Accreditation Participation Requirements

Overview

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

For an organization seeking accreditation for the first time, compliance with most of the Accreditation Participation Requirements (APR) is assessed during the initial survey, including the Early Survey Policy Option. Please note that APR.09.01.01 and APR.09.02.01 are not assessed during the initial survey. For the accredited organization, compliance with the APRs is assessed throughout the accreditation cycle through on-site surveys, the Focused Standards Assessment (FSA), Evidence of Standards Compliance (ESC), and periodic updates of organization-specific data and information. Organizations are either compliant or not compliant with the APRs. When an organization does not comply with an APR, the organization will be assigned a Requirement for Improvement (RFI) in the same context that noncompliance with a standard or element of performance generates an RFI. However, refusal to permit performance of a survey (APR.02.01.01) will lead to a denial of accreditation. Falsification of information (APR.01.02.01) will lead to preliminary denial of accreditation. All RFIs can impact the accreditation decision and follow-up requirements, as determined by established accreditation decision rules. Failure to resolve an RFI can ultimately lead to loss of accreditation.

Standard APR.01.01.01

DMEPOS: The organization submits information to Joint Commission as required.

APR.01.01.01, EP 1

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

Standard APR.01.02.01

DMEPOS: The organization provides accurate information throughout the accreditation process.

Rationale for Standard APR.01.02.01

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

APR.01.02.01, EP 1

DMEPOS: The organization 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 organization to Joint Commission
- Submitted electronically by the organization to 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 Joint Commission. This includes redrafting, reformatting, or deleting document content. However, the organization may submit supporting material that explains the original information submitted to Joint Commission. These additional materials must be properly identified, dated, and accompanied by the original documents.
(See also APR.01.01.01, EP 1)

Standard APR.01.03.01
DMEPOS: The organization reports any changes in the information provided in the application for accreditation and any changes made between surveys.

APR.01.03.01, EP 1
DMEPOS: The organization notifies Joint Commission in writing within 30 days of a change in ownership, control, location, capacity, services offered, or required licensure.
Note 1: When the organization changes ownership, control, location, capacity, or services offered, it may be necessary for Joint Commission to survey the organization again.
Note 2: If the organization does not provide written notification to Joint Commission within 30 days of these changes, the organization may be denied accreditation.
Note 3: The DMEPOS supplier is also required to disclose to the Centers for Medicare & Medicaid Services or the Medicare administrative contractor or fiscal intermediary, the names and addresses of its owners, those with a controlling interest in the organization, or any subcontractor in which the organization directly or indirectly has a 5% or more ownership interest.

Standard APR.02.01.01
DMEPOS: The organization permits the performance of a survey at Joint Commission's discretion.

APR.02.01.01, EP 1
DMEPOS: The organization permits the performance of a survey at Joint Commission's discretion.

Standard APR.05.01.01
DMEPOS: The organization allows Joint Commission to review the results of external evaluations from publicly recognized bodies.

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

APR.05.01.01, EP 1
DMEPOS: When requested, the organization provides Joint Commission with all official records and reports of licensing, examining, reviewing, or planning bodies.

APR.05.01.01, EP 2
DMEPOS: When requested, the supplier of medical equipment provides government officials or their authorized agents with copies of reports from licensing, examining, reviewing, or planning bodies.

Standard APR.06.01.01

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

APR.06.01.01, EP 1
DMEPOS: The organization does not use Joint Commission employees to provide any accreditation-related or certification-related consulting services.

Standard APR.07.01.01
DMEPOS: The organization accepts the presence of Joint Commission surveyor management staff or a Board of Commissioners member in the role of observer of an on-site survey.

APR.07.01.01, EP 1
DMEPOS: The organization allows Joint Commission surveyor management staff or a member of the Board of Commissioners to observe the on-site survey.
Note 1: The observer will not participate in the on-site survey process, including the scoring of standards compliance. Surveyor management staff will only participate in the survey process if they feel it is necessary to bring any potential findings or observations to the attention of the surveyor and the organization.
Note 2: The organization will not incur any additional survey fees because an observer(s) is present.

Standard APR.08.01.01
DMEPOS: The organization accurately represents its accreditation status and the programs and services to which Joint Commission accreditation applies.

APR.08.01.01, EP 1
DMEPOS: The organization's advertising accurately reflects the scope of programs and services that are accredited by Joint Commission.

APR.08.01.01, EP 2
DMEPOS: The organization does not engage in any false or misleading advertising about its accreditation award.

Standard APR.09.01.01
DMEPOS: The organization notifies the public it serves about how to contact its organization management and 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 Joint Commission, including contact information in published materials such as brochures and/or posting this information on the organization's website.

APR.09.01.01, EP 1
DMEPOS: The organization informs the public it serves about how to contact its management to report concerns about patient safety and quality of care.

APR.09.01.01, EP 2
DMEPOS: The organization informs the public it serves about how to contact Joint Commission to report concerns about patient safety and quality of care.

Standard APR.09.02.01
DMEPOS: Any individual who provides care, treatment, or services can report concerns about safety or the quality of care to Joint Commission without retaliatory action from the organization.

Rationale for Standard APR.09.02.01
DMEPOS: Any individual who provides care, treatment, or services should be free to raise concerns to Joint Commission when the organization has not adequately prevented or corrected problems that can or have had a

serious adverse impact on patients. To support this culture of safety, the organization must communicate to staff that such reporting is permitted. Furthermore, the organization must make it clear to staff that no formal disciplinary actions (for example, demotions, reassignments, or change in working conditions or hours) or informal punitive actions (for example, harassment, isolation, or abuse) will be threatened or carried out in retaliation for reporting concerns to Joint Commission.

APR.09.02.01, EP 1
DMEPOS: The organization educates its staff and other persons who provide care, treatment, or services that concerns about the safety or quality of care provided in the organization may be reported to Joint Commission.

APR.09.02.01, EP 2
DMEPOS: The organization informs its staff that it will take no disciplinary or punitive action because an employee or other individual who provides care, treatment, or services reports safety or quality-of-care concerns to Joint Commission.

APR.09.02.01, EP 3
DMEPOS: The organization takes no disciplinary or punitive action against employees or other individuals who provide care, treatment, or services when they report safety or quality-of-care concerns to Joint Commission.

Standard APR.09.04.01
DMEPOS: The organization provides care, treatment, services, and an environment that pose no risk of an "Immediate Threat to Health or Safety."

APR.09.04.01, EP 1
DMEPOS: The organization provides care, treatment, services, and an environment that pose no risk of an "Immediate Threat to Health or Safety."

Environment of Care

Overview
DMEPOS: The goal of this chapter is to promote a safe, functional, and supportive environment within the organization so that quality and safety are preserved. The environment of care is made up of three basic elements:
- The building or space, including how it is arranged and special features that protect patients, visitors, and staff
- Equipment used to support patient care or to safely operate the building or space
- People who work within the organization, patients, and anyone else who enters the environment, all of whom have a role in minimizing risks

This chapter stresses the importance of managing risks in the environment of care, which are different from the risks associated with the provision of care, treatment, or services. Any organization, regardless of its size or location, faces risks in the environment, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. When staff are educated about the elements of a safe environment, they are more likely to follow processes for identifying, reporting, and taking action on environmental risks.

About This Chapter
DMEPOS: The standards are organized around the concepts of planning, implementing, and evaluating of results. The chapter calls for written plans for managing risks in each of these areas. Organizations may choose to address all required components of the environment in a single management plan or in several different plans. If an organization has multiple sites, it may have separate management plans for each of its locations, or it may choose to have one comprehensive set of plans. In any case, the organization must address specific risks and the unique conditions at each of its sites.

The standards address the need to identify someone to manage environmental risks as well as to intervene when

situations threaten people or property; both responsibilities may be assigned to one person. It is important to remember that the standards in this chapter do not prescribe a particular structure (such as a safety committee) or individual (such as one employee hired to be a safety officer) for managing the environment, nor do they prescribe how required planning activities are conducted.

Important aspects of the environment addressed in the standards include the following:
- Safety and security. This section addresses risks in the physical environment, access to security-sensitive areas, product recalls, and smoking.
- Hazardous materials and waste. This section addresses risks associated with hazardous chemicals, radioactive materials, hazardous energy sources, hazardous medications, and hazardous gases and vapors.
- Fire safety. This section addresses risks from fire, smoke, and other products of combustion; fire response plans; fire drills; management of fire detection, alarm, and suppression equipment and systems; and measures to implement during construction or when the Life Safety Code® cannot be met.
- Medical equipment. This section addresses selection, testing, maintenance of medical equipment, and contingencies when equipment fails.
- Utilities. This section addresses inspection and testing of operating components, control of airborne contaminants, and management of disruptions (refer to Standard IM.01.01.03).

Note 1: Emergency management standards are located in a separate chapter.
Note 2: Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.

Other Issues for Consideration
DMEPOS: 1. The organization that provides care, treatment, or services in space it does not own (for example, in leased or complimentary space) may need to communicate with the property owner about maintenance expectations for building equipment and features not under its control. For example, an organization such as this needs access to the maintenance documents. This organization and the property owner may want to discuss any building or equipment problems that could adversely affect the safety or health of patients, staff, and other people coming to the organization, as well as the property owner's plan to resolve such issues.

2. A number of elements of performance describe time frames for completing certain tasks or functions. Joint Commission recognizes that it will not always be possible to meet the exact time frames cited in the requirements. For evaluation purposes, therefore, the following intervals are acceptable:
- Every 36 months/every 3 years = 36 months from the last event, plus or minus 45 days
- Annually/every 12 months/once a year/every year = 1 year from the last event, plus or minus 30 days
- Every 6 months = 6 months from the last event, plus or minus 20 days
- Quarterly/every quarter = every 3 months, plus or minus 10 days
- Monthly/30-day intervals/every month = 12 times a year, once per calendar month
- Every week = once per calendar week

Standard EC.02.01.01
DMEPOS: The organization manages safety and security risks.
Note: For further information on waiver and equivalency requests, see https://www.jointcommission.org/en-us/knowledge-library/environment-of-care/life-safety-code-resources and NFPA 99-2012: 1.4.

Rationale for Standard EC.02.01.01
DMEPOS: Safety and security risks are present in most health care environments. These risks affect all individuals in the organization—patients, visitors, and those who work in the organization. It is important to identify these risks in advance so the organization can prevent or effectively respond to incidents. In some organizations, safety and security are treated as a single function, although in others they are treated as separate functions.

Safety risks may arise from the structure of the physical environment, from the performance of everyday tasks, or from situations beyond the organization's control, such as the weather. Other examples of environmental risks include the physical location of equipment and supplies, architectural barriers, infestations, mobility risks such as scatter rugs,

stairs, staff safety in traveling to patient homes, and location of oxygen cylinders within the patient's home and at the organization's site. Safety incidents are most often accidental. On the other hand, security incidents are often intentional. Security protects individuals and property against harm or loss. Examples of security risks include the potential for violence to patients, violence to staff in the workplace and in the community, theft, and unrestricted access to medications. Security incidents are caused by individuals from either outside or inside the organization.

EC.02.01.01, EP 1
DMEPOS: The organization implements its process to identify safety and security risks associated with the environment of care that could affect all patients, all staff, and people coming to the organization's facilities.
Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.

EC.02.01.01, EP 2
DMEPOS: The organization identifies potential safety and security risks in the patient's home.

EC.02.01.01, EP 3
DMEPOS: The organization takes action to minimize identified safety and security risks.
Note: In the patient's home, actions may be limited to education.

EC.02.01.01, EP 4
DMEPOS: The organization safely stores and handles medical gases.
Note: Safe handling and storage of medical gases should be done in a manner consistent with the Food and Drug Administration, the Department of Transportation, and the Occupational Safety and Health Administration laws and regulations.

EC.02.01.01, EP 8
DMEPOS: The organization controls access to and from areas it identifies as security sensitive.

Standard EC.02.01.03
DMEPOS: The organization prohibits smoking except in specific circumstances.

EC.02.01.03, EP 4
DMEPOS: Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within the site of intentional expulsion (within 1 foot). When other oxygen delivery equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area of administration (within 15 feet). Solid fuel–burning appliances are not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. (For full text, refer to NFPA 99-2012: 11.5.1.1; Tentative Interim Amendment [TIA] 12-6)

Standard EC.02.02.01
DMEPOS: The organization manages risks related to hazardous materials and waste.

Rationale for Standard EC.02.02.01
DMEPOS: Hazardous materials and waste cause harm if they are not managed properly. Examples of such materials include chemicals (cleaning products, solvents, pesticides) and hazardous energy sources. Federal, state, or local regulations often guide the handling, use, and storage of hazardous materials and waste. The organization identifies materials it uses that need special handling to minimize the risks of unsafe use and improper disposal.

Note: This standard does not address oxygen because it is not a "hazardous material." Oxygen is addressed under the safety standard (see EC.02.01.01).

EC.02.02.01, EP 1
DMEPOS: The organization maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation.

EC.02.02.01, EP 2
DMEPOS: The organization manages hazardous materials and waste from receipt or generation through final use or disposal.

EC.02.02.01, EP 3
DMEPOS: The organization has written procedures, including the use of precautions and personal protective equipment, to follow in response to hazardous material and waste spills or exposures.

EC.02.02.01, EP 4
DMEPOS: The organization implements its procedures in response to hazardous material and waste spills or exposures.

EC.02.02.01, EP 11
DMEPOS: For managing hazardous materials and waste, the organization has the permits, licenses, manifests, and safety data sheets required by law and regulation.

EC.02.02.01, EP 12
DMEPOS: The organization 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.

Standard EC.02.03.01
DMEPOS: The organization manages fire risks.

Standard EC.02.03.03
DMEPOS: The organization conducts fire drills.

Rationale for Standard EC.02.03.03
DMEPOS: The organization's plan for fire response is an important part of achieving a fire-safe environment. It is important that this response be evaluated in drill scenarios or actual fire situations in order to assess performance of staff and fire safety equipment. Testing the fire response plan should involve realistic situations, although actual evacuation of patients during the drills is not required.

Standard EC.02.03.05
DMEPOS: The organization maintains fire safety equipment and fire safety building features.
Note 1: This standard does not require organizations to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.
Note 2: The references to the National Fire Protection Association (NFPA) guidelines noted at the elements of performance are for information only.

Standard EC.02.05.03
DMEPOS: The organization has a reliable emergency electrical power source.

Rationale for Standard EC.02.05.03

DMEPOS: Emergency power sources are critical for operating essential equipment, utilities, and other building features during power failures. Emergency power sources must also support fire safety equipment. The source must be adequately designed and fueled so that the equipment functions properly.

Standard EC.02.05.05
DMEPOS: The organization inspects, tests, and maintains utility systems.
Note: At times, maintenance is performed by an external service. In these cases, organizations are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.

Introduction to Standard EC.02.06.01
DMEPOS: Features of the organization's space influence patient outcomes and satisfaction and promote patient safety. The physical space also affects families, staff, and others in the organization. These features of the environment of care include the following:
- Quality of natural and artificial light
- Privacy
- Size and configuration of space
- Security for patients and their belongings
- Clear access to internal and external doors
- Level of noise
- Space that allows staff to work efficiently

When designed into and managed as part of the environment, these elements create safe and suitable surroundings that support patient dignity and allow ease of interaction.

The standards do not specifically address all these features. However, organizations may wish to consider these aspects of the environment when they design and manage spaces. Decisions on what features to pursue should be based on data, such as patient satisfaction information, data collected from staff, and evidence-based design guidelines.

Standard EC.02.06.01
DMEPOS: The organization establishes and maintains a safe, functional environment.

EC.02.06.01, EP 3
DMEPOS: For complex rehabilitation and assistive technology services: When patients are evaluated in the organization's facility, the organization provides private, clean, and safe rooms for fittings and evaluations.

EC.02.06.01, EP 16
DMEPOS: When patients are evaluated in the organization's facility, the organization has a repair shop, located either in the facility or in close proximity, for repair, assembly, or modification of products.

Standard EC.04.01.01
DMEPOS: The organization collects information to monitor conditions in the environment.

EC.04.01.01, EP 1
DMEPOS: The organization develops and implements a process(es) for monitoring, internally reporting, investigating, and documenting the following:
- Injuries to patients, staff, or others within the organization's facilities
- Safety and security incidents, including those related to workplace violence, involving patients, staff (including staff in the field), or others
- Hazardous materials and waste spills and exposures
- Fire safety management problems, deficiencies, and failures
Note 1: This bullet on fire safety management is applicable only for facility-based rehabilitation technology.

- Equipment management problems, failures, and use errors.
- Utility systems management problems, failures, or use errors.
Note 2: This bullet on utility systems management is applicable only for facility-based rehabilitation technology.

EC.04.01.01, EP 17
DMEPOS: The organization identifies, reports within the organization, and investigates equipment management problems, failures, and use errors for equipment provided to the patient.

EC.04.01.01, EP 18
DMEPOS: The organization investigates any incident or injury in which equipment or supplies may have contributed to the incident or injury.
Note: The investigation includes all necessary information, pertinent conclusions about what happened, and whether changes in systems or processes are needed. The organization considers possible links between the items and services furnished and the adverse event.

EC.04.01.01, EP 19
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: When the supplier becomes aware of an incident or injury resulting in a Medicare beneficiary's hospitalization or death, it initiates an investigation within 24 hours.

EC.04.01.01, EP 20
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: When the supplier becomes aware of an incident or injury that does not result in a Medicare beneficiary's hospitalization or death, it initiates an investigation within 72 hours.

EC.04.01.01, EP 21
DMEPOS: The organization reports incidents in which a medical device is connected to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990.

Standard EC.04.01.03
DMEPOS: The organization analyzes identified environment of care issues.

EC.04.01.03, EP 2
DMEPOS: The organization uses the results of data analysis to identify opportunities to resolve environmental safety issues.

Emergency Management

Overview
DMEPOS: Health care organizations will always be at the forefront of emergencies and disaster incidents, whether from acts of terrorism or cybersecurity attacks; natural disasters such as fires, floods, or tornadoes; or new viruses, and the response must be adapted quickly to the situation. Emergencies or disaster incidents often occur rapidly and without notice. Some may unfold on a timeline that allows for advance preparations. Other events may linger for an extended period, as was the case during the COVID-19 pandemic. The structure of the emergency management program should be designed to respond to any type of emergency (all-hazards approach) because of the wide array of possible emergencies and the impossibility of predicting all emergencies that could occur at an organization. Emergency management is conducted by organizations both as individual entities and integrated participants in the larger emergency response community.

About This Chapter
DMEPOS: The “Emergency Management” (EM) chapter is organized sequentially from program development to program evaluation to assist organizations in planning and preparing their responses to the effects of potential emergencies or disaster incidents. An emergency management program is based on the four phases of emergency

management (mitigation, preparedness, response, and recovery) and uses a proactive all-hazards approach to develop a framework for the program (described in EM.09.01.01). The concept of “all-hazards” means preparing for all types of threats or hazards the organization may encounter and the impacts those would have on the organization’s ability to operate and provide services it considers essential or critical.

The all-hazards risk assessment, known as a hazard vulnerability analysis (HVA) (described in EM.11.01.01), is designed to assist the organization in gaining a realistic understanding of its vulnerabilities and prioritizing them to help mitigate and respond to emergencies. The organization considers its prioritized hazards identified as part of its HVA when planning and developing a comprehensive emergency operations plan (EOP) (described in EM.12.01.01). The EOP includes supporting policies and procedures that provide guidance to staff and volunteers on actions to take during emergency or disaster incidents. These response procedures include managing the following six critical areas (described in EM.12.02.01 through EM.12.02.11) regardless of the cause(s) of an emergency:
- Communications
- Staffing
- Patient care and clinical support
- Safety and security
- Resources and assets
- Utilities

The EOP is more than a mere paper plan. For staff to understand the EOP and related policies and procedures, education and training must be provided so that staff become familiar with their roles and responsibilities during an emergency and acquire the skills necessary to perform assigned tasks (as described in EM.15.01.01). Conducting emergency exercises (as described in EM.16.01.01) provides a means to validate the EOP, checklists, and response procedures and to evaluate the skills of staff.

The development of the emergency management standards and elements of performance in this chapter are intended to guide organizations in their efforts to develop and maintain a viable all-hazards emergency management program, EOP, and policies and procedures. When disasters threaten or strike a community, the organization is prepared to take immediate action to deal with and respond quickly to the problem. Because of the unpredictable nature of emergencies, the organization must evaluate the effectiveness of its EOP (described in EM.17.01.01) at least every two years to make certain that it has considered all actions it will take to protect itself, patients, staff, and the community, along with an evaluation of the resources the organization has or can obtain.

