) or Topic	**Subject**	**Question**	**Response**
MOI.02.00, ME 2	Managing Documents	What is meant by managing documents originating from outside the hospital? How does an organization comply with this requirement?	Standard MOI.02.00, ME 2 requires the hospital to have a policy for managing documents originating from outside of the hospital. These documents may include, but are not limited to, lab or test results, medical summaries from outside providers, or medical records transferred with patients from outside organizations. There is not prescriptive guidance for how hospitals should manage documents originating outside the hospital. The standard only requires the hospital to have a written guidance document, such as a policy and procedure, for how to do so. The 'D' icon next to ME 2 indicates that a written document is required for compliance with this ME and the document(s) must clearly specify how the hospital manages documents that originate outside of the hospital. The document(s) must be available for review by surveyors during the survey. It is generally understood that management of these documents must be in accordance with applicable JCI standards as well as laws and regulations. When requirements conflict, the hospital must follow the stricter standard.
MOI.02.02	Abbreviations	When an abbreviation is first used in documentation, the term must first be spelled out in complete form, with the abbreviation in parentheses. Does this statement refer to medical records? Both paper and digital? And secondly, does it also apply if the hospital has a list of permitted and prohibited abbreviations?	Per the intent of MOI.02.02, "if abbreviations are necessary, the first occurrence of the term should be completely spelled out, with the abbreviation listed in parentheses." In ME 3, it states that if a hospital does use abbreviations, it must meet the criteria listed in the bullet points. If the hospital is using an abbreviation, even from the approved list, it must be spelled out on its first occurrence. Standard MOI.02.02 applies to medical record documentation throughout the hospital, in both paper and electronic format. When abbreviations are allowed in the hospital, processes are implemented to prevent or reduce risks to patient safety. This includes having a uniform approved abbreviation list and the initial spelling out of the term when first used. This standard would not apply to policies and procedures, plans, and the like.
MOI.03.01	Medical Records Review	What type of written documents to show integration with the quality and patient safety program are required for the medical records review process?	For the documentation requirement of MOI.03.01, ME 5, there should be some type of written documentation such as data collection and analysis, with action plans for any identified gaps, showing evidence that the medical records review process was completed and the information in MEs 3-4 is met. JCI is not prescriptive in what this document should look like, only that it can provide the surveyors with the information of the review.

Prevention and Control of Infections (PCI)			
Standard(s) or Topic	**Subject**	**Question**	**Response**
PCI.03.00	High-level Disinfection	The hospital implements a process to track high-level disinfected and sterilized instruments used for patient procedures to specific disinfection and sterilization cycles, equipment, and individual patients. Should all instruments that went through high-level disinfection and sterilization be tracked to specific patients or should the Spaulding Classification be applied and limit the implementation of ME7 to procedures with critical and semi-critical infection transmission?	Standard PCI.03.00, ME 7 applies to any reusable instruments used in semi-critical and critical procedures, such as endoscopes used for GI purposes, endocavity ultrasound probes, and surgical instruments. PCI.03.00 does not apply to non-critical equipment or supplies, such as reusable blood pressure cuffs that would undergo low level disinfection. The Spaulding Classification may be applied for this purpose. Cleaning, disinfection, and sterilization of medical equipment should follow any manufacturer's instructions, guidelines from established organizations (for example, AAMI or ISO), the item's intended use, and any relevant national/local regulations.

Global Health Impact (GHI)			
Standard(s) or Topic	**Subject**	**Question**	**Response**
GHI	GHI Chapter Scoring	What will be the scope of the review for the Global Health Impact chapter?	The 8th edition introduces a new chapter on Global Health Impact (GHI), which was developed in collaboration with the International Hospital Federation's Geneva Sustainability Centre. Standards in the GHI chapter will be scored as a normal chapter, but will not factor into the organization's JCI accreditation decision. The results of the survey will provide a baseline for how the organization is currently performing with regard to the GHI standards. For organizations surveyed before 1 January 2026. As of 1 January 2026, the GHI standards will factor into the accreditation decision as normal.
GHI.05.00	Environmental Risks	What does the phrase "environmental risks within the community" mean?	Climate stressors can vary from region to region and within different communities. Climate stressors may include things like increasing temperatures, changes in precipitation patterns, and changes in water levels, all of which can impact the vulnerability of human systems within communities. The result can be flooding, heat waves, droughts, and other related weather events. Climate stressors can add onto or exacerbate economic downturns and declining infrastructure, for example. Per GHI.05.00, ME 3, the organization must be conducting an assessment of the environmental factors and associated risks they pose to their local community.

General			
Standard(s) or Topic	**Subject**	**Question**	**Response**
General	D Icon	If a standard includes two or three measurable elements that require a mandatory document, and one calls for a policy while another calls for a program, is it acceptable to respond with a single document, such as a program that also covers the measurable element requiring a policy?	The document may be a policy, procedure, program, or less formal document addressing the issue identified in the standard such as a temperature log for refrigerators. When multiple measurable elements within the same standard call for a document, it may be acceptable to respond with a single document if it meets the requirements of each of the measurable elements. If the program you are providing as documentation entails the applicable policy details, that would be sufficient.
SE Policy	Sentinel Events	What are the time frames hospitals must comply with regarding comprehensive systematic analyses - what must be done within 30 days and what must be done within 45 days?	According to the Sentinel Event Policy Chapter the organization is required to: Prepare a thorough and credible comprehensive systematic analysis and corrective action plan within 30 business days of the event or of becoming aware of the event, and Submit its comprehensive systematic analysis and corrective action plan to Joint Commission International, or otherwise provide its response to the sentinel event using an approved methodology within 45 business days of the known occurrence of the event for Joint Commission International evaluation.