Introduction to the Emergency Management Program, Standard EM.09.01.01

DMEPOS: The emergency management program provides a comprehensive approach to meeting the health, safety, and security needs of the organization, its staff, and its patient population and community prior to, during, and after an emergency or disaster. The emergency management program utilizes an all-hazards approach. An all-hazards approach does not mean planning for anything that could go wrong in minute detail. Instead, the all-hazards approach focuses on developing emergency preparedness capacities and capabilities that can address a wide range of emergencies or disasters that may significantly impact the organization’s ability to continue to operate and provide services.

While creating an emergency management program, the organization considers the four phases of disaster management (mitigation, preparedness, response, and recovery) and how each phase will affect the organization before, during, and after an emergency or disaster incident. The mitigation phase includes actions taken to prevent or reduce the cause, impact, and consequences of disasters. The preparedness phase includes planning, training, and educational activities to provide a framework that can be utilized when emergencies and disaster incidents occur. The response phase occurs following an emergency or a disaster incident in which response procedures are initiated and may continue for extended periods based on the type of emergency or disaster incident (such as a pandemic). Disaster response plans are implemented to protect the safety and well-being of the organization’s staff and patients and to facilitate the provision of services for the community at large, even when organization operations become disrupted. Restoration efforts and the return to normal operations occur during the recovery period; based on the impact of the emergency or disaster incident, recovery procedures may be prolonged.

Standard EM.09.01.01
DMEPOS: The organization has a comprehensive emergency management program that utilizes an all-hazards approach.

Rationale for Standard EM.09.01.01
DMEPOS: A comprehensive emergency management program provides a systematic analysis for planning, shared decision making, internal and external collaborations, and assignment of available resources (staff, space, supplies) to effectively prepare for, respond to, and recover from all incidents and emergencies. The critical components of the program include emergency policies and procedures; communication and coordination of response activities; education and training; testing and evaluation of exercises; and resources needed to continue to provide care, treatment, and services. The structure should be designed to respond to any type of emergency (all-hazards approach) because of the wide array of possible emergencies and the impossibility of predicting all emergencies that could impact the organization.

EM.09.01.01, EP 1
DMEPOS: The organization 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

EM.09.01.01, EP 2
DMEPOS: If the organization is part of a health care system (such as hospitals, hospital systems, corporate health care organizations) 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 facility 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 facility's unique circumstances, patient population, and services offered
- Each separately certified facility is capable of actively using the unified and integrated emergency management program and is in compliance with the program
- A documented community-based risk assessment utilizing an all-hazards approach
- A documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified facility within the health system
- A unified and integrated emergency plan
- Integrated policies and procedures
- A coordinated communication plan
- A training and testing program

EM.09.01.01, EP 3
DMEPOS: The organization complies with all applicable federal, state, and local emergency preparedness laws and regulations.

Introduction to Leadership, Standard EM.10.01.01

DMEPOS: An emergency or disaster incident can suddenly and significantly increase demand for a wide range of clinical services and suddenly and significantly affect the organization's ability to provide these services. Developing an emergency management program and emergency operations plan is the responsibility of the organization's leaders at all levels, including the emergency management program lead. Leadership responsibility and oversight help to make certain that necessary policies and procedures are developed, enough resources are available, and priorities of the emergency management program are fulfilled. In addition, a committee is established to support the initiatives and goals of the emergency management program.

Standard EM.10.01.01
DMEPOS: The organization's leadership provides oversight and support of the emergency management program.

Rationale for Standard EM.10.01.01
DMEPOS: The organization's leaders provide oversight in the development and implementation of the emergency management program as they are ultimately responsible for maintaining safe operations during an emergency and often need to make significant and timely decisions. The identification of a qualified emergency management program lead is important to ensure that critical components of the program are addressed in the mitigation, preparedness, response, and recovery phases and integrated throughout the organization and within the larger community response network. A committee approach makes certain that the emergency management program, the operations plan, policies and procedures, and education and training all include varying insights.

EM.10.01.01, EP 1
DMEPOS: The organization's 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 supports the emergency management program
- Review of after-action reports (AAR) and improvement plans

Note 1: Each organization defines who the members of the leadership group are as well as their roles and responsibilities for emergency management–related activities.
Note 2: If the organization is part of a health care system (such as hospitals, hospital systems, corporate health care organizations) that has a unified and integrated EM program, the organization's leaders collaborate with the system's EM leadership structure.
Note 3: 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.

EM.10.01.01, EP 2
DMEPOS: The organization's leaders identify an 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 emergency management education and training
- Planning and conducting exercises to test the emergency operations plan and response procedures
- Identifying and collaborating with community response partners

Note 1: Education, training, and experience in emergency management should be taken into account when considering the qualifications of the individual(s) who lead the program.
Note 2: If the organization is part of a health care system (such as hospitals, hospital systems, corporate health care organizations) that has a unified and integrated EM program, the system's designated EM program lead may serve as the organization's EM program lead provided there is collaboration with the identified organization leader(s).

EM.10.01.01, EP 3
DMEPOS: The organization has a committee that oversees the emergency management program. The committee includes the emergency program lead and other participants identified by the organization; meeting frequency, goals, and responsibilities are defined by the committee.
Note 1: Based on the size and needs of the organization, the committee may include the owners/operators, medical director, organizational leaders, clinical staff, or others and may be incorporated into an existing committee.
Note 2: If the organization is part of a health care system (such as hospitals, hospital systems, corporate health care organizations) that has a unified and integrated EM program, the identified organization leader(s) collaborates with the system's EM program committee.

EM.10.01.01, EP 4
DMEPOS: The organization's committee provides input and assists in the coordination of the preparation, development, implementation, evaluation, and maintenance of the organization'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 1: If the organization is part of a health care system (such as hospitals, hospital systems, corporate health care organizations) that has a unified and integrated EM program, the identified organization leader(s) collaborates with the system's EM program committee.
Note 2: 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 provides areas needing improvement.

Introduction to Hazard Vulnerability Analysis (HVA), Standard EM.11.01.01
DMEPOS: Effective emergency planning starts with an unbiased assessment of risks and hazards that could impact the organization's ability to provide services. Development of the hazard vulnerability analysis (HVA) is guided by known risks, historical data, and statistics. This process should involve community partners and be communicated to community emergency response agencies.

The risk assessment includes an evaluation of the natural hazards, human-caused hazards, technological hazards, hazardous materials, and emerging infectious diseases that could pose a significant risk to a health care organization and its off-site locations. The risk assessment should also consider hazards that would potentially necessitate relocation of services or evacuation and the impact on essential business functions. The risks are prioritized to determine which of these presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the organization and its ability to continue to provide services. The organization would then begin planning physical mitigation strategies aimed at reducing long-term vulnerabilities.

Therefore, reviewing, updating, and utilizing a current HVA helps guide the organization in the development of or revisions to its emergency operations plan and policies and procedures. The HVA is used to plan and develop education and training, and it is also used to plan emergency exercises.

Standard EM.11.01.01
DMEPOS: The organization conducts a hazard vulnerability analysis utilizing an all-hazards approach.

Rationale for Standard EM.11.01.01
DMEPOS: Organizations should continually evaluate their known risks and prioritize them to understand their vulnerabilities and prepare to respond to emergencies. The risk assessment includes an evaluation of the natural hazards, human-caused hazards, technological hazards, hazardous materials, and emerging infectious diseases that

could pose a significant risk to a health care organization and its off-site locations. The risks are prioritized to determine which of the hazards present the highest likelihood of occurring and the impacts those will have on the operating status of the organization and its ability to provide services.

EM.11.01.01, EP 1

DMEPOS: The organization conducts a hazard vulnerability analysis (HVA) using an all-hazards approach that includes the following:
- Hazards that are likely to impact the organization's geographical 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 organizations if they significantly differ from the main site

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

EM.11.01.01, EP 2

DMEPOS: The organization's hazard vulnerability analysis includes the following:
- Natural hazards (such as flooding, wildfires)
- Human-caused hazards (such as active shooter 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 Ebola, Zika Virus, SARS-CoV-2)

EM.11.01.01, EP 3

DMEPOS: The organization evaluates and prioritizes the findings of the hazard vulnerability analysis to determine which hazards present the highest likelihood of occurring and the impacts those hazards will have on the operating status of the organization and its ability to provide services. The findings are documented.

EM.11.01.01, EP 4

DMEPOS: The organization uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the organization and help reduce disruption of essential services or functions.
Note: Mitigation activities may include reviewing agreements with other health care facilities, establishing an alternative meeting place in the event the agency is not accessible, reviewing supplies on hand and vendor alternatives, planning how to protect medical records and back up electronic records, and finding alternative fuel sources.

Introduction to the Emergency Operations Plan, Standard EM.12.01.01

DMEPOS: The emergency operations plan (EOP) is based on an all-hazards approach that guides the organization in responding to and recovering from a variety of emergency or disaster incidents that could impact the organization's operations and its ability to continue providing services. The EOP identifies what services the organization will provide during an emergency and to whom it will provide these services. Plans or services for at-risk or vulnerable populations should be coordinated with efforts of local community partners to address these patients' unique needs.

The EOP includes policies and procedures that detail what the organization will do during an emergency or disaster incident and how it will coordinate and guide communications, staffing, patient clinical and support services, safety and security, resources and assets, and utilities. A successful response relies on a comprehensive and flexible EOP that guides decision making at the onset of an emergency and as an emergency evolves.

The EOP includes the organization's incident command structure (ICS), which guides operational decisions to effectively respond to an incident. The ICS provides defined roles and responsibilities for leaders and identifies who will complete major tasks. The organization's incident command leader(s) actively engages with the local community's incident command, health care coalition, health care systems, and other relevant stakeholders during the onset of any widespread emergency to leverage the support and resources that may be needed. Organizations should choose an

ICS based on the unique needs and structure of the organization.

During a declared public health emergency, 1135 waivers are granted through the federal government which waives or modifies certain requirements and flexibilities to accommodate the needs of those impacted by an emergency or disaster. Requests for 1135 waivers can be made directly by an organization or may be requested on behalf of a health care system, or by county or state authorities. The requests for 1135 waivers are made via email to the CMS Survey & Operations Group (SOG) location in the organization's service area, or by calling the state or CMS SOG location. Information regarding each organization and justification for requesting the waiver or modification will be required.

Standard EM.12.01.01
DMEPOS: The organization develops an emergency operations plan based on an all-hazards approach.
Note: The organization considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency operations plan.

Rationale for Standard EM.12.01.01
DMEPOS: The organization's all-hazards emergency operations plan (EOP) guides the organization in responding to and recovering from a variety of emergency or disaster incidents by providing management structure for the organization to operate under, staff activities to be carried out, and a description of how those activities should interact during an emergency. The EOP identifies what services the organization will continue to provide in the event of an emergency or disaster incident, as well as how the organization will cohesively and effectively work with its emergency management partners.

EM.12.01.01, EP 1
DMEPOS: The organization 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:
- Leadership structure (roles and responsibilities)
- 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

Note: If the organization is part of a health care system (such as hospitals, hospital systems, corporate health care organizations) that has a unified and integrated EM program, the system's EOP addresses policies and procedures specific to each organization's needs.

EM.12.01.01, EP 2
DMEPOS: The organization's emergency operations plan identifies the patient population(s) that it will serve and the types of services it would have the ability to provide in an emergency or disaster event.

EM.12.01.01, EP 5
DMEPOS: The emergency operations plan includes the organization's incident command structure (ICS) with defined roles and responsibilities during an emergency or disaster incident, operations decisions, and authority for emergency operations plan activation.
Note 1: The ICS provides an organized structure in which major tasks that are needed during an emergency or disaster incident will be completed by an identified person.
Note 2: If the organization is part of a health care system (such as hospitals, hospital systems, corporate health care

organizations) that has a unified and integrated EM program, the system's ICS may be utilized provided there is collaboration with the identified organization leader(s).

EM.12.01.01, EP 6
DMEPOS: The organization's emergency operations plan includes a process for cooperating and collaborating with other health care organizations, relevant community partners (such as fire, police, local incident command, and public health departments), and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff).

Introduction to Communications, Standard EM.12.02.01
DMEPOS: When an emergency occurs, the need to communicate is immediate. The organization's communications plan identifies how the organization communicates, with whom it communicates, and how to generate consistent and reliable messages to its key stakeholders and community partners. The organization's communications plan identifies which personnel are involved, what forms of communication it will implement to notify and maintain communications with its staff and community partners, and how the organization will communicate its equipment and resource needs and available occupancy. Different emergency or disaster incidents will require a variety of communications; therefore, the organization considers its prioritized hazards when determining primary and alternate communication methods.

Testing both the primary and alternate communications methods during emergency management exercises allows participants to identify gaps or weaknesses and provides opportunities to make improvements in the communications plan, which will prevent failures during or after an actual emergency or disaster incident. (For testing requirements, refer to Standard EM.16.01.01)

Standard EM.12.02.01
DMEPOS: The organization has a communications plan that addresses how it will initiate and maintain communications during an emergency.
Note: The organization considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.

Rationale for Standard EM.12.02.01
DMEPOS: An effective communications plan describes how and when the organization will communicate information to its staff, patients, families and caregivers, other health care organizations, community partners (such as fire, police, local incident command, public health departments) and relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff). The communications plan should account for the rapid evolution of an emergency or a disaster and the need to consistently provide clear information regarding the emergency and the organization's ability to provide services both internally and externally. The resources and tools used for maintaining communications (primary or alternate means) are a critical element of disaster preparedness.

EM.12.02.01, EP 1
DMEPOS: The organization maintains a contact list of individuals and entities that are to be notified in response to an emergency or disaster incident. The list of contacts includes the following, based on the settings and services provided:
- 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 (such as 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.

EM.12.02.01, EP 2
DMEPOS: The organization's communications plan describes how it will establish and maintain communications to deliver coordinated messages and information during an emergency or disaster incident to the following individuals, based on the settings and services provided:
- Staff and volunteers
- Patients and family or caregivers
- Community partners (such as fire department, emergency medical services, police, and public health department)
- Relevant authorities (such as 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.

EM.12.02.01, EP 5
DMEPOS: In the event of an emergency or evacuation, the organization's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the organization'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

EM.12.02.01, EP 6
DMEPOS: The organization'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
- Testing the functionality of the organization'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, reverse 911 notification systems.

Introduction to Staffing, Standard EM.12.02.03
DMEPOS: When the organization activates its emergency operations plan in response to an emergency or a disaster, it may find that it is unable to meet or maintain the immediate needs of patients. An emergency staffing plan focuses on strategies for quickly and effectively managing all staff and volunteers who may be needed during an incident response. During an emergency or disaster incident, organizations should anticipate staffing needs, such as shortages, and prepare to obtain staff from other sources, such as a staffing agency or disaster medical assistance teams.

Under disaster conditions or declared public health emergencies, organizations that choose to use volunteer practitioners (such as nurses, respiratory therapists, physical therapists) need to verify that these practitioners are qualified and competent to provide safe and adequate care, treatment, or services. Verifying the identity and licensure of volunteer practitioners is one way to make certain that they are qualified and competent to provide care, treatment, or services. Each volunteer practitioner should provide a valid government-issued photo identification and at least one additional form of identification. For licensure verification, volunteer practitioners may provide their current license to practice, or other forms of verification as determined by the organization.

Testing health care staffing needs during emergency management exercises allows participants to identify gaps or weaknesses and provides opportunities to make improvements. The organization's own staff can become overwhelmed, exhausted, or depleted during extended emergency or disaster incidents. Failure to recognize and develop an emergency staffing plan may result in an inability to provide the necessary services. (For testing requirements, refer to Standard EM.16.01.01)

Standard EM.12.02.03

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

Rationale for Standard EM.12.02.03
DMEPOS: The organization's emergency staffing plan should be activated in response to an emergency or disaster when the organization is unable to meet or maintain the immediate needs of its patients. Organizations that anticipate staffing shortages, based on their prioritized risks, are better prepared to quickly obtain staff from within their health care system, from staffing agencies, or from federally deployed disaster medical assistance teams. Organizations should stand ready to adjust their staffing models to meet the needs of their staff; for example, supporting their staff's emotional and mental health needs during an emergency or disaster.

EM.12.02.03, EP 1
DMEPOS: The organization develops a staffing plan for managing all staff and volunteers based on the settings and services provided 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, and those deployed as part of the disaster medical assistance teams
Note: If the organization determines that it will never use volunteers during disasters, this is documented in its plan.

EM.12.02.03, EP 2
DMEPOS: The organization'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
- Verifying the identity and licensures of volunteer practitioners (such as nurses, respiratory therapists, physical therapists)
Note: Verifying the identity and licensure of volunteer practitioners is one way to make certain that they are qualified and competent to provide care, treatment, or services. Each volunteer practitioner should provide a valid government-issued photo identification and at least one additional form of identification (such as a current health care organization picture identification). For licensure verification, volunteer practitioners may provide their current license to practice or other forms of verification as determined by the organization.

EM.12.02.03, EP 6
DMEPOS: 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

Introduction to Patient Care and Clinical Support, Standard EM.12.02.05
DMEPOS: Planning for patient care and clinical support focuses on equipment and other resources that play a direct role in an incident response. The organization's emergency operations plan addresses patient care and clinical support activities that include transfer plans, continuity of care, and rapid acquisition of patient care supplies, special equipment (such as oxygen or ventilators), and health care records, especially when evacuation or transfer is imminent. Patients receiving care, treatment, or services in their homes are especially vulnerable, and organizations should develop a personal emergency preparedness plan that is based on the patient's needs and priority level, as determined by the organization. The plan should be reviewed and confirmed with patients and family or caregivers.

Establishing a patient's priority level helps prepare the organization to quickly triage who needs immediate resources or assistance when evacuation is imminent. When the organization informs state or local emergency preparedness officials about its patients in need, the organization takes a more communicative and collaborative approach to providing care, treatment, and services to those who are most vulnerable or categorically high-risk patients.

Testing the patient care and clinical support activities plan during emergency management exercises allows participants to identify gaps or weaknesses and provides opportunities to make improvements. Evacuation, transfer, and rapid acquisition of medications, health care records, and special equipment often fails during an actual emergency or disaster incident, especially when plans are not followed or executed accordingly. (For testing requirements, refer to Standard EM.16.01.01)

Standard EM.12.02.05

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

Rationale for Standard EM.12.02.05

DMEPOS: A well-thought-out plan that maintains an organization's ability to provide critical services and quickly identify high-risk patients during emergencies or disasters can be a matter of life and death for its patients. Planning for patient and clinical support focuses on equipment and resources that play a direct role in an incident response. The organization's emergency operations plan addresses patient care and clinical support activities, including transfer plans, continuity of care, and rapid acquisition of medication, health care records, and special equipment, especially when evacuation is imminent.

EM.12.02.05, EP 5

DMEPOS: The organization's plan for providing patient care and clinical support includes policies and procedures that describe how it will inform state and local emergency preparedness officials about its patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.

EM.12.02.05, EP 6

DMEPOS: The organization's plan for providing patient care and clinical support includes written procedures for determining what services are needed in the event that there is an interruption in services during or due to an emergency or disaster incident.

Introduction to Safety and Security, Standard EM.12.02.07

DMEPOS: Developing a plan for safety and security is essential for protecting the safety and health of all staff and patients during an emergency or disaster incident. The plan for safety and security includes ways in which the organization will track the location of its on-duty staff and patients, provide accountability for safe evacuation or when sheltering in place, or work with local authorities to identify when travel or other hazardous conditions become unsafe and limit the organization's access to patients.

Testing safety and security measures during emergency management exercises allows participants to identify gaps or weaknesses and provide opportunities to make improvements. The organization can quickly become overwhelmed by rapidly unfolding incidents, such as civil unrest, natural disasters, or other escalating incidents. Failure to recognize and plan for these may result in the inability to provide the essential services needed for the preservation of safety and security (from both accidental and intentional harm) for all those within the facility or travelling to a patient's home. (For testing requirements, refer to Standard EM.16.01.01)

Standard EM.12.02.07

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

Rationale for Standard EM.12.02.07
DMEPOS: Emergencies and disasters often create new and rapidly changing safety and security concerns. The plan for safety and security should include the possible need for heightening security measures, tracking and accountability of staff and patients, and minimizing exposures to hazards.

EM.12.02.07, EP 3
DMEPOS: The organization's plan for safety and security measures for staff and volunteers includes, but is not limited to, the following:
-A system to track the location of its on-duty staff and volunteers
-A plan for how staff and volunteers will evacuate or shelter in place
-Identification of unsafe travel conditions for staff and volunteers

Introduction to Resources and Assets, Standard EM.12.02.09
DMEPOS: Resource utilization and asset acquisition occurs systemically every day in health care organizations. Under normal operating conditions, an organization can accurately predict its supply and demand for things such as water and oxygen based on its rate of consumption. Managing resources and assets focuses on those resources that would be critically needed in an emergency or disaster incident in order to remain operational. The organization needs to develop a plan for how it will monitor, track, and obtain the resources and assets that would be needed, including identifying how and when resources will be delivered to a facility or a patient's home, based on the organization's prioritized risks as determined in its hazard vulnerability analysis.

Often, the delivery of and competition for resources presents unique challenges during major disasters or catastrophic events. Some organizations rely on established contractual agreements (memorandum of understanding) and expect their vendors will continue to provide for the delivery of critically needed resources, but this may not be the case in an emergency, especially when other health care systems within the community are competing for the same resources. Organizations should consider planning for alternative ways to obtain resources. Organizations that work closely with community partners and other health care organizations can establish ways to share critically needed resources, including staff and other supplies.

Testing of resources and assets during emergency management exercises allows participants to identify gaps or weaknesses and provides opportunities to make improvements. Failure to recognize and plan for challenges to acquire, ration, or replenish critical resources may result in the inability to maintain functional operations and the inability to continue to provide services to a vulnerable community. (For testing requirements, refer to Standard EM.16.01.01)

Standard EM.12.02.09
DMEPOS: The organization has a plan for managing resources and assets during an emergency or disaster incident.
Note: The organization considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for resources and assets.

Rationale for Standard EM.12.02.09
DMEPOS: Access to resources can often be difficult when the needs in a community or region are greater than locally available resources; therefore, the organization's plan includes continual assessment on how to obtain, allocate, mobilize, replenish, and conserve its resources and assets during and after an emergency or disaster incident.

EM.12.02.09, EP 1

DMEPOS: The organization's plan for managing its resources and assets describes in writing how it will document, track, monitor, and locate the resources and assets that will be needed during and after an emergency or disaster incident to remain operational.
Note: For tracking and monitoring, the organization should consider the following resources: medications and related supplies, medical/surgical supplies, laboratory equipment and supplies, personal protective equipment, oxygen and supplies, potable or bottled water and nutrition, and non-potable water supply.

EM.12.02.09, EP 2
DMEPOS: The organization'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, based on the settings and services provided:
- Coordinating within the health care 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

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

Introduction to Utilities, Standard EM.12.02.11
DMEPOS: Different types of emergencies can have a detrimental impact on a facility's utility system(s) and utilities within a patient's home. Emergencies, particularly with prolonged power outages, can quickly create life-threatening situations for people who depend on medical equipment powered by electricity (such as ventilators, oxygen concentrators, infusion pumps, mobility devices). When developing the plan, the organization should identify utilities that would be considered essential or critical (such as emergency power; heating, ventilating, and air conditioning; plumbing; and medical gas) for facility operations and those that could impact care within a patient's home. For services provided in a patient's home, this would include identifying the essential or critical utilities (such as running water, electricity, and heating/cooling) and determining alternatives for how care, treatment, or services will be provided if those utilities are not operational.

Testing and evaluating the facility's utility systems for potential failures or identifying those utilities in a patient's home that could impact care, treatment, or services during emergency management exercises allows participants to identify gaps and weaknesses and provide opportunities to make improvements. Failure to plan for real event situations that can lead to a partial or complete loss of utility systems may result in the inability to maintain functional operations and the need for evacuation from the facility. (For the emergency operations plan's testing requirements, refer to Standard EM.16.01.01)

Standard EM.12.02.11
DMEPOS: The organization has a plan for managing essential or critical utilities during an emergency or disaster incident.
Note: The organization considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.

Rationale for Standard EM.12.02.11
DMEPOS: Emergencies and disaster incidents can have a detrimental impact on the organization's utility system(s), including loss of the system(s). The list of essential or critical systems that could potentially fail during an emergency includes heating, ventilation, and air conditioning; network connectivity; and refrigeration equipment. The organization must be prepared with alternate ways for providing essential or critical systems to maintain functional operations. If the organization provides care, treatment, or services in patients' homes, it must also consider alternative ways of doing so if the utility systems there fail.

EM.12.02.11, EP 1

DMEPOS: The organization's plan for managing utilities describes in writing the utility systems that it considers essential or critical to be able to continue to provide care, treatment, and services during an emergency or disaster incident. The plan also includes alternatives for how care, treatment, and services will be provided if the utility system(s) in a patient's home is non-operational.
Note: Examples of essential or critical utility systems may include running water, electricity, and heating/cooling.

Introduction to the Continuity of Operations Plan (COOP), Standard EM.13.01.01
DMEPOS: The continuity of operations plan (COOP) is an extension of the emergency operations plan that begins with assessing the hazards or risks identified as part of the hazard vulnerability analysis and the impact those may have on business functionality to deliver essential or critical services. The COOP provides guidance on how the organization will continue to perform its essential business functions and deliver essential or critical services. Essential or critical services include health care services, administrative or vital records, information technology, financial services, security systems, communications or telecommunications, and building operations. Essential business functions are activities and tasks that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption.

The organization's leaders identify and prioritize those essential services deemed necessary to remain operational and make certain that essential business functions can continue with minimal downtime in the event of an interruption. The COOP includes succession plans and delegation of authority. In addition, roles and responsibilities are clearly delineated and include processes to determine who has the authority to activate the continuity plan.

Testing the COOP for potential failures during emergency management exercises allows participants to identify gaps or weaknesses and provides opportunities to make improvements. Failure to recognize and plan for challenges that may disrupt the organization's ability to provide essential services and functions may result in the inability to remain fully operational and needing to relocate services, close, or evacuate the facility. (For testing requirements, refer to Standard EM.16.01.01)

Standard EM.13.01.01
DMEPOS: The organization has a continuity of operations plan.
Note: The organization considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a continuity of operations plan.

Rationale for Standard EM.13.01.01
DMEPOS: The continuity of operations plan provides guidance on how the organization will continue to perform its essential business functions, deliver essential services, delegate authority, and implement succession plans when there has been a disruption to normal operations. The organization's leaders identify and prioritize those essential services that are deemed necessary to remain operational and make certain that critical business functions continue working during an emergency or disaster incident. The leaders consider costs associated with acceptable and unacceptable levels of risk and prioritize where and when to focus resources, funding, and other assets.

EM.13.01.01, EP 1
DMEPOS: The organization 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 organization. These key leaders identify and prioritize the services and functions that are considered essential or critical for maintaining operations.
Note 1: The COOP provides guidance on how the organization 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.
Note 2: If the organization is part of a health care system (such as hospitals, hospital systems, corporate health care organizations) that has a unified and integrated EM program, the system's COOP addresses each organization's specific needs.

EM.13.01.01, EP 2
DMEPOS: The organization'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: Examples of options to consider for continuing to provide essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth.

EM.13.01.01, EP 3
DMEPOS: The organization 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.

EM.13.01.01, EP 4
DMEPOS: The organization has a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the organization 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 organization 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.

Introduction to Disaster Recovery, Standard EM.14.01.01
DMEPOS: Disaster recovery strategies focus on how and when the organization will return to full functionality after an emergency or disaster incident has occurred. Disaster recovery plans are developed utilizing an all-hazards approach and historical data and may include event-specific recovery strategies. A disaster recovery plan is a documented, structured approach that describes how the organization will quickly restore services and resume operations. Phases of recovery can vary depending on the incident and the damages or impacts to the organization. Response, continuity of operations, and recovery procedures are often conducted concurrently. Therefore, identifying connected functions, tasks, or activities in the post-emergency environment will facilitate a coordinated transition from response to recovery.

Standard EM.14.01.01
DMEPOS: The organization has a disaster recovery plan.
Note: The organization considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a disaster recovery plan.

Rationale for Standard EM.14.01.01
DMEPOS: The disaster recovery plan is an essential part of continuity of operations and provides strategies to quickly handle incidents, reduce downtime, and minimize financial loss so that the organization can continue to operate or return to full functionality after an emergency or disaster incident.

EM.14.01.01, EP 1
DMEPOS: The organization has a disaster recovery plan that describes in writing its strategies for when and how it will do the following:
- Conduct damage assessments at organization sites
- Restore critical systems and essential services
- Return to full operations
- Reinstate patient care services

Note: If the organization is part of a health care system (such as hospitals, hospital systems, corporate health care organizations) that has a unified and integrated EM program, the system's disaster recovery plan addresses strategies specific to each organization's needs.

Introduction to Education and Training, Standard EM.15.01.01

DMEPOS: Disaster response requires a unique set of capabilities related to knowledge, skills, and abilities. The organization establishes emergency management education and training based on its prioritized risks. Education and training should be provided to new and existing staff, individuals providing services under arrangement, and volunteers that enables them to function efficiently and effectively during an emergency or disaster incident. The initial education and training should focus on the activation and response procedures of the emergency operations plan; communications plan; evacuation, shelter-in-place, lockdown, and surge procedures; and where and how to obtain resources and supplies for emergencies (such as procedures manuals or equipment). The organization provides ongoing education and training to staff. Training occurs at least every two years and when there are significant changes in policy or procedures, changes in staff roles or responsibilities, or changes in procedures necessitating just-in-time education during an emergency event.

Education and training can be demonstrated in a variety of ways, such as learning modules, in-class training, or participation in emergency exercises. Additional training is required for those with specific incident command roles or specific job roles. Participation in exercises and real incidents will sustain a level of efficiency and readiness in the event of an emergency or disaster incident.

Standard EM.15.01.01
DMEPOS: The organization has an emergency management education and training program.
Note: The organization considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.

Rationale for Standard EM.15.01.01
DMEPOS: Organizations that plan education and training related to emergency management are better prepared for their next emergency or disaster incident. An effective education and training program prepares staff to respond to a variety of emergencies and to quickly adjust to changing situations while continuing to provide safe patient care.

EM.15.01.01, EP 1
DMEPOS: The organization has a written education and training program in emergency management that is based on the prioritized risks identified as part of its hazard vulnerability analysis, emergency operations plan, communications plan, and policies and procedures.
Note: If the organization is part of a health care system (such as hospitals, hospital systems, corporate health care organizations) that has a unified and integrated EM program, the system's education and training program includes information specific to each organization.

EM.15.01.01, EP 2
DMEPOS: The organization 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.

EM.15.01.01, EP 3
DMEPOS: The organization 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: Organizations 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.

Introduction to Exercises and Testing, Standard EM.16.01.01

DMEPOS: Exercises to test the emergency operations plan are done through either discussion-based or operations-based exercises and are critical for organizations and their community partners to assess the effectiveness of policies, plans, and procedures. An exercise program utilizes past emergency or disaster incidents (real or scenario based) to begin planning, conducting, and evaluating its next exercises. The cycle ends with identifying opportunities for improvement. An effective exercise program maximizes efficiency, resources, time, and funding by ensuring a coordinated and integrated approach to building, sustaining, and delivering capabilities. Exercises should reflect disasters that could occur based on the organization's hazard vulnerability analysis and should include testing of the six critical areas (communications, staffing, patient clinical and support services, safety and security, resources and assets, and utilities). A full-scale, operations-based exercise is planned and conducted with community partners as one way in which the organization can assess its impact and role as part of a larger community. These types of planned events take months to prepare for and often involve many resources and commitment of personnel. Discussion-based exercises can also be conducted as a way in which to assess and review a specific function or operation within the emergency operations plan.

Standard EM.16.01.01

DMEPOS: The organization plans and conducts exercises to test its emergency operations plan and response procedures.

Note: The organization considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.

Rationale for Standard EM.16.01.01

DMEPOS: Conducting emergency exercises is an essential part of testing and assessing all facets of the emergency operations plan through discussion-based or operations-based exercises. Exercises should be designed to incorporate the six critical areas (communications, staffing, patient clinical and support services, safety and security, resources and assets, and utilities) and should be comprehensive enough to test the organization's emergency plans and response capabilities to failure. Organizations that participate with community partners during such exercises can establish common goals to better respond to emergencies or disasters, including the sharing of resources or the identification of alternative care sites.

EM.16.01.01, EP 1

DMEPOS: The organization 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 in order to assess how prepared the organization may be if a real event or disaster were to occur based on past experiences.

Note 2: If the organization is part of a health care system (such as hospitals, hospital systems, corporate health care organizations) that has a unified and integrated EM program, the system's testing plan includes testing needs specific to each organization.

Note 3: 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.

EM.16.01.01, EP 4

DMEPOS: The organization is required to conduct one exercise per year to test the emergency operations plan.

- One year, the annual exercise 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 year, the annual exercise must consist of either an operations-based (as described above) or discussion-based exercise as follows:
  - 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 organization would be exempt from conducting a full-scale, community-based exercise or a functional, facility-based exercise at its next annual exercise if it experiences an actual emergency or disaster incident. An exemption only applies if the organization provides documentation that it activated its emergency operations plan. This exemption excludes mock disaster drills, tabletops, seminars, or workshops.

Note 2: If the organization is part of a health care system (such as hospitals, hospital systems, corporate health care organizations) that has a unified and integrated EM program, each organization may choose to conduct its own exercise or participate in one of the system's exercises.

Note 3: See the Glossary for the definitions of operations-based and discussion-based exercises.

Introduction to Evaluation, Standard EM.17.01.01

DMEPOS: Organizations are required to evaluate all emergency exercises (real or simulated) and make recommendations for improvements to their leaders. Exercise scenarios and real emergency or disaster incidents stress the organization's response procedures and capabilities. Once the incident is resolved, the organization evaluates any identified deficiencies and opportunities for improvement and uses the experience to make changes to the emergency operations plan, policies, procedures, education, or training. The recommendations for improvement are then communicated to leaders. The improvement plan may include the need for equipment or repairs if there was facility damage and provides interim actions until the issues are resolved. Leaders review the recommendations and determine which improvements take priority for implementation.

Standard EM.17.01.01

DMEPOS: The organization evaluates its emergency management program, emergency operations plan, and continuity of operations plans.

Rationale for Standard EM.17.01.01

DMEPOS: Organizations that evaluate each event or exercise are better prepared for emergencies because they often find unknown risks or failures through these reviews. It is important to then update the emergency management program and emergency operations plan to correct these deficiencies. Improving the plan makes it more effective at sustaining critical operations and protecting lives.

EM.17.01.01, EP 1

DMEPOS: The organization's 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 address the effectiveness of the organization's 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.

EM.17.01.01, EP 2
DMEPOS: The after-action reports, identified opportunities for improvement, and recommended actions to improve the emergency management program are forwarded to leaders for review.

EM.17.01.01, EP 3
DMEPOS: The organization 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

Equipment Management

Overview
DMEPOS: Medical equipment and supplies are used in a variety of settings to achieve therapeutic benefits and enhance the activities of daily living for patients. The “Equipment Management” (EQ) chapter makes available in one place all the standards that address the provision of medical equipment and supplies.

The goal of these standards is to promote the safe and effective use of medical equipment and supplies. Significant variables exist pertaining to the provision of medical equipment and supplies, such as alternative sites of care, advances in manufacturing and technology, availability of equipment (both over-the-counter and by prescription), and patient compliance with the intended use of the equipment and supplies. It is important for organizations to comply with these standards in order to improve the safety and quality of the provision of medical equipment and supplies under these circumstances.

About This Chapter
DMEPOS: The standards in this chapter cover the following processes important to the management of equipment and supplies:
- Selection and delivery
- Setup
- Maintenance
- Back up and emergency maintenance
- Storage

Applicability
In most cases, the standards are applicable both for equipment that the patient rents and for equipment the patient purchases. However, the standards for equipment maintenance, backup, and on-call availability do not apply to equipment that the patient purchases, unless the organization chooses to retain responsibility for these activities.

The first five standards are applicable to organizations that provide medical equipment and supplies directly to patients.

The last standard addresses equipment that is not provided to patients, but is used by the organization’s staff, as marked in the applicability grid for this chapter.

Standard EQ.01.01.01

DMEPOS: The organization selects and delivers equipment and supplies.

EQ.01.01.01, EP 2
DMEPOS: The organization provides only durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and other items that meet applicable Food and Drug Administration regulations and medical device effectiveness and safety standards.

EQ.01.01.01, EP 3
DMEPOS: For custom orthotics and prosthetics services: The organization assesses custom orthotics and prosthetics for structural safety and follows the manufacturer's guidelines prior to face-to-face fitting or delivery of the product.
Note: Considerations might include weight limits, functioning closures, and absence of defects.

EQ.01.01.01, EP 4
DMEPOS: For custom orthotics and prosthetics services: The organization has access, either directly or through another provider, to the equipment needed to modify or adjust custom orthotics and prosthetics.

EQ.01.01.01, EP 5
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The supplier provides the beneficiary with equipment for trial and simulation, as needed.

EQ.01.01.01, EP 6
DMEPOS: The organization informs the patient of the expected time frames for delivery of medical equipment and supplies.

EQ.01.01.01, EP 7
DMEPOS: The organization secures medical equipment and supplies during transport and delivery to prevent damage and to avoid staff injury.

EQ.01.01.01, EP 8
DMEPOS: The organization delivers medical equipment and supplies in a time frame that meets the patient's needs, as agreed upon by the patient or caregiver, organization, and prescribing physician or other licensed practitioner.

EQ.01.01.01, EP 9
DMEPOS: The organization delivers medical equipment and supplies that are sanitary, clean, and undamaged.

EQ.01.01.01, EP 10
DMEPOS: The organization selects and delivers medical equipment and supplies to the patient that are consistent with the patient's known and identified needs, risks, and limitations.

EQ.01.01.01, EP 11
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: When delivering respiratory equipment, supplies, and services to Medicare beneficiaries, the supplier complies with all of the following current American Association for Respiratory Care Practice Guidelines:
- Oxygen Therapy in the Home or Extended Care Facility
- Long Term Invasive Mechanical Ventilation in the Home
- Intermittent Positive Pressure Breathing

EQ.01.01.01, EP 12
DMEPOS: The organization verifies that the patient received the medical equipment and supplies. Verification of delivery is documented.
Note: Some examples of methods for verifying delivery include, but are not limited to the following: Contacting the patient to confirm that delivery occurred, providing the patient with a return receipt to complete upon delivery, and

retaining a copy of the delivery service's tracking slip as well as the supplier's own invoice. Proof of delivery can also be demonstrated by verifying a sample of deliveries and using the data collected for a performance improvement indicator.

EQ.01.01.01, EP 13
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: Prior to delivery of equipment or supplies, the organization verifies or authenticates that the equipment and supplies meet the following:
- Are not adulterated, counterfeit, or suspected of being counterfeit
- Have not been obtained by fraud or deceit
- Are branded correctly and labeled for their intended distribution channels
The verification or authentication of the equipment and supplies is documented.

Standard EQ.01.02.01
DMEPOS: The organization safely sets up medical equipment in the patient's home.

EQ.01.02.01, EP 1
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The supplier sets up all medical equipment in the time frame agreed to by the beneficiary or caregiver, the organization, and the prescribing physician or other licensed practitioner.

EQ.01.02.01, EP 2
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: When the supplier coordinates setup of medical equipment with another organization, all equipment is set up in the time frame agreed to by the beneficiary or caregiver, the organization, and the prescribing physician or other licensed practitioner.

EQ.01.02.01, EP 3
DMEPOS: When setting up medical equipment in the home, the organization does the following:
- Provides all supplies that are necessary to operate the equipment
- Unpacks and assembles the equipment and performs safety and operational checks
- Adapts, fits, or adjusts the medical equipment to meet the patient's needs
- Correctly stores the medical equipment and associated supplies

EQ.01.02.01, EP 4
DMEPOS: When setting up medical equipment in the patient's home, the organization does the following: Determines whether equipment can be used safely within the patient's home. The determination includes, as appropriate to the equipment, an evaluation of all of the following:
- The condition of electrical outlets and extension cords, grounding, and the possibility of circuit overload
- The possibility of exposure to heat sources or open flames
- The possibility of exposure to liquids
- The availability of an emergency power source, such as a generator or a charged backup battery
- Whether the home can accommodate the specific electrical and environmental requirements of the equipment
Note: The determination considers the electrical and environmental requirements of the equipment that need to be met and is intended to bring to light any concerns about the equipment's safe use in the patient's home.

EQ.01.02.01, EP 5
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: When setting up respiratory equipment and supplies for Medicare beneficiaries, the supplier complies with all of the following current American Association for Respiratory Care Practice Guidelines:
- Oxygen Therapy in the Home or Extended Care Facility
- Long Term Invasive Mechanical Ventilation in the Home
- Intermittent Positive Pressure Breathing

Standard EQ.01.03.01
DMEPOS: The organization maintains, tests, and inspects the medical equipment it provides to patients.