Various	Risk Assessment	What are needed risk assessment strategies?	Chapter FMS outlines what a hospital needs to do for risk assessments. FMS.02.00 ME 1 lists the eight programs that require risk assessments to be completed. It is up to the hospital to develop an annual risk assessment program that incorporates each of the eight FMS programs. JCI is not prescriptive in any strategy to be used in these areas. AOP.02.00 requires hospitals to conduct risk assessments in order to identify any services and patient populations that could be considered high risk for falls. COP.05.00 ME 1 requires the hospital to conduct an environmental risk assessment related to minimizing suicide and self-harm risk. IPSG.03.02 ME 3 requires the hospital to conduct risk assessments for areas storing concentrated electrolytes. PCC.01.04 ME 1 and 3 require the hospital to perform risk assessments to identify vulnerable populations applicable to the hospital's services. GLD.04.02 ME 4 requires risk assessments to be completed to reduce diagnostic errors. As part of HCT.01.00, the individual overseeing health information technology should conduct risk assessments to assess security risks. MOI.01.02 ME 1 requires hospitals to conduct risk assessments for reducing information security risks. PCI.02.00 ME 1 and ME 2 require hospitals to conduct risk assessments related to infection control and prevention. Risk assessments should be completed to identify areas that require additional cleaning and disinfection as per the intent of PCI.04.00. In the intent of PCI.06.00, part of the food management and preparation should include risk assessment completion. The intents can provide guidance in each of these areas, but JCI is not prescriptive in the specific strategies used.

Survey Process Guide			
Standard(s) or Topic	**Subject**	**Question**	**Response**
SPG	Look back period	What is the expected look back period for re-accreditation? For any measurable elements with annual requirements, would an organization have to show three reports for three years?	The look back period for triennial surveys conducted on or after 1 January 2025 may look as far back as the date of the hospital's previous full survey to assess for continuous compliance on measurable elements that were also in the 7th edition. For any new requirement as of 1/1/2025, the look back period will go back to 1/1/2025. For annual documents, as of 1/1/2025, the expectation is that you start to retain these documents for a minimum of 3 years. So in 2025, we will look for 1 year of reports. In 2026, we will look for reports from 2 years (2025 & 2026). And in 2027, we will review reports from the last 3 years, and this will continue going forward.

SPG	General	In the 8th edition, it is mentioned that if the provision of one or more clinical services is eventually suspended due to an ongoing reconstruction, a new building, a mandate from the authorities, a natural catastrophe, or other unforeseen event, this may constitute a major risk to the accreditation process. If JCI is not notified, will this place the organization at an accreditation risk?	In the 8th edition, JCI has classified a type of temporary accreditation status titled “Preliminary Denial of Accreditation” that results when JCI determines that one or more of the following conditions are present: • An immediate threat to health or staff safety exists within the organization (seen in the top red row of the SAFER Matrix). • An individual who does not possess a valid license, registration, or certification (for example, expired license) is providing or has provided health care services in the organization that would, under applicable laws and regulations, require such a license, registration, or certification and which placed the organization’s patients at risk for a serious adverse outcome. • JCI is reasonably persuaded that the organization submitted falsified documents or misrepresented information in seeking to achieve or retain accreditation. • The organization has not met the policy for reporting requirements to JCI as outlined in the Accreditation Participation Requirements. • The organization fails to submit an acceptable Strategic Improvement Plan within 120 calendar days of the organization’s survey. • The provision of one or more clinical services has been suspended due to ongoing reconstruction, construction of new building, a mandate set forth by a governmental/regulatory authority, or the results of a natural disaster or another unforeseen event. If the provision of one or more clinical services has been suspended, it is the organization’s responsibility to establish measures to resolve those services affected. The type of service(s) affected will also be considered. If the services interrupted cause the organization to no longer meet eligibility requirements listed in the manual, this could be cause for the organization to fall into preliminary denial. JCI should be notified of any changes that occur after the application has been received. JCI understands that the recovery of services may take time. The preliminary denial of accreditation status is temporary and can be modified pending corrective action. JCI will work with the hospital to support them throughout the process of resolving the issue.
SPG	General	Could you please elaborate more on contracted and visiting health care practitioners?	The glossary defines contracted services as: “services provided through a written agreement, either through another organization, agency, or individually. The agreement specifies the services or staff to be provided on behalf of the applicant organization, the duration of the agreement, and the fees to provide these services or staff.” In the 8th edition, contracted and visiting health care practitioners could be any outside practitioners who the hospital has an agreement with for clinical services. This could include lab personnel (AOP.03.00, AOP.03.06, AOP.03.07, AOP.03.09), radiology/diagnostic imaging personnel (AOP.05.06), anesthesiologist or anesthesia services (ASC.01.00), nursing (SQE.03.00), physicians/medical staff, or other clinical staff (SQE). Contracted clinical services are also addressed in GLD.05.00-GLD.05.01 and GLD.06.01. Performance metrics should be included in the contracted services contract.