EQ.01.03.01, EP 1
DMEPOS: The organization obtains from the manufacturer copies of features, warranties, and instructions for each type of non-custom-fabricated item it supplies to patients.

EQ.01.03.01, EP 2
DMEPOS: The organization performs routine and preventive maintenance on its medical equipment at defined intervals and according to manufacturers' guidelines. The organization documents the performance of this maintenance.
Note: If the manufacturer does not have guidelines for routine and/or preventive maintenance, the organization establishes such guidelines. For example, the organization may choose to have discussions with the manufacturer, observe its own failure rates for the equipment, examine maintenance schedules of like products, or use any other method that is effective.

EQ.01.03.01, EP 3
DMEPOS: The organization performs basic safety, operation, and function checks and repairs on medical equipment according to the organization's policy and manufacturers' guidelines. The organization documents the performance of these checks and repairs.

EQ.01.03.01, EP 4
DMEPOS: Basic safety and operational checks of infusion pumps include a volumetric test of the accuracy of each pump's infusion rate between use by different patients (when used in the home) or at intervals defined by the organization (when used in a freestanding ambulatory infusion center).

EQ.01.03.01, EP 6
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The supplier provides or arranges for loaner equipment equivalent to the original equipment during any repair of beneficiary-owned equipment.
Note: Loan equipment may be provided free of charge or for a fee.

EQ.01.03.01, EP 7
DMEPOS: The organization documents identification information for medical equipment and supplies in order to respond to recalls.
Note: Such information may include the name of the manufacturer, model number, serial number, lot number, or internal tracking systems.

EQ.01.03.01, EP 8
DMEPOS: The organization acts on recalls and equipment hazard notices, including notifying patients, staff, and prescribing physicians or other licensed practitioners, when necessary.

Standard EQ.01.04.01
DMEPOS: The organization provides patients with emergency maintenance, replacement, or backup of medical equipment, when needed.

EQ.01.04.01, EP 1
DMEPOS: The organization identifies the medical equipment it provides that would threaten a patient's life or health if it were to fail or malfunction.

EQ.01.04.01, EP 2
DMEPOS: For any equipment that would threaten a patient's life if it were to fail or malfunction, the organization provides patients with access to services 24 hours a day, 7 days a week.

EQ.01.04.01, EP 3
DMEPOS: For any equipment that would threaten a patient's life if it were to fail or malfunction, the organization provides a backup system that duplicates the function of the equipment to be replaced.

EQ.01.04.01, EP 4
DMEPOS: For all patients who are ventilator dependent, the organization provides a backup system, a self-inflating resuscitation bag, and a spare breathing circuit. The backup system must duplicate the function of the ventilator for a minimum of three times the organization's maximum response time.

EQ.01.04.01, EP 5
DMEPOS: For patients receiving life-sustaining infusions, the organization provides infusion control devices with an alternative power source designed to provide service for a minimum of three times the organization's maximum response time.

EQ.01.04.01, EP 6
DMEPOS: For any equipment that would threaten a patient's health if it were to fail or malfunction, the organization provides or arranges for either backup equipment, equipment repair, or equipment replacement.

EQ.01.04.01, EP 7
DMEPOS: When an equipment failure or malfunction could threaten a patient's health and no backup equipment is in the home, the organization repairs or replaces the equipment, or arranges for repair or replacement if the patient's home is too far from the organization (for example, with an affiliated partner or contractor closer to the patient's residence).

EQ.01.04.01, EP 8
DMEPOS: For all patients receiving oxygen therapy where equipment malfunction would threaten the patient's life, the organization provides a backup oxygen supply that will last a minimum of three times the organization's maximum response time and function at the prescribed flow rate, frequency, and duration.

EQ.01.04.01, EP 9
DMEPOS: For patients with an oxygen concentrator, the organization does the following:
- Determines the amount of backup oxygen required by considering its maximum response time and providing a backup supply of oxygen sufficient to ensure no interruption in the prescribed oxygen use
- When a patient refuses a backup supply of oxygen, educates the patient about what to do in the event that the oxygen concentrator fails

Standard EQ.01.05.01
DMEPOS: The organization receives and stores medical equipment and supplies at its site(s).

EQ.01.05.01, EP 1
DMEPOS: The organization designates clearly identified, separate areas for storing each of the following types of equipment:
- Obsolete equipment
- Equipment requiring maintenance or repair
- Dirty equipment
- Clean equipment
- Patient-ready equipment

EQ.01.05.01, EP 2
DMEPOS: The organization stores equipment and supplies in the appropriately designated areas, addressing storage considerations such as expiration dates, temperature requirements, and battery charge requirements.

EQ.01.05.01, EP 3
DMEPOS: The organization processes equipment that requires cleaning and disinfecting in a separate area designated for this use.

EQ.01.05.01, EP 4
DMEPOS: The organization maintains the cleanliness of patient-ready medical equipment.

EQ.01.05.01, EP 5
DMEPOS: The organization maintains the cleanliness of all storage areas.

Standard EQ.02.01.01
DMEPOS: The organization maintains, tests, and inspects medical equipment used by staff in the provision of care, treatment, or services.

EQ.02.01.01, EP 1
DMEPOS: The organization performs routine and preventive maintenance on medical equipment used by staff in the provision of care, treatment, or services at defined intervals and according to the manufacturers' guidelines. The organization documents the performance of these checks.
Note: If the manufacturer does not have guidelines for routine and/or preventive maintenance, the organization establishes such guidelines. For example, the organization may choose to have discussions with the manufacturer, observe its own failure rates for the equipment, examine maintenance schedules of like products, or use any other method that is effective.

EQ.02.01.01, EP 2
DMEPOS: The organization performs basic safety and operational checks on medical equipment used by staff in the provision of care, treatment, or services, according to organization policy and the manufacturers' guidelines. The organization documents the performance of these checks.

EQ.02.01.01, EP 3
DMEPOS: The organization evaluates the performance of devices used for analyzing, measuring, and testing medical equipment, according to the manufacturers' guidelines. The organization documents the performance of these checks.

Human Resources

Overview
DMEPOS: The contribution that human resources management makes to an organization’s ability to provide safe, quality care cannot be overestimated. The quality of the organization’s staff will, in large part, determine the quality of the care, treatment, and services it provides.

The World Health Organization’s Global Strategy on Human Resources for Health: Workforce 2030 asserts that the mere availability of staff is not sufficient to provide effective service coverage and emergency management; staff competence, motivation, and support are also important factors. The ability of health care organizations to respond effectively to modern priorities like community-based health services and evolving epidemiologic profiles is reliant on establishing a strong, effective workforce. After staff are hired, even the smallest organization has a responsibility to see that staff receive the education and training they need to provide quality care and to keep patients safe.

About This Chapter
DMEPOS: The standards and elements of performance in this chapter address the organization’s responsibility to establish and verify staff qualifications, orient staff, and provide staff with the training they need to support the care,

treatment, or services the organization provides. After staff are on the job, the organization must provide for the assessment of staff competence and performance.

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

Rationale for Standard HR.01.01.01
DMEPOS: The organization needs to establish requirements for verifying the qualifications of staff, including contract staff who provide services to the organization's patients. To support safe, quality care, contract staff need to be managed in the same manner as employees. Consistent with Standards LD.03.06.01 and LD.04.03.09, the organization defines essential requirements, such as number and mix of individuals needed to provide safe, quality care; hiring competent individuals to complete assigned responsibilities; and clarification of the responsibility (the organization's or the contractor's) for verifying qualifications of contract staff. The organization needs to have verification of the information required in this standard, whether the organization or the contract firm verifies the information. This evidence may include information such as copies of documents obtained from the contract firm, an audit performed by the contract firm of its staff files, or an audit performed by the organization.

HR.01.01.01, EP 2
DMEPOS: The organization verifies and documents the following:
- Credentials of staff using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed.
- Credentials of 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.

HR.01.01.01, EP 3
DMEPOS: The organization verifies and documents that the applicant has the education and experience required by the job responsibilities.

HR.01.01.01, EP 4
DMEPOS: The organization obtains a criminal background check on the applicant as required by law and regulation or organization policy. Criminal background checks are documented.

HR.01.01.01, EP 5
DMEPOS: Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented.

HR.01.01.01, EP 8
DMEPOS: The organization has written policies and job descriptions that specify the following staff requirements specific to the specialized equipment, supplies, and services it provides to patients:
- Qualifications
- Experience
- Applicable certification, registration, or licensure
- Training requirements
- Continuing education requirements

HR.01.01.01, EP 9

DMEPOS: The organization maintains copies or other verification of licenses, registrations, and certifications for personnel who provide patient care, treatment, or services.

HR.01.01.01, EP 14
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization employs a qualified rehabilitation technology supplier (RTS) that possesses one of the following credentials: Certified Rehabilitative Technology Supplier (CRTS) or Assistive Technology Professional (ATP).

HR.01.01.01, EP 15
DMEPOS: For organizations that provide complex rehabilitative wheelchairs and assistive technology: The trained technicians have all of the following:
- Factory training from manufacturers of the products the organization supplies
- Experience in the field of rehabilitation technology
Note: Experience includes, but is not limited to, on-the-job training or familiarity with rehabilitation patients, products, and services.
- For DMEPOS suppliers serving Medicare beneficiaries: Completed at least 10 hours annually of continuing education specific to rehabilitation technology
- Ability to program and repair sophisticated electronics associated with power wheelchairs, alternative drive controls, and power seating systems

HR.01.01.01, EP 19
DMEPOS: Upon request, the organization provides copies of policies, job descriptions, certifications, registrations, and licensures to its accreditation organization and government officials or their authorized agents.

HR.01.01.01, EP 20
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: Staff who provide patient care, treatment, or services have the qualifications required by the organization's job descriptions and policies.

Standard HR.01.02.05
DMEPOS: The organization has the necessary staff to support the care, treatment, or services it provides.

HR.01.02.05, EP 19
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization employs (as a W-2 employee) at least one qualified individual per location as a rehabilitation technology supplier (RTS).

HR.01.02.05, EP 20
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization determines the number of trained technicians available to serve each location, based on the size and scope of the location's business.

Standard HR.01.02.07
DMEPOS: The organization determines how staff function within the organization.

HR.01.02.07, EP 1
DMEPOS: All staff who provide patient care, treatment, or services possess a current license, certification, or registration, in accordance with law and regulation.

HR.01.02.07, EP 2
DMEPOS: Staff who provide patient care, treatment, or services practice within the scope of their license, certification, or registration and as required by law and regulation.

HR.01.02.07, EP 5
DMEPOS: When students provide care, treatment, or services, they are supervised by staff.

Standard HR.01.03.01
DMEPOS: Staff are supervised effectively.

HR.01.03.01, EP 1
DMEPOS: Supervisors understand the care, treatment, or services provided by staff under their supervision.

HR.01.03.01, EP 3
DMEPOS: Supervisors have clinical and supervisory experience pertinent to the level of care and service provided and in accordance with law and regulation and organization policy.

Standard HR.01.04.01
DMEPOS: The organization provides orientation to staff.

HR.01.04.01, EP 1
DMEPOS: The organization orients its staff to the key safety content it identifies before staff provides care, treatment, or services. Completion of this orientation is documented.
Note: Key safety content may include specific processes and procedures related to the provision of care, treatment, and services; the environment of care; and infection control.

HR.01.04.01, EP 3
DMEPOS: The organization orients staff on the following:
- Relevant policies and procedures
- Their specific job duties, including those related to infection prevention and control and assessing and managing pain
Completion of this orientation is documented.

Standard HR.01.05.03
DMEPOS: Staff participate in ongoing education and training.

Rationale for Standard HR.01.05.03
DMEPOS: Ongoing education is critical to providing patients with clinically competent health care professionals. The organization is not required to provide continuing education units (CEUs) but should facilitate ongoing education and training by identifying the educational needs of its clinical staff. Ways in which this can be accomplished are by identifying risks in the environment and analyzing data gathered in competence assessment results, patient feedback, performance improvement activities, staff self-assessment, current practice guidelines changes, or legislative initiatives.

HR.01.05.03, EP 1
DMEPOS: Staff participate in ongoing education and training to maintain or increase their competency and, as needed, when staff responsibilities change. Staff participation is documented.

HR.01.05.03, EP 2
DMEPOS: The organization's education and training comply with law and regulation.

HR.01.05.03, EP 5
DMEPOS: Staff participate in education and training that is specific to the needs of the patient population served by the organization. Staff participation is documented.

HR.01.05.03, EP 29
DMEPOS: As part of its workplace violence prevention program, the organization 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 organization 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, staff, external law enforcement and, when utilized, security personnel
- Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents
- The reporting process for workplace violence incidents

Introduction to Standards HR.01.06.01 and HR.01.07.01
DMEPOS: A close relationship exists between competence assessment and performance evaluation. Sometimes this relationship can be confusing. Competence assessment lets the organization know whether its staff have the ability to use specific skills and to employ the knowledge necessary to perform their jobs. Examples of competencies that might be assessed for home medical equipment services could be a staff member's ability to program a continuous positive airway pressure machine.

When the organization defines specific competencies, it should consider the needs of its patient population, the types of procedures conducted, conditions or diseases treated, and the kinds of equipment it uses. An example of a specific competency that could be assessed for home medical equipment services could be a staff member's ability to program a ventilator for a patient on total assist.

Where competency assessment focuses on specific knowledge, skill, and ability, performance evaluations are broader in scope. Performance evaluations are not only focused on a staff member's competence, they also include other expectations that have been established for each staff member. For example, a performance evaluation might include expectations relative to whether a staff member participates in education and training offered by the organization or how well a staff member carries out job responsibilities and manages time.

What competency assessments and performance evaluations share is the requirement that they are performed at least once every three years. This does not mean, however, that they have to be performed together at the same time. Some organizations, often those that are smaller in size, may choose to combine competency assessments with performance evaluations. Others may choose to handle these activities separately. If an organization chooses to combine the activities, it needs to make sure that the performance evaluation contains specific competencies. However these two activities are conducted, feedback on performance is most useful to staff if it is given whenever an opportunity arises.

Standard HR.01.06.01
DMEPOS: Staff are competent to perform their responsibilities.

HR.01.06.01, EP 1
DMEPOS: The organization defines the competencies it requires of its staff who provide patient care, treatment, or services.

HR.01.06.01, EP 3
DMEPOS: An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence.
Note: When a suitable individual cannot be found to assess staff competence, the organization can utilize an outside individual for this task. If a suitable individual inside or outside the organization cannot be found, the organization may consult the competency guidelines from an appropriate professional organization to make its assessment.

HR.01.06.01, EP 5
DMEPOS: Staff competence is initially assessed and documented as part of orientation.

HR.01.06.01, EP 6
DMEPOS: Staff competence is assessed and documented once every three years, or more frequently as required by organization policy or in accordance with law and regulation.

HR.01.06.01, EP 14
DMEPOS: Technical staff are competent to deliver and set up equipment, provide services, and train patients and caregivers.

Standard HR.01.07.01
DMEPOS: The organization evaluates staff performance.

HR.01.07.01, EP 1
DMEPOS: The organization evaluates staff based on performance expectations that reflect their job responsibilities.

HR.01.07.01, EP 2
DMEPOS: The organization evaluates staff performance once every three years, or more frequently as required by organization policy or in accordance with law and regulation. This evaluation is documented.

Infection Prevention and Control

Overview
DMEPOS: The complex underlying health conditions and equipment used in home care settings increase risk for infection and infection-related rehospitalization for patients. This underscores the continued critical importance of the consistent application of core infection prevention and control practices.

To help reduce the possibility of acquiring and transmitting an infection, organizations need to implement infection prevention and control activities. The Infection prevention and control activities should also be practical and reasonable to follow while aligning with law, regulation, and evidence-based guidelines. No organization wants to jeopardize a patient's health because its infection control activities are outmoded or too confusing to practice daily.

The standards in this chapter address the structures and activities necessary to establish and operate effective infection prevention and control activities. Every organization, regardless of its size or the services it provides, should recognize that its infection prevention and control program plays a major role in its efforts to improve patient safety and quality of care.

Standard IC.04.01.01
DMEPOS: The organization maintains and documents an organizationwide infection prevention and control program for the prevention and control of infections and communicable diseases.

IC.04.01.01, EP 3
DMEPOS: The organization has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections and communicable diseases. The policies and procedures are in accordance with applicable law and regulation, nationally recognized evidence-based guidelines, and standards of practice, including the use of standard precautions.
Note: Standard precautions include hand hygiene, environmental cleaning and disinfection, injection and medication safety, use of personal protective equipment, minimizing potential exposures, and reprocessing of reusable medical equipment or devices. For full details on standard precautions, refer to the Centers for Disease Control and Prevention Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings at https://www.cdc.gov/infection-control/hcp/core-practices.

IC.04.01.01, EP 8
DMEPOS: The organization provides infection control education to staff, patients, family, and other caregivers.

Standard IC.06.01.01
DMEPOS: The organization implements activities for the prevention and control of infections and communicable diseases.

IC.06.01.01, EP 3
DMEPOS: The organization implements activities for the surveillance, identification, prevention, control, and investigation of infections and communicable diseases, including the use of standard precautions.

Information Management

Overview
DMEPOS: Every episode of care generates health information that must be managed systematically by the organization. All data and information used by the organization are categorized, filed, and maintained. The system should accurately capture health information generated by the delivery of care, treatment, or services. Health information should be accessed by authorized users who will use health information to provide safe, quality care. Unauthorized access can be limited by the adoption of policies that address the privacy, security, and integrity of health information.

Depending on the type of organization, the system used for information management may be basic or sophisticated. As technology develops, many organizations find their information management systems in a state of transition from paper to fully electronic or a combination of the two. Regardless of the type of system used, these standards are designed to be equally compatible with noncomputerized systems and evolving technologies.

About This Chapter
DMEPOS: As with other chapters, planning is the initial focus of “Information Management” (IM). A well-planned system meets the internal and external information needs of the organization with efficiency and accuracy. Planning provides for continuity in the event that the organization’s operations are disrupted or fail. The organization also plans to protect the privacy, security, and integrity of the data and information it collects, which results in preserving confidentiality. The chapter concludes with a standard on maintaining accurate health information.

Requirements in this chapter apply to all types of information managed by the organization, unless the requirement specifically limits the type of information to health information. Refer to the Glossary for a definition of health information.

Introduction to Standard IM.01.01.01
DMEPOS: Planning is the most critical part of the organization’s information management process and requires the collaborative involvement of all levels and areas of the organization. The organization’s plan for information management considers the full spectrum of data generated and used by the organization; financial data, human resources data, supply inventories, and health information are examples of the different types of data that are considered in the information management planning process. Planning for the management of information does not necessarily result in a single, comprehensive written information management plan; however, planning does establish clear relationships between the organization’s needs and its goals. In addition to the organization’s goals, the organization’s mission, services, staff, patient safety practices, modes of service delivery, resources, and technology are considered during the information management planning process.

Information management planning supports effective information sharing among staff, administration, and patients; for example, patients can help the organization identify barriers to effective communication among caregivers. Planning also supports key relationships with outside services and contractors; licensing, accrediting, and regulatory bodies; as well as purchasers, payers, and employers. By identifying internal and external information needs, organizations can make information available when and where it is needed. Understanding the flow of information results in efficient data collection and distribution and the effective security of health information.

Standard IM.01.01.01
DMEPOS: The organization plans for managing information.

IM.01.01.01, EP 2
DMEPOS: The organization identifies how data and information enter, flow within, and leave the organization.

Introduction to Standard IM.01.01.03
DMEPOS: The primary goal of the information continuity process is to return the organization to normal operations as soon as possible with minimal downtime and no data loss. The organization needs to be prepared for events that could impact the availability of data and information regardless of whether interruptions are scheduled or unscheduled (due to a local or regional disaster or an emergency). Interruptions to an organization's information system can potentially have a devastating impact on its ability to deliver quality care and continue its business operations. Planning for emergency situations helps the organization mitigate the impact that interruptions, emergencies, and disasters have on its ability to manage information. The organization plans for interruptions by training staff on alternative procedures, testing the organization's emergency operations plan, conducting regularly scheduled data backups, and testing data restoration procedures.

Regardless of whether an organization uses a paper-based system or an electronic system, a plan to address the process for information continuity, including knowledge-based information, should be in place. Organizations that plan for maintaining access to electronic information systems by using various electronic backup and restoration procedures can quickly recover from interruptions with minimal downtime and data loss.

Standard IM.01.01.03
DMEPOS: The organization plans for continuity of its information management processes.

IM.01.01.03, EP 1
DMEPOS: The organization follows a written plan for managing interruptions to its information processes (paper-based, electronic, or a mix of paper-based and electronic).

IM.01.01.03, EP 2
DMEPOS: The organization's plan for managing interruptions to information processes addresses the following:
- Scheduled and unscheduled interruptions of electronic information systems
- Training for staff on alternative procedures to follow when electronic information systems are unavailable
- Backup of electronic information systems

Introduction to Standard IM.02.01.01
DMEPOS: The privacy of health information is a critical information management concern. Privacy of health information applies to electronic, paper, and verbal communications. Protecting the privacy of health information is the responsibility of the entire organization. Organizations protect privacy by limiting the use of information to only what is needed to provide care, treatment, or services.

Privacy, along with security, results in the confidentiality of health information. Health information is kept confidential when the information is secure and its use is limited. The end result of protecting the privacy and security of health information is the preservation of confidentiality. To illustrate this relationship, confidentiality is violated in situations when a patient's health information is used, accessed, or disclosed to an individual who does not have permission to access the information or when an individual uses a patient's health information for purposes outside of delivering care, treatment, or services. A confidentiality violation occurs when an individual is able to bypass privacy and security measures to gain access to health information. The organization's written policy on the privacy of health information can assist the organization to maintain the confidentiality of health information while providing access to appropriate care providers.

Note: For additional guidance about limiting the use of information, refer to 45 CFR 164.502(b) and 164.514(d) under "Minimum Necessary" within the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Standard IM.02.01.01
DMEPOS: The organization protects the privacy of health information.

IM.02.01.01, EP 1
DMEPOS: The organization follows a written policy addressing the privacy of health information.
(See also RI.01.01.01, EP 7)

IM.02.01.01, EP 3
DMEPOS: The organization uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy.
(See also RI.01.01.01, EP 7)

IM.02.01.01, EP 4
DMEPOS: The organization discloses health information only as authorized by the patient or as otherwise consistent with law and regulation.
(See also RI.01.01.01, EP 7)

IM.02.01.01, EP 6
DMEPOS: The organization maintains confidential patient records in accordance with privacy and security standards of the Health Insurance Portability and Accountability Act (HIPAA) and other applicable state laws.
Note: Patient records include clinical records.
(See also RI.01.01.01, EP 7)

Introduction to Standard IM.02.01.03
DMEPOS: The security and integrity of health information are closely related. Health information is collected and processed through various information sources and systems throughout the organization. As a result, breaches in security can lead to the unauthorized disclosure or alteration of health information. When this occurs, the integrity of the data and information is compromised. Even simple mistakes, such as writing the incorrect date of a service or diagnosis, can undermine data integrity just as easily as intentional breaches. For these reasons, an examination of the use of paper and electronic information systems is considered in the organization's approach to maintaining the security and integrity of health information. Regardless of the type of system, security measures should address the use of security levels, passwords, and other forms of controlled access. Because information technology and its associated security measures are continuously changing, the organization should do its best to stay informed about technological developments and best practices that can help it improve information security and therefore protect data integrity.

Monitoring access to health information systems can help organizations be vigilant about protecting health information security. Regular security audits can identify system vulnerabilities in addition to security policy violations. For example, as part of the process, the organization could identify system users who have altered, edited, or deleted information. The results from this audit process can be used to validate that user permissions are appropriately set. Conducting security audits can be particularly effective in identifying when employee turnover causes vulnerabilities in security because user access and permissions were not removed or updated.

Standard IM.02.01.03
DMEPOS: The organization maintains the security and integrity of health information.

IM.02.01.03, EP 1
DMEPOS: The organization follows a written policy that addresses the security of health information, including access, use, and disclosure.

IM.02.01.03, EP 2
DMEPOS: The organization implements a written policy addressing the following:
- The integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction
- The 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 organization's control.

IM.02.01.03, EP 5
DMEPOS: The organization protects against unauthorized access, use, and disclosure of health information.

IM.02.01.03, EP 6
DMEPOS: The organization protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.

IM.02.01.03, EP 7
DMEPOS: The organization controls the intentional destruction of health information.

IM.02.01.03, EP 9
DMEPOS: The organization maintains secure patient records in accordance with privacy and security standards of the Health Insurance Portability and Accountability Act (HIPAA) and other applicable state laws.

Standard IM.02.02.01
DMEPOS: The organization effectively manages the collection of health information.

Rationale for Standard IM.02.02.01
DMEPOS: Within the organization, health information can come from multiple sources. The use of standardized language can help clarify information that is used by different individuals for various purposes. Capturing data in standardized language can lead to greater data integrity and reliability, as well as an increased potential for ease of use by internal and external systems and users. The more consistent the organization’s efforts are to capture accurate data in standardized language, the more likely the organization will be to rely on that data for patient-related purposes, including reimbursement, risk management, performance improvement, and infection surveillance.

IM.02.02.01, EP 2
DMEPOS: The organization uses standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.

IM.02.02.01, EP 3
DMEPOS: The organization follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes the following:
- U,u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d, qod
- Trailing zero (X.0 mg)
- Lack of leading zero (.X mg)
- MS
- MSO4
- MgSO4
Note 1: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may

not be used in medication orders or other medication-related documentation.
Note 2: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.

Introduction to Standard IM.02.02.03
DMEPOS: Standardizing the collection of data, a concept that is supported by the requirements of Standard IM.02.02.03, helps with the effective dissemination of data and information. Consistency in data collection systems (paper-based, electronic, or a combination) creates the foundation for retrieving and disseminating data and information in the most useful format. For information about data collection and dissemination, visit the website of the Office of the National Coordinator for Health Information Technology (ONC) (http://www.healthit.gov/).

Standard IM.02.02.03
DMEPOS: The organization retrieves, disseminates, and transmits health information in useful formats.

Rationale for Standard IM.02.02.03
DMEPOS: The ease of use of health information between systems and users contributes to its potential usefulness within the organization and for external reporting purposes. Data stored in different formats cannot easily be converted to a new format or transferred to other organizations or providers. For example, immediate access to infection control data can impact patient safety within the organization and outside of the organization. As more organizations automate various processes and activities, these systems need to allow for transmitting and receiving critical data while maintaining data integrity.

IM.02.02.03, EP 2
DMEPOS: The organization's storage and retrieval systems make health information accessible when needed for patient care, treatment, or services.

IM.02.02.03, EP 3
DMEPOS: The organization disseminates data and information in useful formats within time frames that are defined by the organization and consistent with law and regulation.

Standard IM.03.01.01
DMEPOS: Knowledge-based information resources are available, current, and authoritative.

IM.03.01.01, EP 1
DMEPOS: The organization provides access to knowledge-based information resources during hours of operation.

Leadership

Overview
DMEPOS: The safety and quality of care, treatment, or services depend on many factors, including the following:
- A culture that fosters safety as a priority for everyone who works in the organization
- The planning and provision of services that meet the needs of patients
- The availability of resources—human, financial, and physical—for providing care, treatment, or services
- The recruitment and retention of competent staff
- Ongoing evaluation of and improvement in performance

Management of these important functions is the direct responsibility of leaders; they are, in effect, responsible for the care, treatment, or services that the organization provides to its patients. In organizations with a governing body, governance has ultimate responsibility for this oversight. In larger organizations, different individuals or groups may be assigned different responsibilities, and they bring with them different skills, experience, and perspectives. In these situations, the way that the leaders interact with each other and manage their assigned accountabilities can affect overall organization performance. In smaller organizations, these responsibilities may be handled by just one or two

individuals. This chapter addresses the role of leaders in managing their diverse and, at times, complex responsibilities.

Leaders shape the organization’s culture, and the culture, in turn, affects how the organization accomplishes its work. A healthy, thriving culture is built around the organization’s mission and vision, which reflect the core values and principles that the organization finds important. Leaders must ask some basic questions in order to provide this focus: How does the organization plan to meet the needs of its population(s)? By what ethical standards will the organization operate? What does the organization want to accomplish through its work? Once leaders answer these questions, the culture of the organization will begin to take shape. Leaders also have an obligation to set an example of how to work together to fulfill the organization’s mission.

On a more practical level, leaders oversee operations and guide the organization on a day-to-day basis. They keep operations running smoothly so that the important work of the organization—serving its patients—can continue.

To meet their obligations effectively, leaders must collaborate, which means working together in a spirit of collegiality to achieve a common end. In smaller organizations, this may mean that a single leader or small group of leaders works closely with staff in order to meet the organization’s managerial needs. In this case, key staff members share governance and decision making with senior leaders to direct the day-to-day operations, assess needs, secure resources, and plan for the future. Senior managers direct the day-to-day operations of the organization; governance determines what resources the organization needs and then secures those resources.

Proactive Risk Assessment

DMEPOS: By undertaking a proactive risk assessment, an organization can correct process problems and reduce the likelihood of experiencing adverse events. An organization can use a proactive risk assessment to evaluate a process to see how it could fail, to understand the consequences of such a failure, and to identify parts of the process that need improvement. The term "process" applies broadly to processes that are integral to patient care, such as medication administration and wound care.

Proactive risk assessments are useful for analyzing new processes before they are implemented. Processes need to be designed with a focus on quality and reliability to achieve desired outcomes and protect patients. Proactive risk assessments are also used to evaluate existing processes that have the greatest potential for affecting patient safety. An organization’s choice of which process it will assess may be based in part on information published periodically by Joint Commission about frequently occurring sentinel events and processes that pose high risk to patients.

A proactive risk assessment increases understanding within the organization about the complexities of process design and management of circumstances if the process fails. If an adverse event occurs, the organization may be able to use the information gained from the prior risk assessment to minimize the consequences of the event—and to avoid simply reacting to it.

Although there are several methods that could be used to conduct a proactive risk assessment, the following steps make up one approach:

1. Describe the chosen process (for example, through a flowchart).
2. Identify ways in which the process could break down or fail to perform its desired functions, which is often referred to as failure mode.
3. Identify the possible effects that a breakdown or failure of the process could have on patients and the seriousness of the possible effects.
4. Prioritize the potential process breakdowns or failures.
5. Determine why the prioritized breakdowns or failures could occur, which may involve performing a hypothetical root cause analysis.
6. Design or redesign the process and/or underlying systems to minimize risk of the effects on patients.
7. Test and implement the newly designed or redesigned process.
8. Monitor the effectiveness of the newly designed or redesigned process.

About This Chapter
DMEPOS: This chapter is divided into four sections: Leadership Structure, Leadership Relationships, Organization Culture and System Performance Expectations, and Operations. The organization's culture, systems, and leadership structure and relationships all come together to shape and drive its operations.

The standards in the Leadership Structure section identify and define the various leadership groups and their responsibilities. The standards in Leadership Relationships address the development of the organization's mission, vision, and goals as well as communication among leaders. The standards in the Organization Culture and System Performance Expectations section focus on the framework for the organization's culture and systems. These standards also demonstrate how leaders help shape the culture of an organization and how culture, in turn, affects important systems within the organization (for example, data use, planning, communication, changing performance, staffing). The standards in the Operations section address the functions that are important to patient safety and high-quality care, treatment, or services. Some leaders may not be directly involved in the day-to-day operations of the organization, but the decisions they make and the initiatives they implement do affect operations.

Introduction to Leadership Structure, Standards LD.01.01.01 Through LD.01.04.01
DMEPOS: Each organization, regardless of its complexity, has a structured leadership. Many leadership responsibilities directly affect the provision of care, treatment, or services, as well as the day-to-day operations of the organization. In some cases, these responsibilities will be shared among leaders, and in other cases, a particular leader has primary responsibility. Individual leaders may have several different roles. Regardless of the organization's structure, it is important that leaders carry out all their responsibilities.

How well leaders work together is key to effective organization performance, and the standards emphasize this. Leaders with different responsibilities—governance, management, and the clinical staff—bring different skills, experiences, and perspectives to the organization. Working together means that leaders have the opportunity to participate in discussions and have their opinions heard. Depending on the topic and the organization, individuals may participate in decision making, and the governing body may delegate decision making to certain leaders. Final decisions, however, are always the ultimate responsibility of governance; this key principle is assumed in any standard that describes how leaders work together.

Standard LD.01.01.01
DMEPOS: The organization has a leadership structure.

Rationale for Standard LD.01.01.01
DMEPOS: Every organization has a leadership structure to support operations. Many functions need to be carried out, including governance, administration, and oversight of care, treatment, or services. In some organizations, leaders have distinct roles in carrying out these functions; in others a single individual may perform all leadership functions.

LD.01.01.01, EP 1
DMEPOS: The organization identifies those responsible for governance.

LD.01.01.01, EP 2
DMEPOS: Governance identifies those responsible for planning, management, and operational activities.

LD.01.01.01, EP 3
DMEPOS: Governance identifies those responsible for the provision of care, treatment, or services.

Standard LD.01.03.01
DMEPOS: Governance is ultimately accountable for the safety and quality of care, treatment, or services.

Rationale for Standard LD.01.03.01

DMEPOS: Governance's ultimate responsibility for safety and quality derives from its legal responsibility and operational authority for organization performance. In this context, governance provides for internal structures and resources, including staff, that support safety and quality.

LD.01.03.01, EP 1
DMEPOS: Governance defines in writing its responsibilities.

LD.01.03.01, EP 2
DMEPOS: Governance provides for organization management and planning and creates an operating budget that reflects the organization's goals and objectives.

LD.01.03.01, EP 3
DMEPOS: Governance approves the organization's written scope of services.

LD.01.03.01, EP 4
DMEPOS: Governance selects the chief executive.

LD.01.03.01, EP 5
DMEPOS: Governance provides for the resources needed to maintain safe, quality care, treatment, or services.

LD.01.03.01, EP 6
DMEPOS: Governance works with other leaders to annually evaluate the organization's performance in relation to its mission, vision, and goals.

LD.01.03.01, EP 19
DMEPOS: The organization has one or more individuals who perform leadership functions, with the authority, responsibility, and accountability to direct the organization and its key activities and operations.

Standard LD.01.04.01
DMEPOS: A chief executive manages the organization.

LD.01.04.01, EP 1
DMEPOS: The chief executive provides for the following:
- Information and support systems
- Physical and financial assets

LD.01.04.01, EP 11
DMEPOS: When the chief executive or administrator is absent from the organization, a qualified individual is designated to perform the duties of this position.

Introduction to Leadership Relationships, Standard LD.02.01.01
DMEPOS: How well leaders work together and manage conflict affects an organization's performance. In fulfilling its role, governance involves senior managers and leaders of the clinical staff in governance and management functions.

Good relationships thrive when leaders work together to develop the mission, vision, and goals of the organization; encourage honest and open communication; and address conflicts of interest.

Standard LD.02.01.01
DMEPOS: The mission, vision, and goals of the organization support the safety and quality of care, treatment, or services.

Rationale for Standard LD.02.01.01
DMEPOS: The primary responsibility of leaders is to provide for the safety and quality of care, treatment, or services. The purpose of the organization's mission, vision, and goals is to define how the organization will achieve safety and quality. The leaders are more likely to be aligned with the mission, vision, and goals when they create them together. The common purpose of the organization is most likely achieved when it is understood by all who work in or are served by the organization.

LD.02.01.01, EP 1
DMEPOS: Leaders work together to create the organization's mission, vision, and goals, which guide the leaders' actions and are communicated to staff and the population(s) the organization serves.

Introduction to Organization Culture and System Performance Expectations, Standards LD.03.01.01 Through LD.03.06.01
DMEPOS: An organization's culture reflects the beliefs, attitudes, and priorities of its members, and it influences the effectiveness of performance. Although there may be a dominant culture, in many larger organizations, diverse cultures exist that may or may not share the same values. In fact, diverse cultures can exist even in smaller organizations. Organization performance can be effective in either case. Successful organizations will work to develop a culture of safety and quality.

In a culture of safety and quality, all individuals are focused on maintaining excellence in performance. They accept the safety and quality of patient care, treatment, or services as personal responsibilities and work together to minimize any harm that might result from unsafe or poor quality of care, treatment, or services. Leaders create this culture by demonstrating their commitment to safety and quality and by taking actions to achieve the desired state. In a culture of this kind, one finds teamwork, open discussions of concerns about safety and quality, and the encouragement of and reward for internal and external reporting of safety and quality issues. Attention is focused on the performance of systems and processes instead of the individual, although reckless behavior and a blatant disregard for safety are not tolerated. Organizations are committed to ongoing learning and have the flexibility to accommodate changes in technology, science, and the environment.

The leaders provide for the effective functioning of the organization with a focus on safety and quality. Leaders plan, support, and implement key systems critical to this effort. Joint Commission has identified five key systems that influence the effective performance of an organization:
1. Using data
2. Planning
3. Communicating
4. Changing performance
5. Staffing

The following diagram illustrates the role of leadership in the performance of these systems.

[INSERT FIGURE 1 JPEG]

Leadership provides the foundation for effective performance. The five key systems serve as pillars that are based on the foundation set by leadership and, in turn, support the many organizationwide processes (such as medication management) that are important to individual care, treatment, or services. Culture permeates the entire structure.

The five key systems are interrelated and need to function well together. The integration of these systems throughout the organization will facilitate the effective performance of the organization as a whole. Leaders develop a vision and goals for the performance of these systems and then evaluate their performance. Leaders use results to develop strategies for future improvements.

Performance of many aspects of these systems may be directly observable. But in many cases organizations demonstrate compliance through performance in standards located in other sections of this manual. These leadership

standards are cited when patterns of performance suggest organizationwide issues.

The effective performance of these systems results in a culture in which safety and quality are priorities. The organization demonstrates this through a proactive, nonpunitive culture that is monitored and sustained by related reporting systems and improvement initiatives.

Many of the concepts in the following section have long existed in the standards.

Standard LD.03.01.01
DMEPOS: Leaders create and maintain a culture of safety and quality throughout the organization.

Rationale for Standard LD.03.01.01
DMEPOS: Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to quality and set expectations for those who work in the organization. Leaders evaluate the culture on a regular basis using a variety of methods, such as formal surveys, focus groups, staff interviews, and data analysis.

Leaders create structures, processes, and programs that allow this positive culture to flourish, and motivate staff to provide input that advances safe, quality care. For example, do organizational structures support staff, whether office-based, facility-based, or in the field, in giving feedback? Are staff across the organization (support staff as well as physicians and other licensed practitioners) given the same access to communicate concerns to leadership?

Behavior that intimidates others and affects morale or staff turnover undermines a culture of safety and can be harmful to patient care. Leaders must address such behavior in individuals working at all levels of the organization, including management, clinical and administrative staff, and governing body members.

LD.03.01.01, EP 1
DMEPOS: Leaders regularly evaluate the culture of safety and quality.

LD.03.01.01, EP 2
DMEPOS: Leaders prioritize and implement changes identified by the evaluation.

LD.03.01.01, EP 4
DMEPOS: Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.

LD.03.01.01, EP 5
DMEPOS: Leaders create and implement a process for managing behaviors that undermine a culture of safety.

LD.03.01.01, EP 9
DMEPOS: The organization has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team that includes the following:
- An annual analysis of possible safety and security risks related to workplace violence
- Policies and procedures to prevent and respond to workplace violence
- A process to report incidents and to analyze incidents and trends, which are then reported to governance
- A process for follow-up and support for victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary

Standard LD.03.02.01
DMEPOS: The organization uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

Rationale for Standard LD.03.02.01
DMEPOS: Data help organizations make the right decisions. When decisions are supported by data, organizations are more likely to move in directions that help them achieve their goals. Successful organizations measure and analyze their performance. When data are analyzed and turned into information, this process helps organizations see patterns and trends and understand the reasons for their performance. Many types of data are used to evaluate performance, including data on outcomes of care, safety and quality initiatives, patient satisfaction, process variation, and staff perceptions.

LD.03.02.01, EP 1
DMEPOS: Leaders set expectations for using data and information for the following:
- Improving the safety and quality of care, treatment, or services
- Creating a culture of safety and quality
- Decision making that supports the safety and quality of care, treatment, or services
- Identifying and responding to internal and external changes in the environment

LD.03.02.01, EP 2
DMEPOS: Leaders evaluate how effectively data and information are used throughout the organization.

Standard LD.03.03.01
DMEPOS: Leaders use organizationwide planning to establish structures and processes that focus on safety and quality.

Rationale for Standard LD.03.03.01
DMEPOS: Planning is essential to the following:
- The achievement of short- and long-term goals
- Meeting the challenge of external changes
- The design of services and work processes
- The creation of communication channels
- The improvement of performance
- The introduction of innovation

Planning includes contributions from the populations served, those who work for the organization, and other interested groups or individuals.

LD.03.03.01, EP 1
DMEPOS: Planning activities focus on the following:
- Improving patient safety and health care quality
- Supporting a culture of safety and quality
- Adapting to changes in the environment

LD.03.03.01, EP 2
DMEPOS: Planning is organizationwide, systematic, and involves designated individuals and information sources.

LD.03.03.01, EP 3
DMEPOS: Leaders evaluate the effectiveness of planning activities.

Standard LD.03.04.01
DMEPOS: The organization communicates information related to safety and quality to those who need it, including staff, patients, families, and external interested parties.

Rationale for Standard LD.03.04.01
DMEPOS: Effective communication is essential among individuals and groups within the organization and between the organization and external parties. Poor communication often contributes to adverse events and can compromise

safety and quality of care, treatment, or services. Effective communication is timely, accurate, and usable by the audience.

LD.03.04.01, EP 1
DMEPOS: 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 organization of changes in the environment

LD.03.04.01, EP 2
DMEPOS: Leaders evaluate the effectiveness of communication methods.

Standard LD.03.05.01
DMEPOS: Leaders manage change to improve the performance of the organization.

Rationale for Standard LD.03.05.01
DMEPOS: Change is inevitable, and agile organizations are able to manage change and rapidly execute new plans. The ability of leaders to manage change is necessary for performance improvement, for successful innovation, and to meet environmental challenges. The organization integrates change into all relevant processes so that its effectiveness can be sustained, assessed, and measured.

LD.03.05.01, EP 1
DMEPOS: The organization has a systematic approach to change and performance improvement.

LD.03.05.01, EP 2
DMEPOS: Structures for managing change and performance improvement do the following:
- Foster the safety of the patient and the quality of care, treatment, or services
- Support a culture of safety and quality
- Adapt to changes in the environment

LD.03.05.01, EP 3
DMEPOS: Leaders evaluate the effectiveness of processes for the management of change and performance improvement.

Standard LD.03.06.01
DMEPOS: Those who work in the organization are focused on improving safety and quality.

Rationale for Standard LD.03.06.01
DMEPOS: The safety and quality of care, treatment, or services are highly dependent on the people who work in the organization. The mission, scope, and complexity of services define the design of work processes and the skills and number of individuals needed. In a successful organization, work processes and the environment make safety and quality paramount. This standard, therefore, applies to all those who work in or for the organization.

LD.03.06.01, EP 1
DMEPOS: Leaders design work processes to focus individuals on safety and quality issues.

LD.03.06.01, EP 2
DMEPOS: Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, or services.

LD.03.06.01, EP 3

DMEPOS: Those who work in the organization are competent to complete their assigned responsibilities.

LD.03.06.01, EP 4
DMEPOS: Leaders evaluate the effectiveness of those who work in the organization to promote safety and quality.

Standard LD.03.07.01
DMEPOS: Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)

LD.03.07.01, EP 1
DMEPOS: Performance improvement occurs organizationwide.

LD.03.07.01, EP 2
DMEPOS: As part of performance improvement, leaders, or managers delegated by leaders, do the following:
- Set priorities for data collection, performance improvement activities, and patient health outcomes
- Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities
Note: Examples of areas of risk include blood-borne infections, wound care, undetected urinary tract infections, oxygen-related fires, and patient handoff to or from the home care organization.
- Identify the frequency of data collection for performance improvement activities
- Reprioritize performance improvement activities in response to changes in the internal or external environment

Standard LD.03.08.01
DMEPOS: New or modified services or processes are well designed.

LD.03.08.01, EP 1
DMEPOS: The organization's design of new or modified services or processes incorporates the following:
- The needs of patients, staff, and others
- The results of performance improvement activities
- Information about potential risks to patients, sentinel events experienced by the organization, and general information about sentinel events relevant to the organization
- Evidence-based information in the decision-making process
Note 1: A proactive risk assessment is one of several ways to assess potential risks to patients. For suggested components, refer to the Proactive Risk Assessment section at the beginning of this chapter.
Note 2: Evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards.

Introduction to Standard LD.03.09.01
DMEPOS: This standard describes a safety program that integrates safety priorities into all processes, functions, and services within the organization, including patient care, support, and contract services. It addresses the responsibility of leaders to establish an organizationwide safety program; to proactively explore potential system failures; to analyze and take action on problems that have occurred; and to encourage the reporting of adverse events and close calls (“near misses”), both internally and externally. The organization’s culture of safety and quality supports the safety program (refer to Standard LD.03.01.01).

This standard does not require the creation of a new structure or office in the organization. It only emphasizes the need to integrate patient safety activities, both existing and newly created, with the organization’s leadership, which is ultimately responsible for this integration.

It is also critical that the organization, when establishing a patient safety program, integrate the roles and responsibilities of the patient and the patient's family with reducing unanticipated adverse events or adverse outcomes by providing sufficient information about the risks related to the care or services provided, instructions on minimizing those risks, and the consequences of not following such instructions aimed at reducing risk.

Standard LD.03.09.01
DMEPOS: The organization has an organizationwide, integrated patient safety program.

LD.03.09.01, EP 1
DMEPOS: The leaders implement an organizationwide patient safety program as follows:
- One or more qualified individuals manage the safety program.
- All departments, programs, and services within the organization 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.

LD.03.09.01, EP 2
DMEPOS: 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, or services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.

LD.03.09.01, EP 3
DMEPOS: The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment.
Note: This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for their blameworthy errors.

LD.03.09.01, EP 4
DMEPOS: The leaders define patient safety event and communicate this definition throughout the organization.
Note: At a minimum, the organization's definition includes those events subject to review as described in the "Sentinel Event Policy" (SE) chapter of this manual.

LD.03.09.01, EP 5
DMEPOS: The organization 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.

LD.03.09.01, EP 6
DMEPOS: The leaders make support systems available for staff who have been involved in an adverse or sentinel event.
Note: Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals.

LD.03.09.01, EP 8
DMEPOS: To improve safety, the organization analyzes and uses information about system or process failures and, when conducted, the results of proactive risk assessments.

LD.03.09.01, EP 9
DMEPOS: The leaders disseminate lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation.

LD.03.09.01, EP 10

DMEPOS: At least once a year, the leaders provide governance with written reports on the following:
- All system or process failures
- The number and type of sentinel events
- Whether the patients and the families were informed of the event
- All actions taken to improve safety, both proactively and in response to actual occurrences

LD.03.09.01, EP 11
DMEPOS: Leaders facilitate mandatory reporting of significant adverse events, and voluntary reporting of such events to programs in which the organization participates.
Note: Examples of voluntary programs include Joint Commission Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated.

Introduction to Operations, Standards LD.04.01.01 Through LD.04.03.07
DMEPOS: Although some leaders may not be involved in the day-to-day, hands-on operations of the organization, their decisions and work affect, either directly or indirectly, every aspect of operations. They are the driving force behind the culture of the organization. Leaders establish the ethical framework in which the organization operates, create policies and procedures, and secure resources and services that support patient safety and quality care, treatment, or services. Policies, procedures, resources, and services are all influenced by the culture of the organization, and, in turn, influence the culture.

Standard LD.04.01.01
DMEPOS: The organization complies with law and regulation.

LD.04.01.01, EP 1
DMEPOS: The organization is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the organization is seeking accreditation from Joint Commission.
Note 1: Applicable law and regulation include, but are not limited to, individual and facility licensure, certification, US Food and Drug Administration regulations, Drug Enforcement Agency regulations, Centers for Medicare & Medicaid Services regulations, Occupational Safety and Health Administration regulations, Department of Transportation regulations, Health Insurance Portability and Accountability Act, and other local, state, and federal laws and regulations.
Note 2: Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state laws.
Note 3: For more information on how to obtain a CLIA certificate, see https://www.cms.gov/medicare/quality/clinical-laboratory-improvement-amendments/apply.

LD.04.01.01, EP 2
DMEPOS: The organization provides care, treatment, or services in accordance with licensure requirements, laws, and rules and regulations.

LD.04.01.01, EP 3
DMEPOS: Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies.

LD.04.01.01, EP 10
DMEPOS: The organization displays all licenses, certificates, and permits to operate in an area accessible to customers and patients.

LD.04.01.01, EP 13
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The supplier complies with Medicare statutes, regulations, manuals, program instructions, and contractor policies and articles.

Standard LD.04.01.03
DMEPOS: The organization develops an annual operating budget and, when needed, a long-term capital expenditure plan.

LD.04.01.03, EP 1
DMEPOS: Leaders solicit comments from those who work in the organization when developing the operational and capital budgets.

LD.04.01.03, EP 3
DMEPOS: The operating budget reflects the organization's goals and objectives.

LD.04.01.03, EP 4
DMEPOS: Governance approves an annual operating budget and, when needed, a long-term capital expenditure plan.

LD.04.01.03, EP 13
DMEPOS: The organization manages revenues and expenses on an ongoing basis as they relate to patient services, including planning to meet the needs of patients and maintain business operations by having an operating budget, as appropriate to the business' size and scope of services.

Standard LD.04.01.05
DMEPOS: The organization effectively manages its programs, services, sites, or departments.

Rationale for Standard LD.04.01.05
DMEPOS: Leaders at the program, service, site, or department level create a culture that enables the organization to fulfill its mission and meet its goals. They support staff and instill in them a sense of ownership of their work processes. Leaders may delegate work to qualified staff, but the leaders are responsible for the care, treatment, or services provided in their areas.

LD.04.01.05, EP 2
DMEPOS: Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals.

LD.04.01.05, EP 3
DMEPOS: The organization defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments.

LD.04.01.05, EP 4
DMEPOS: Staff are held accountable for their responsibilities.

LD.04.01.05, EP 5
DMEPOS: Leaders provide for the coordination of care, treatment, or services among the organization's different programs, services, sites, or departments.

Standard LD.04.01.07
DMEPOS: The organization has policies and procedures that guide and support patient care, treatment, or services.

LD.04.01.07, EP 1
DMEPOS: Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, or services.

Standard LD.04.01.11
DMEPOS: The organization makes space and equipment available as needed for the provision of care, treatment, or services.

Rationale for Standard LD.04.01.11
DMEPOS: The resources allocated to services provided by the organization have a direct effect on patient outcomes. Leaders should place highest priority on high-risk or problem-prone processes that can affect patient safety. Examples include infection control, medication management, use of anesthesia, and others defined by the organization.

LD.04.01.11, EP 5
DMEPOS: The leaders provide for interior and exterior space, equipment, information systems, supplies, and other resources that are safe, maintained, and supervised to meet the needs of the patients.

LD.04.01.11, EP 6
DMEPOS: The organization governs its business so that it obtains and provides appropriate quality equipment, items, and services to patients.

LD.04.01.11, EP 7
DMEPOS: The organization has a physical location.

Standard LD.04.02.01
DMEPOS: The leaders address any conflict of interest that affects or has the potential to affect the safety or quality of care, treatment, or services.

LD.04.02.01, EP 2
DMEPOS: The leaders follow a written policy that defines situations that represent a conflict of interest, the need to disclose the conflicts, and how the organization will address these conflicts of interest.

LD.04.02.01, EP 4
DMEPOS: The organization reviews its relationships with other care providers, educational institutions, manufacturers, and payers to determine whether conflicts of interest exist and whether they are within law and regulation.

LD.04.02.01, EP 5
DMEPOS: Information about the relationship between care, treatment, or services and financial incentives is available upon request to all patients and those individuals who work in the organization.

Standard LD.04.02.03
DMEPOS: Ethical principles guide the organization’s business practices.

LD.04.02.03, EP 1
DMEPOS: The organization develops and implements a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.

LD.04.02.03, EP 4
DMEPOS: Marketing materials accurately represent the organization and address the care, treatment, or services that the organization provides either directly or by contractual arrangement.

LD.04.02.03, EP 5

DMEPOS: Care, treatment, or services are provided based on patient needs, regardless of compensation or financial risk-sharing with those who work in the organization.

LD.04.02.03, EP 7
DMEPOS: Patients receive information about charges for which they will be responsible.

LD.04.02.03, EP 17
DMEPOS: The organization implements business practices to prevent and control fraud, waste, and abuse by using procedures that articulate standards of conduct so that the organization complies with applicable law and regulation.

LD.04.02.03, EP 18
DMEPOS: The organization implements business practices to prevent and control fraud, waste, and abuse by designating one or more individuals in leadership positions to address compliance issues.

LD.04.02.03, EP 19
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The supplier implements financial management practices for accurate accounting and billing to beneficiaries and the Medicare program.

LD.04.02.03, EP 20
DMEPOS: The organization's financial records are accurate, complete, current, and reflect cash- or accrual-based accounting practices.

LD.04.02.03, EP 21
DMEPOS: The organization maintains accounts that link equipment and items to the patient.

LD.04.02.03, EP 22
DMEPOS: The organization manages revenues and expenses on an ongoing basis, as they relate to patient services, including reconciliation of charges to patients for equipment, supplies, and services, with invoices, receipts, and deposits, and by tracking actual revenues and expenses.

Standard LD.04.02.05
DMEPOS: When internal or external review results in the denial of care, treatment, or services, or payment, the organization makes decisions regarding the ongoing provision of care, treatment, or services, and discharge or transfer, based on the assessed needs of the patient.

Rationale for Standard LD.04.02.05
DMEPOS: The organization is professionally and ethically responsible for providing care, treatment, or services within its capability and law and regulation. At times, such care, treatment, or services are denied because of payment limitations. In these situations, the decision to continue providing care, treatment, or services or to discharge the patient is based solely on the patient's identified needs.

LD.04.02.05, EP 1
DMEPOS: Decisions regarding the provision of ongoing care, treatment, or services or discharge are based on the assessed needs of the patient and ordered by the physician or other licensed practitioner when such order is required, regardless of the recommendations of any internal or external review.

LD.04.02.05, EP 2
DMEPOS: The safety and quality of care, treatment, or services do not depend on the patient's ability to pay, which includes not discontinuing or reducing care.

Standard LD.04.03.01

DMEPOS: The organization provides services that meet patient needs.

LD.04.03.01, EP 1
DMEPOS: The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements.

Standard LD.04.03.07
DMEPOS: Patients with comparable needs receive the same standard of care, treatment, or services throughout the organization.

Rationale for Standard LD.04.03.07
DMEPOS: Comparable standards of care means that the organization can provide the services that patients need within established time frames and that those providing care, treatment, or services have the required competence. Organizations may provide different services to patients with similar needs as long as individual outcomes are not affected. For example, some patients may receive equipment with enhanced features because of insurance situations. This does not ordinarily lead to different outcomes. Also, organizations may choose to have branch offices that offer different services from one another. Different settings, processes, or payment sources should not result in different standards of care.

LD.04.03.07, EP 1
DMEPOS: Variances in staff, setting, or payment source do not affect outcomes of care, treatment, or services in a negative way.

Introduction to Oversight of Care, Treatment, or Services Provided Through Contractual Agreement, Standard LD.04.03.09
DMEPOS: The same level of care should be delivered to patients regardless of whether services are provided directly by the organization or through contractual agreement. Leaders provide oversight to make sure that care, treatment, or services provided directly are safe and effective. Likewise, leaders must also oversee contracted services to make sure that they are provided safely and effectively. Standard LD.04.03.09 outlines the requirements for leadership oversight of care, treatment, or services provided through contractual agreement.

The only contractual agreements subject to the requirements in Standard LD.04.03.09 are those for the provision of care, treatment, or services provided to the organization's patients. Such services include any licensed professional service, home medical equipment, clinical respiratory, and rehabilitation technology services. This standard does not apply to contracted services that are not directly related to patient care. In addition, contracts for consultation or referrals are not subject to the requirements in Standard LD.04.03.09. However, regardless of whether or not a contract is subject to this standard, the actual performance of any contracted service is evaluated at the other standards in this manual appropriate to the nature of the contracted service.

Monitoring Contracted Services
The expectations that leaders set for the performance of contracted services should reflect basic principles of risk reduction, safety, staff competence, and performance improvement. The requirements outlined in Standards HR.01.06.01, EC.01.01.01, EC.02.01.01, and PI.01.01.01 can provide ideas for setting expectations related to these topics. Additional ideas for expectations can come from the elements of performance (EPs) found in specific standards applicable to the contracted service. Although leaders have the same responsibility for oversight of contracted services outside the organization's expertise as they do for contracted services within the organization's expertise, it may be more difficult to determine how to monitor such services.

The EPs do not prescribe the methods for evaluating contracted services; leaders are expected to select the best methods in which their organization oversees the quality and safety of services provided through contractual agreement. Examples of sources of information that may be used for evaluating contracted services include the following:

- Review of information about the contractor’s Joint Commission accreditation or certification status
- Direct observation of the provision of care
- Audit of documentation, including patient records
- Review of incident reports
- Review of periodic reports submitted by the individual or organization providing services under contractual agreement
- Collection of data that address the efficacy of the contracted service
- Review of performance reports based on indicators required in the contractual agreement
- Input from staff and patients
- Review of patient satisfaction studies
- Review of results of risk management activities

If contracted services do not meet expectations, leaders take steps to improve care, treatment, or services. In some cases, it may be best to work with the contractor to make improvements, whereas in other cases it may be best to renegotiate or terminate the contractual relationship. When the leaders anticipate the renegotiation or termination of a contractual agreement, planning needs to occur so that the continuity of care, treatment, or services is not disrupted.

Standard LD.04.03.09
DMEPOS: Care, treatment, or services provided through contractual agreement are provided safely and effectively.

LD.04.03.09, EP 2
DMEPOS: The organization describes, in writing, the nature and scope of services provided through contractual agreements.

LD.04.03.09, EP 3
DMEPOS: Designated leaders approve contractual agreements.

LD.04.03.09, EP 4
DMEPOS: Leaders monitor contracted services by establishing expectations for the performance of the contracted services.

LD.04.03.09, EP 5
DMEPOS: Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services.
Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it.

LD.04.03.09, EP 6
DMEPOS: Leaders monitor contracted services by evaluating these services in relation to the organization's expectations.

LD.04.03.09, EP 7
DMEPOS: Leaders take steps to improve contracted services that do not meet expectations.
Note: Examples of improvement efforts to consider include the following:
- Increase monitoring of the contracted services
- Provide consultation or training to the contractor
- Renegotiate the contract terms
- Apply defined penalties
- Terminate the contract

LD.04.03.09, EP 8

DMEPOS: When contractual agreements are renegotiated or terminated, the organization maintains the continuity of patient care.

Medication Management

Overview
DMEPOS: Medication management is an important component in the palliative, symptomatic, and curative treatment of many diseases and conditions. However, medications are also capable of causing great harm if the incorrect dose or medication is inadvertently administered to a patient. To eliminate any potential harm that could be caused by medications, organizations need to develop an effective and safe medication management system.

A safe medication management system addresses an organization's medication processes, which in many organizations includes the following (as applicable):
- Planning
- Selection and procurement
- Storage
- Ordering
- Preparing and dispensing
- Administration
- Monitoring
- Evaluation

The "Medication Management" (MM) chapter addresses these critical processes, including those undertaken by the organization and those provided through contracted pharmacy services. However, the specifics of the medication management system used by the organization can vary depending on the care, treatment, or services it provides. Not all organizations will implement all of the medication processes. For example, home care settings implement the medication management process based on the care, treatment, or services they provide.

Effective and safe medication management also involves multiple services and disciplines working closely together. The medication management standards address activities involving various individuals within an organization's medication management system.

In addition, an effective medication management system includes mechanisms for reporting potential and actual medication-related errors and a process to improve medication management processes and patient safety based on this information.

In essence, a well-planned and implemented medication management system supports patient safety and improves the quality of care by doing the following:
- Reducing variation, errors, and misuse
- Using evidence-based practices to develop medication management processes
- Managing critical processes to promote safe medication management throughout the organization
- Standardizing equipment and handling processes, including those for sample medications, across the organization to improve the medication management system
- Monitoring the medication management process for efficiency, quality, and safety

About This Chapter
DMEPOS: The goal of the medication management standards is to provide a framework for an effective and safe medication management system. Effective and safe medication management is dependent on carefully implementing medication management processes based on the care, treatment, or services provided by the organization. Planning provides the groundwork for the following critical areas of performance outlined in this chapter:
- Managing high-alert and hazardous medications
- Selecting and procuring medications
- Storing medications

- Managing emergency medications
- Controlling medications brought into the organization by patients, their families, or licensed practitioners
- Managing medication orders
- Preparing medications
- Labeling medications
- Dispensing medications
- Retrieving recalled or discontinued medications
- Administering medications
- Managing investigational medications
- Monitoring patients' reactions to medications
- Responding to real or potential adverse drug events, adverse drug reactions, and medication errors

Selected elements of performance (EPs) that are applicable to sample medications include a note that states, "This element of performance is also applicable to sample medications." Joint Commission is not endorsing the use of sample medications. The note is only intended to identify which Medication Management EPs are applicable to sample medications for organizations that permit their use. Medication Management EPs that do not include this note are not applicable to sample medications.

Standard MM.01.01.01
DMEPOS: The organization plans its medication management processes.

Rationale for Standard MM.01.01.01
DMEPOS: Medication management is often complicated, involving many people and processes. For this reason, the organization plans each part of the process with care so that safety and quality are maintained. This planning may involve the coordinated efforts of multiple services and disciplines.

MM.01.01.01, EP 1
DMEPOS: The organization follows a written policy that describes that the following information about the patient is accessible to staff who participate in the management of the patient's medications:
- Age
- Sex
- Diagnoses
- Allergies
- Sensitivities
- Current medications
- Height and weight (when necessary)
- Pregnancy and lactation information (when necessary)
- Laboratory results (when necessary)
- Any additional information required by the organization

Note 1: This element of performance does not apply in emergency situations.
Note 2: This element of performance is also applicable to sample medications.

Standard MM.01.01.03
DMEPOS: The organization safely manages high-alert and hazardous medications.

Rationale for Standard MM.01.01.03
DMEPOS: High-alert medications are those medications that bear a heightened risk of causing significant patient harm and/or sentinel events when they are used in error and, as a result, require special safeguards to reduce the risk of errors. Examples of high-alert medications include opioids, insulin, anticoagulants, and neuromuscular blocking agents. Lists of high-alert medications are available from organizations such as the Institute for Safe Medication Practices (ISMP).

Hazardous drugs and medications are those in which studies in animals or humans indicate that exposure to them

has a potential for causing cancer, developmental or reproductive toxicity, genotoxicity, or harm to organs. An example of a hazardous drug is one that contains antineoplastic agents or other ingredients that cause the aforementioned risks. Lists of hazardous drugs are available from the National Institute for Occupational Safety and Health (NIOSH).

For safe management, the organization needs to develop its own lists of both high-alert medications and hazardous drugs. These should be based on the organization's unique utilization patterns, its own internal data about medication errors and sentinel events, and known safety issues published in professional literature. It is up to the organization to determine whether medications that are new to the market are high alert or hazardous. In addition, the organization may separately choose to include other drugs that require special precautions such as investigational medications, controlled substances, and psychotherapeutic medications.

Note: For a list of high-alert medications, see https://www.ismp.org/recommendations. For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf.

MM.01.01.03, EP 1
DMEPOS: The organization identifies, in writing, its high-alert and hazardous medications.
Note 1: This element of performance is also applicable to sample medications.
Note 2: For a list of high-alert medications, see https://www.ismp.org/recommendations. For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf.

MM.01.01.03, EP 2
DMEPOS: The organization follows a process for managing high-alert and hazardous medications.
Note: This element of performance is also applicable to sample medications.

Standard MM.03.01.01
DMEPOS: The organization safely stores medications.

Rationale for Standard MM.03.01.01
DMEPOS: Medication storage is designed to assist in maintaining medication integrity, promote the availability of medications when needed, minimize the risk of medication diversion, and reduce potential dispensing errors. Law and regulation and manufacturers' guidelines further define the organization's approach to medication storage.

MM.03.01.01, EP 1
DMEPOS: For organizations that store medications at their site(s): The organization stores only approved medications and medications selected by the organization.

MM.03.01.01, EP 2
DMEPOS: For organizations that store medications at their site(s): The organization stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.
Note: This element of performance is also applicable to sample medications.

MM.03.01.01, EP 3
DMEPOS: For organizations that store medications at their site(s): The organization stores controlled (scheduled) medications to prevent diversion, in accordance with law and regulation.
Note: This element of performance is also applicable to sample medications.

MM.03.01.01, EP 4
DMEPOS: For organizations that store medications at their site(s): The organization follows a written process addressing the control of the medication between receipt by the organization and delivery to or administration at the

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

MM.03.01.01, EP 6
DMEPOS: For organizations that store medications at their site(s): The organization prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation.
Note: This element of performance is also applicable to sample medications.

MM.03.01.01, EP 7
DMEPOS: For organizations that store medications at their site(s): All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.
Note: This element of performance is also applicable to sample medications.

MM.03.01.01, EP 18
DMEPOS: For organizations that store medications at their site(s): The organization periodically inspects all medication storage areas.
Note: This element of performance is also applicable to sample medications.

Standard MM.03.01.03
DMEPOS: The organization safely manages emergency medications.

Rationale for Standard MM.03.01.03
DMEPOS: Patient emergencies occur frequently in health care settings. The organization, therefore, needs to plan how it will address patient emergencies and what medications and supplies it will need. Although the processes may be different, the organization treats emergency medications with the same care for safety as it does medications in nonemergency settings.

MM.03.01.03, EP 1
DMEPOS: Organization leaders determine which emergency medications and their associated supplies will be accessible for patient use in inpatient facilities, ambulatory infusion suites, and patient homes, and which medications and their associated supplies will be available directly from clinical staff. Whenever possible, emergency medications are accessible in the most ready-to-administer forms.

MM.03.01.03, EP 6
DMEPOS: When emergency medications or supplies are used or expired, the organization replaces them as soon as possible to maintain a full stock.

Introduction to Standard MM.04.01.01
DMEPOS: Medication errors may occur when staff are communicating or transcribing medication orders. Verbal and telephone orders are particularly susceptible to error. The organization is responsible for reducing the potential for medication errors and the misinterpretation of these medication orders. As part of this process, the organization determines the required elements of a medication order, the type of medication orders that are deemed acceptable for use, and the actions to take when medication orders are incomplete, illegible, or unclear. Clear understanding and communication between staff members who are involved in the medication process are essential.

Standard MM.04.01.01
DMEPOS: Medication orders or prescriptions are clear and accurate.

MM.04.01.01, EP 1
DMEPOS: For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization follows a written policy that identifies the specific types of medication orders or prescriptions that it deems acceptable for use.

Note: There are several different types of medication orders. Medication orders commonly used include the following:
- As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom
- Standing orders: A prewritten medication order and specific instructions from the physician or other licensed practitioner to administer a medication to a person in clearly defined circumstances specified in the instructions
- Automatic stop orders: Orders that include a date or time to discontinue a medication
- Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status
- Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval
- Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status
- Signed and held orders: New prewritten (held) medication orders and specific instructions from a physician or other licensed practitioner to administer medication(s) to a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s)
- Orders for compounded drugs or drug mixtures not commercially available
- Orders for medication-related devices (for example, nebulizers, catheters)
- Orders for investigational medications
- Orders for herbal products
- Orders for medications at discharge or transfer

MM.04.01.01, EP 2
DMEPOS: For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization follows a written policy that defines the following:
- The minimum required elements of a complete medication order, which must include medication name, medication dose, medication route, and medication frequency
- The precautions for ordering medications with look-alike or sound-alike names
- Actions to take when medication orders are incomplete, illegible, or unclear
- For medication titration orders, required elements include 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: Examples of objective clinical measures to be used to guide titration changes include blood pressure, respiratory rate, and the Confusion Assessment Method (CAM).

MM.04.01.01, EP 7
DMEPOS: For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: If the organization uses preprinted medication order sheets or prescriptions, it reviews and updates them at time frames it identifies, or sooner if necessary, based on current evidence and practice.

MM.04.01.01, EP 8
DMEPOS: For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization prohibits summary (blanket) orders to resume previous medications.

MM.04.01.01, EP 14
DMEPOS: For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization requires a physician or other licensed practitioner order or, as permitted by law and regulation, organization-specific protocol(s) developed in consultation with a physician to administer influenza and pneumococcal polysaccharide vaccines.

Standard MM.05.01.07
DMEPOS: The organization safely prepares medications.

MM.05.01.07, EP 2

DMEPOS: Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.

MM.05.01.07, EP 3
DMEPOS: During preparation, staff visually inspect the medication for particulates, discoloration, or other loss of integrity.

Standard MM.05.01.09
DMEPOS: Medications are labeled.
Note: This standard is applicable to all organizations that prepare and administer medications.

Rationale for Standard MM.05.01.09
DMEPOS: A label on every medication and medication container has long been a standard of practice by the pharmacy profession and is required by law and regulation. A standardized method to label medications and containers promotes medication safety.

MM.05.01.09, EP 1
DMEPOS: Medication containers are labeled whenever medications are prepared but not immediately administered.
Note 1: This element of performance does not apply to segregated pill boxes that store medications by day and time of day.
Note 2: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.
Note 3: This element of performance is also applicable to sample medications.

MM.05.01.09, EP 2
DMEPOS: Information on medication labels is displayed in a standardized format, in accordance with law and regulation and standards of practice.
Note: This element of performance is also applicable to sample medications.

MM.05.01.09, EP 3
DMEPOS: All medications prepared in the organization are correctly labeled with the following:
- Medication name, strength, and amount (if not apparent from the container)
Note: This is also applicable to sample medications.
- Expiration date when not used within 24 hours
- Expiration date and time when expiration occurs in less than 24 hours
- The date prepared and the diluent for all compounded intravenous admixtures and parenteral nutrition formulas

MM.05.01.09, EP 7
DMEPOS: When preparing individualized medications for multiple patients, the label also includes the following:
- The patient's name
- Directions for use and applicable accessory and cautionary instructions

MM.05.01.09, EP 10
DMEPOS: When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the following:
- The patient's name
- Directions for use and applicable accessory and cautionary instructions

Standard MM.05.01.17
DMEPOS: The organization follows a process to retrieve recalled or discontinued medications.

MM.05.01.17, EP 3

DMEPOS: For organizations that store or dispense medications: When a medication is recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA), the organization notifies the prescribers and those who dispense or administer the medication.
Note: This element of performance is also applicable to sample medications.

Standard MM.06.01.01
DMEPOS: The organization safely administers medications.

MM.06.01.01, EP 1
DMEPOS: Only authorized clinical staff administer medications. The organization defines, in writing, those who are authorized to administer medication, with or without supervision, in accordance with law and regulation.
Note: This does not prohibit self-administration of medications by patients, when indicated.

MM.06.01.01, EP 3
DMEPOS: Before administration, the individual administering the medication does the following:
- Verifies that the medication selected matches the medication order and product label
- Visually inspects the medication for particulates, discoloration, or other loss of integrity
- Verifies that the medication has not expired
- Verifies that no contraindications exist
- Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route
- Discusses any unresolved concerns about the medication with the patient's physician or other licensed practitioner, prescriber (if different from the patient's physician or other licensed practitioner), and/or staff involved with the patient's care, treatment, or services

MM.06.01.01, EP 9
DMEPOS: Before administering a new medication, the patient or family is informed about any potential for clinically significant adverse drug reactions or other concerns regarding administration of a new medication.

Standard MM.06.01.03
DMEPOS: Medications are safely and accurately administered by patients and families.
Note: The term "self-administered medication(s)" may refer to medications administered by a family member.

MM.06.01.03, EP 3
DMEPOS: The organization educates patients and families involved in self-administration about the following:
- Medication name, type, and reason for use
- How to administer medication, including process, time, frequency, route, and dose
- Anticipated actions and potential side effects of the medication administered
- Monitoring the effects of the medication

MM.06.01.03, EP 7
DMEPOS: The organization supervises patients and families until they determine the patient and family can safely and competently administer medications.

Standard MM.06.01.05
DMEPOS: The organization safely manages investigational medications.

Rationale for Standard MM.06.01.05
DMEPOS: Investigational medications can be of great help to the patient. In some cases, investigational medications may represent one of a few options in the patient's care plan. The organization contributes to the safety of patients participating in investigational or clinical medication studies by controlling and monitoring the use of these medications.
Note: For a discussion of patient rights regarding the use of investigational medications, see Standard RI.01.03.05.

MM.06.01.05, EP 1
DMEPOS: The organization follows a written process addressing the use of investigational medications that includes review, approval, supervision, and monitoring.

MM.06.01.05, EP 2
DMEPOS: If the organization operates a pharmacy, the written process for the use of investigational medications specifies that the pharmacy controls the storage, dispensing, labeling, and distribution of investigational medications.

MM.06.01.05, EP 3
DMEPOS: The written process for the use of investigational medications specifies that when a patient is involved in an investigational protocol that is independent of the organization, the organization evaluates the patient's continued participation in the protocol.

Standard MM.07.01.01
DMEPOS: The organization monitors patients to determine the effects of their medication(s).

MM.07.01.01, EP 1
DMEPOS: The organization monitors the patient's perception of side effects and the effectiveness of the patient's medication(s).
Note: This element of performance is also applicable to sample medications.

MM.07.01.01, EP 2
DMEPOS: The organization monitors the patient's response to medication(s) by taking into account clinical information from the patient record, relevant lab values, clinical response, and medication profile.
Note: This element of performance is also applicable to sample medications.

Standard MM.07.01.03
DMEPOS: The organization responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.

Rationale for Standard MM.07.01.03
DMEPOS: Adverse drug reactions and medication errors place patients at considerable risk. For safe, quality care, organizations must have systems in place to respond to and monitor a patient in the event of an adverse drug reaction or medication error.

MM.07.01.03, EP 1
DMEPOS: The organization follows a written process to respond to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.
Note: This element of performance is also applicable to sample medications.

MM.07.01.03, EP 2
DMEPOS: The organization follows a written process addressing prescriber notification in the event of an adverse drug event, significant adverse drug reaction, or medication error.
Note: This element of performance is also applicable to sample medications.

MM.07.01.03, EP 3
DMEPOS: The organization complies with internal and external reporting requirements for actual or potential adverse drug events, significant adverse drug reactions, and medication errors.
Note: This element of performance is also applicable to sample medications.

Standard MM.08.01.01

DMEPOS: The organization evaluates the effectiveness of its medication management processes.

MM.08.01.01, EP 1
DMEPOS: As part of its evaluation of the effectiveness of medication management, the organization does the following:
- Collects data on the performance of its medication management system
- Analyzes data on its medication management system
- Compares data over time to identify risk points, levels of performance, patterns, trends, and variations of its medication management system
Note: This element of performance is also applicable to sample medications.

MM.08.01.01, EP 5
DMEPOS: Based on analysis of its data, as well as review of the literature for new technologies and best practices, the organization identifies opportunities for improvement in its medication management processes.

MM.08.01.01, EP 6
DMEPOS: When opportunities are identified for improvement of the medication management system, the organization does the following:
- Takes action on improvement opportunities identified as priorities for its medication management system
- Evaluates its actions to confirm that they resulted in improvements
Note: This element of performance is also applicable to sample medications.

MM.08.01.01, EP 8
DMEPOS: The organization takes action when planned improvements for its medication management processes are either not achieved or not sustained.

National Patient Safety Goals

Goal 1
DMEPOS: Improve the accuracy of patient identification.

Standard NPSG.01.01.01
DMEPOS: Use at least two patient identifiers when providing care, treatment, or services.
Note: In the home care setting, patient identification is less prone to error than in other settings. At the first encounter, the requirement for two identifiers is appropriate; thereafter, and in any situation of continuing one-on-one care in which the licensed practitioner "knows" the patient, one of the identifiers can be facial recognition. In the home, the correct address is also confirmed. The patient’s confirmed address is an acceptable identifier when used in conjunction with another individual-specific identifier.

Rationale for Standard NPSG.01.01.01
DMEPOS: Wrong-patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual. Acceptable identifiers may be the individual’s name, an assigned identification number, telephone number, or other person-specific identifier.

NPSG.01.01.01, EP 1
DMEPOS: Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures.

NPSG.01.01.01, EP 2
DMEPOS: Label containers used for blood and other specimens in the presence of the patient.

Goal 7
DMEPOS: Reduce the risk of health care–associated infections.

Standard NPSG.07.01.01
DMEPOS: Comply 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.

Rationale for Standard NPSG.07.01.01
DMEPOS: According to the Centers for Disease Control and Prevention, each year, millions of people acquire an infection while receiving care, treatment, or services in a health care organization. Consequently, health care–associated infections (HAIs) are a patient safety issue affecting all types of health care organizations. One of the most important ways to address HAIs is by improving the hand hygiene of health care staff. Compliance with the World Health Organization (WHO) and/or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines will reduce the transmission of infectious agents by staff to patients, thereby decreasing the incidence of HAIs. To ensure compliance with this National Patient Safety Goal, an organization should assess its compliance with the CDC and/or WHO guidelines through a comprehensive program that provides a hand hygiene policy, fosters a culture of hand hygiene, monitors compliance, and provides feedback.

NPSG.07.01.01, EP 1
DMEPOS: Implement 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.

NPSG.07.01.01, EP 2
DMEPOS: Set goals for improving compliance with hand hygiene guidelines.

NPSG.07.01.01, EP 3
DMEPOS: Improve compliance with hand hygiene guidelines based on established goals.

Goal 9
DMEPOS: Reduce the risk of patient harm resulting from falls.

Standard NPSG.09.02.01
DMEPOS: Reduce the risk of falls.

Rationale for Standard NPSG.09.02.01
DMEPOS: Falls account for a significant portion of injuries in hospitalized patients, long term care residents, and home care recipients. In the context of the population it serves, the services it provides, and its environment of care, the organization should evaluate the patient's risk for falls and take action to reduce the risk of falling as well as the risk of injury, should a fall occur. The evaluation could include a patient's fall history; review of medications and alcohol consumption; gait and balance screening; assessment of walking aids, assistive technologies, and protective devices; and environmental assessments.

NPSG.09.02.01, EP 1
DMEPOS: Assess the patient's risk for falls.

NPSG.09.02.01, EP 2
DMEPOS: Implement interventions to reduce falls based on the patient's assessed risk.

NPSG.09.02.01, EP 3
DMEPOS: Educate staff on the fall reduction program in time frames determined by the organization.

NPSG.09.02.01, EP 4

DMEPOS: Educate the patient and, as needed, the family on any individualized fall reduction strategies.

Goal 15
DMEPOS: The organization identifies safety risks inherent in its patient population.

Standard NPSG.15.02.01
DMEPOS: Identify risks associated with home oxygen therapy such as home fires.

Rationale for Standard NPSG.15.02.01
DMEPOS: A critical aspect of safe patient care at home relates to the use of oxygen. Oxygen administration presents a high risk for fire due to the acceleration of flame that oxygen causes in the presence of flammable substances (such as upholstery and clothing) and open flames (such as candles, gas appliances, and smoking materials). Smoking is a major reason for burn incidents involving home medical oxygen therapy. Oxygen cylinders that are not safely stored create risks for fire and explosion; standards addressing storage of cylinders are included in the “Environment of Care” (EC) chapter.
This NPSG addresses the importance of a home oxygen assessment that identifies potential safety risks in the environment. Patients and families need to understand and modify behaviors that could lead to a serious safety event. For that reason, home care agencies that interact with their patients have a responsibility to reduce risk by assessing the environment and educating the patient and family. Issues to consider in both the home risk assessment and in patient and family education include whether or not the patient lives alone, the patient’s cognitive ability, and whether individuals smoke in the home.
An oxygen safety risk assessment should be conducted before starting oxygen therapy in the home and when home care services are initiated. However, when more than one organization provides services in the home, it is the responsibility of each organization to assess potential fire risks when its staff enters the home.

NPSG.15.02.01, EP 1
DMEPOS: Conduct a home oxygen safety risk assessment before starting oxygen therapy in the home and when home care services are initiated that addresses at least the following:
- Whether there are smoking materials in the home
- Whether or not the home has functioning smoke detectors
Note: Home care staff may ask the patient and family whether smoke detectors are functioning or may test the smoke detectors if they are accessible. However, testing smoke detectors is not required.
- Whether there are other fire safety risks in the home, such as the potential for open flames
Document the performance of the risk assessment. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5)

NPSG.15.02.01, EP 2
DMEPOS: Reevaluate potential fire risks at intervals established by the organization. Evidence of unsafe practices leading to potential risk is used to establish these intervals. Document the reevaluation of potential fire risks.

NPSG.15.02.01, EP 3
DMEPOS: Inform and educate the patient, family, and/or caregiver about the following:
- The findings of the safety risk assessment
- The causes of fire
- Fire risks for neighboring residences and buildings
- Precautions that can prevent fire-related injuries
- Recommendations to address the specific identified risk(s)
Document the provision of information and education. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5.)

NPSG.15.02.01, EP 4

DMEPOS: Assess the patient's, family's, and/or caregiver's level of comprehension of identified risks and compliance with suggested interventions during home visits. Document this assessment.

NPSG.15.02.01, EP 5
DMEPOS: Implement strategies to improve patient and/or family compliance with oxygen safety precautions when unsafe practices are observed in the home. This includes notifying the physician or other licensed practitioner ordering the oxygen. Document the implementation of strategies to address compliance.
Note: Other strategies to be considered include additional education, placing written reminders in specific locations, and exploring alternative living arrangements with the patient and family.

Provision of Care, Treatment, and Services

Overview
DMEPOS: The standards in the "Provision of Care, Treatment, and Services" (PC) chapter center around the integrated and cyclical process that allows care to be delivered according to patient needs and the organization's scope of services. This care process may occur between multiple organizations or it may be limited to the organization itself. The complexity of providing care, treatment, or services through this process often demands a collaborative, interdisciplinary approach and a mutual effort among those who work in the organization to coordinate care in a manner that is conducive to optimal patient outcomes, quality, and safety.

The provision of care, treatment, or services is composed of the following four core components of the care process:
1. Assessing patient needs
2. Planning care, treatment, or services
3. Providing care, treatment, or services
4. Coordinating care, treatment, or services

Within these core processes, care activities include the following:
- Providing access to levels of care and/or disciplines necessary to meet the patient's needs
- Interventions based on the plan of care, including the education or instruction of patients regarding their care, treatment, or services
- Coordinating care to promote continuity when patients are referred, discharged, or transferred

The activities are performed by a wide variety of staff. Therefore, communication, collaboration, and coordination are among the most important work habits that must be adopted so that care, treatment, or services are provided at the highest level.

About This Chapter
DMEPOS: The standards in this chapter are placed within a logical framework that demonstrates the continuum of care as a cyclical process that may occur over short or long periods of time and may be continual or episodic in nature. Therefore, the standards are organized to relate to the patient's experience from entry into the organization care process to discharge or transfer.

This chapter addresses the following:
- Accepting the patient for care, treatment or services
- Assessing and reassessing the patient
- Planning the patient's care
- Providing the patient with care, treatment, or services
- Coordinating the patient's care, treatment, or services
- Providing the patient with education
- Meeting the patient's need for continuing care, treatment, or services after discharge or transfer

Standard PC.01.01.01

DMEPOS: The organization accepts the patient for care, treatment, or services based on its ability to meet the patient's needs.

PC.01.01.01, EP 2
DMEPOS: The organization follows a written process for accepting a patient that addresses the following:
- Its ability to provide the care, treatment, or services required by the patient
- Criteria to determine the patient's eligibility for care, treatment, and services
- Procedures for accepting referrals

Introduction to Standard PC.01.02.01
DMEPOS: The goal of assessment is to determine the care, treatment, or services that will meet the patient's initial and continuing needs. Patient needs must be reassessed throughout the course of care, treatment, or services.

Identifying and delivering the right care, treatment, or services depends on the following three processes:
1. Collecting information about the patient's health history as well as physical, functional, and psychosocial status
2. Analyzing the information in order to understand the patient's needs for care, treatment, or services
3. Making care, treatment, or service decisions based on the analysis of information collected

The depth and frequency of assessment depends on a number of factors, including the patient's needs, program goals, and the care, treatment, or services provided. Assessment activities may vary between settings, as defined by the organization's leaders.

Information gathered at the patient's first contact may indicate the need for more data or a more intensive assessment. At a minimum, the need for further assessment is determined by the care, treatment, or services sought; the patient's presenting condition(s); and whether the patient agrees to the recommended care, treatment, or services.

Standard PC.01.02.01
DMEPOS: The organization assesses and reassesses its patients.

PC.01.02.01, EP 1
DMEPOS: The organization defines, in writing, the scope and content of screening, assessment, and reassessment information it collects. Patient information is collected according to these requirements.
Note: In defining the scope and content of the information it collects, the organization may want to consider information that it can obtain, with the patient's consent, from the patient's family and the patient's other care providers, as well as information conveyed on any medical jewelry.

PC.01.02.01, EP 2
DMEPOS: The organization defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed.
Note: Examples of criteria could include those that identify when a nutritional, functional, or pain assessment should be performed for patients who are at risk.

PC.01.02.01, EP 5
DMEPOS: Based on the patient's condition and the care, treatment, or services it provides, the organization defines, in writing, which of the following information it collects in the patient's assessment and reassessment:
- Pertinent diagnoses
- Pertinent physical findings
- Pertinent medical history
- Functional status
- Psychosocial status
- Cultural or religious practices that may affect care

- Care the family or support system is capable of and willing to provide
- Educational needs, including the abilities, motivation, and readiness to learn
- Barriers and safety hazards in the home environment
- Any other relevant information that may affect the patient's goals

PC.01.02.01, EP 9
DMEPOS: The home medical equipment or rehabilitation technology service's written definition of data and information collected during assessment and reassessment includes any medical equipment the patient uses.

PC.01.02.01, EP 29
DMEPOS: For custom orthotics and prosthetics services: The organization performs an in-person diagnosis-specific functional clinical examination for the use of custom orthotics and prosthetics.
Note: Such an exam could include sensory function, range of motion, joint stability, skin condition (integrity, color, temperature), presence of edema and wounds, vascularity, pain, manual muscle testing, compliance, cognitive ability, and medical history.

PC.01.02.01, EP 30
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization evaluates seating, positioning, and specialty assistive technology to verify that they meet the beneficiary's needs.

PC.01.02.01, EP 31
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization assesses the beneficiary's need for and use of custom orthotics or prosthetics, previous use of a custom orthotic or prosthetic, results of diagnostic evaluations, and beneficiary expectations.

PC.01.02.01, EP 32
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization determines the appropriate custom orthotic or prosthetic and specifications. The determination is based on the therapeutic benefits the beneficiary hopes to achieve and on the strength, durability, and function needed by the beneficiary for the custom orthotic or prosthetic being considered.

Standard PC.01.02.03
DMEPOS: The organization assesses and reassesses the patient and the patient's condition according to defined time frames.

PC.01.02.03, EP 1
DMEPOS: The organization conducts the patient's initial assessment in accordance with written time frames it defines and law and regulation.
(See also RC.01.03.01, EP 2)

PC.01.02.03, EP 3
DMEPOS: Each patient is reassessed as necessary based on their plan for care or changes in their condition.
Note: Reassessments may also be based on the patient's diagnosis; desire for care, treatment, or services; response to previous care, treatment, or services; and/or the patient's setting requirements.

Introduction to Standard PC.01.02.09
DMEPOS: People who are victims of abuse or neglect may come to an organization for a variety of reasons. Sometimes the reason a patient seeks health care is not connected to their experience with abuse or neglect; however, by assessing patients who may be possible victims of abuse or neglect, health care organizations fulfill an important role in helping to protect patients.

Standard PC.01.02.09

DMEPOS: The organization assesses the patient who may be a victim of possible abuse and neglect or exploitation.

PC.01.02.09, EP 1
DMEPOS: The organization has written criteria to identify those patients who may be victims of physical assault, sexual assault, sexual molestation, domestic abuse, or elder or child abuse, neglect, and exploitation. The patient is evaluated at the time of contact.
Note: Criteria can be based on age, sex, and circumstance.
(See also RI.01.06.03, EP 3)

PC.01.02.09, EP 2
DMEPOS: To assist with referrals of possible victims of abuse, neglect, and exploitation, the organization maintains a list of private and public community agencies that can provide or arrange for assessment and care.

PC.01.02.09, EP 3
DMEPOS: The organization educates staff about how to recognize signs of possible abuse, neglect, and exploitation and about their roles in follow-up.

PC.01.02.09, EP 6
DMEPOS: The organization internally reports cases of possible abuse, neglect, and exploitation.
(See also RI.01.06.03, EP 3)

PC.01.02.09, EP 7
DMEPOS: The organization reports cases of possible abuse, neglect, and exploitation to external agencies, in accordance with law and regulation.
(See also RI.01.06.03, EP 3)

Introduction to Standard PC.01.03.01
DMEPOS: Planning for care, treatment, or services is individualized to meet the patient's unique needs. The first step in the process includes creating an initial plan for care, treatment, or services that is appropriate to the patient's specific assessed needs. To continue to meet the patient's unique needs, the plan is maintained and revised based on the patient's response. The plan may be modified or terminated based on reassessment; the patient's need for further care, treatment, or services; or the patient's achievement of goals. The modification of the plan for care, treatment, or services may result in planning for the patient's transfer to another setting or discharge.

Standard PC.01.03.01
DMEPOS: The organization plans the patient's care.

PC.01.03.01, EP 1
DMEPOS: The organization plans the patient's care, treatment, or services based on needs identified by the patient's assessment.
Note: The patient's strengths are considered along with their identified needs.

PC.01.03.01, EP 5
DMEPOS: The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.

PC.01.03.01, EP 11
DMEPOS: For custom orthotics and prosthetics services: The organization establishes goals and expected outcomes for the patient.
Note: Examples of goals or outcomes include reducing pain, increasing comfort, enhancing function and independence, providing joint stability, preventing deformity, increasing range of motion, addressing cosmetic issues, and promoting healing.

PC.01.03.01, EP 22
DMEPOS: Based on the goals established in the patient's plan of care, staff evaluate the patient's progress.

PC.01.03.01, EP 23
DMEPOS: The organization revises plans and goals for care, treatment, or services based on the patient's needs.

PC.01.03.01, EP 29
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization, in collaboration with the prescribing physician or other licensed practitioner, reviews the patient's record and incorporates information related to the patient's condition(s) or to the actual equipment, supplies, or services provided.

Standard PC.02.01.01
DMEPOS: The organization provides care, treatment, or services for each patient.

PC.02.01.01, EP 1
DMEPOS: The organization provides the patient with care, treatment, or services according to the patient's individualized plan of care.

PC.02.01.01, EP 2
DMEPOS: Staff provide care, treatment, or services in accordance with professional standards of practice, law, and regulation.

Standard PC.02.01.03
DMEPOS: The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.

PC.02.01.03, EP 1
DMEPOS: Prior to providing care, the organization obtains or renews orders (verbal or written) from a physician or allowed practitioner in accordance with professional standards of practice and law and regulation.

PC.02.01.03, EP 3
DMEPOS: The organization consults with the prescribing physician or other licensed practitioner as needed to confirm their order(s).

PC.02.01.03, EP 4
DMEPOS: The organization reviews orders and prescriptions for appropriateness and accuracy before providing care, treatment, or services.

PC.02.01.03, EP 5
DMEPOS: Prior to implementing an order or prescription, staff obtain answers to any questions that exist.

PC.02.01.03, EP 6
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization recommends any necessary changes, refinements, or additional evaluations to the prescribed equipment, supplies, and services.

PC.02.01.03, EP 7
DMEPOS: The organization provides care, treatment, or services using the most recent patient order(s).

PC.02.01.03, EP 10

DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization provides all medical equipment and supplies to serve a medical purpose covered under the Medicare program and may require the physician or other licensed practitioner to collaborate and coordinate clinical services with other health care professionals (for example, providers of orthotics and prosthetics; occupational, physical, and respiratory therapists; and pedorthists).

PC.02.01.03, EP 11
DMEPOS: The organization confirms that the item delivered to the patient is consistent with the prescribing physician's or other licensed practitioner's order.

PC.02.01.03, EP 12
DMEPOS: For custom orthotics and prosthetics services: The organization confirms that the implementation plan is consistent with the prescribing physician's or other licensed practitioner's dispensing order and/or the written plan of care and that it is in accordance with Medicare rules.

PC.02.01.03, EP 20
DMEPOS: Before taking action on a verbal order or verbal report of a critical test result, staff uses a record and "read back" process to verify the information.

Standard PC.02.01.05
DMEPOS: The organization provides interdisciplinary, collaborative care, treatment, or services.

Rationale for Standard PC.02.01.05
DMEPOS: The focus of this standard is on disciplines internal to the organization, not those external to it. The organization may communicate with and take steps to collaborate with providers outside of the organization, understanding that for some of these providers the organization will have little control.

PC.02.01.05, EP 1
DMEPOS: All disciplines that provide care, treatment or services to the patient collaborate in the care of the patient and coordinate their efforts to support the goals outlined in the plan of care.

PC.02.01.05, EP 3
DMEPOS: For complex rehabilitation and assistive technology services: The organization coordinates services with the prescribing physician or other licensed practitioner to conduct face-to-face evaluations of the patient in a setting conducive to the patient's condition.

PC.02.01.05, EP 7
DMEPOS: The organization defines the time frames for providing information about the patient to the responsible physician or other licensed practitioner.

PC.02.01.05, EP 8
DMEPOS: The organization informs the physician or other licensed practitioner when there is an unanticipated change in the patient's condition or the patient is discharged or transferred.

PC.02.01.05, EP 9
DMEPOS: The organization provides information about the patient to the responsible physician or other licensed practitioner within its defined time frames.

PC.02.01.05, EP 17
DMEPOS: When the organization cannot provide equipment, items, or services that have been ordered for a patient, it notifies the prescribing licensed practitioner within five calendar days.
Note: In rare instances, there may be customized items for which the organization was not notified by the vendor

within the five day time frame that the item cannot be provided as specified. The organization is still responsible for notifying the prescribing licensed practitioner, even if it is outside the five day time frame.

PC.02.01.05, EP 19
DMEPOS: For custom orthotics and prosthetics services: The organization communicates to the prescribing physician or other licensed practitioner the recommended treatment plan and any optional plans, including disclosure of potential risks or benefits involved.

PC.02.01.05, EP 21
DMEPOS: For complex rehabilitation and assistive technology services: The organization includes information from other health care team members, such as physical therapists, occupational therapists, and the physician or other licensed practitioner, in the delivery of its products.

PC.02.01.05, EP 24
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization solicits feedback from the physician or other licensed practitioner, as necessary, to determine the effectiveness of the device, prosthetic, orthotic, or shoe provided to the patient.

Introduction to Standard PC.02.02.01
DMEPOS: Coordination of care is recognized as a major challenge in the safe delivery of care. The rise of chronic illness means that a patient's care, treatment, or services likely include an array of providers in a variety of health care settings, including the patient's home.

The Institute of Medicine's report "Crossing the Quality Chasm—A New Health System for the 21st Century" notes that "because of the special vulnerability that accompanies illness or injury, coordination of care takes on special importance. Many patients depend on those who provide care to coordinate services—whether tests, consultations, or procedures—to ensure that accurate and timely information reaches those who need it at the appropriate time." Health care providers and organizations need to work together to coordinate their efforts in order to provide safe, quality care.

Standard PC.02.02.01
DMEPOS: The organization coordinates the patient's care, treatment, or services based on the patient's needs.

PC.02.02.01, EP 1
DMEPOS: The organization maintains continuity in the way it shares and receives patient information with other providers of care, treatment, or services.

PC.02.02.01, EP 2
DMEPOS: The organization's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information.
Note: Such information may include the patient's condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.

PC.02.02.01, EP 3
DMEPOS: The organization coordinates the patient's care, treatment, or services within a time frame that meets the patient's needs.
Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, or services.

PC.02.02.01, EP 10
DMEPOS: When the organization uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, or services.

PC.02.02.01, EP 13
DMEPOS: For custom orthotics and prosthetics services: The organization refers the patient to a physician or other licensed practitioner for treatments or interventions that are beyond the organization's scope of practice.

PC.02.02.01, EP 16
DMEPOS: The organization provides follow-up to the patient consistent with the services or equipment provided and recommendations from the physician or other licensed practitioner or health care team.

Standard PC.02.02.03
DMEPOS: The organization makes food and nutrition products available to its patients.

PC.02.02.03, EP 11
DMEPOS: The organization stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.

Standard PC.02.02.05
DMEPOS: The organization provides the patient with access to care, treatment, or services during nonbusiness hours.

PC.02.02.05, EP 2
DMEPOS: For providers of respiratory equipment, supplies, and services: The organization provides respiratory equipment and services 24 hours a day, 7 days a week, as needed by the patient.

PC.02.02.05, EP 3
DMEPOS: The organization provides the patient with information about whom to contact for assistance when the organization is closed.

PC.02.02.05, EP 4
DMEPOS: The organization provides the patient with information about normal business hours and how to contact the organization for assistance.

Introduction to Standard PC.02.03.01
DMEPOS: Chronic disease is on the rise, and patients are becoming increasingly responsible for managing their own health at home. Acute care patients are often discharged or released from health care settings with instructions for self-care that can range from changing bandages to caring for drains to home infusion. Consequently, patient education continues to take on greater importance in influencing the patient's outcome and in promoting healthy behaviors. To equip the patient to provide for their health care needs, the organization needs to assess the patient's learning needs and use methods of education and instruction that are matched to the patient's level of understanding.

Standard PC.02.03.01
DMEPOS: The organization provides patient education and training based on each patient's needs and abilities.

PC.02.03.01, EP 1
DMEPOS: The organization assesses the patient's learning needs.
Note: This assessment could include the patient's cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.

PC.02.03.01, EP 2
DMEPOS: The organization tailors education and training materials and techniques to the needs of individual patients or caregivers.

PC.02.03.01, EP 3

DMEPOS: The organization tailors education and training materials and techniques to accommodate the patient's or caregiver's learning preferences and language.
(See also RI.01.01.03, EP 1)

PC.02.03.01, EP 4
DMEPOS: The organization provides education and training to the patient based on the patient's assessed needs.

PC.02.03.01, EP 5
DMEPOS: The organization coordinates the patient education and training provided by all disciplines involved in the patient's care, treatment, or services.

PC.02.03.01, EP 10
DMEPOS: Based on the patient's condition and assessed needs, the education and training provided to the patient by the organization include the following:
- An explanation of the plan for care, treatment, or services
- Procedures to follow if care, treatment, or services are disrupted by a natural disaster or an emergency
- Basic health practices and safety
- Information on the safe and effective use of medications
- Nutrition interventions (for example, supplements) and modified diets
- Infection prevention and control
- Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
- Information on personal hygiene and grooming
- Information on oral health
- Basic physical and structural home safety
- Information on the safe and effective use of medical equipment or supplies provided by the organization
- Information on the storage, handling, and access to medical gases and supplies
- Information on the identification, handling, and safe disposal of hazardous medications and infectious wastes
- Habilitation or rehabilitation techniques to help the patient reach maximum independence
- Information on the use of restraint

PC.02.03.01, EP 11
DMEPOS: The organization provides written and verbal instructions to the patient and/or caregiver about the equipment, supplies, and services provided. The instructions cover the following topics, as appropriate to the equipment, supplies, or services:
- Use of the equipment or supplies
- Maintenance of the equipment
- Potential hazards and safety considerations related to the equipment, supplies, or services
Note: Written instructions may include pictures to illustrate the information being provided.

PC.02.03.01, EP 12
DMEPOS: The organization provides or coordinates the provision of instructions related to setup, features, routine use, troubleshooting, cleaning, and maintenance of equipment or supplies it provides.
Note: Setup includes preparation of formulas.

PC.02.03.01, EP 13
DMEPOS: The organization provides information and instructions about infection control issues related to the equipment and supplies it provides.

PC.02.03.01, EP 14
DMEPOS: For mail-order supplies or equipment: The organization verifies that the patient has received training and written instructions with the initial delivery of the equipment or supplies.

PC.02.03.01, EP 15
DMEPOS: The organization provides education and training that is tailored to the risks, complexity, and manufacturers' instructions or specifications for the items being provided.

PC.02.03.01, EP 16
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization provides education and training about respiratory equipment, supplies, and services to patients or caregivers. This training and instruction is consistent with the following current American Association for Respiratory Care Practice Guidelines:
- Long Term Invasive Mechanical Ventilation in the Home
- Oxygen Therapy in the Home or Extended Care Facility
- Intermittent Positive Pressure Breathing
- Providing Patient and Caregiver Training
- Suctioning of the Patient in the Home

PC.02.03.01, EP 17
DMEPOS: For custom orthotics and prosthetics services: The organization provides the following instructions to the patient or caregiver:
- Use, cleaning, and maintenance instructions
- The procedure for repairing, replacing, or adjusting the items, including any risks involved and the estimated time for the repair, replacement, or adjustment process
- How to don and doff the custom orthotic or prosthetic, including how to adjust closures for proper fit
- How to inspect the skin for pressure areas, redness, irritation, skin breakdown, pain, or edema
- How and when to use an interface, such as stockinettes, socks, gloves, or shoes, to accommodate the custom orthotic or prosthetic
- How to report any problems related to the custom orthotic or prosthetic to the supplier or prescribing physician or other licensed practitioner

Note: Such problems include changes in skin condition, increased pain, increased edema, wound concerns, changes in general health, height and/or weight, and intolerance to wearing the custom orthotic or prosthetic.
- How to schedule follow-up appointments as necessary
- How to establish a wear schedule based on tolerance of the custom orthotic or prosthetic

PC.02.03.01, EP 18
DMEPOS: For custom orthotics and prosthetics services: The organization provides instructions to the patient or caregiver about the necessary supplies (for example, adhesives, solvents, and lubricants) needed to attach, maintain, and clean the items. The organization also provides information about how to obtain more of the necessary supplies.

PC.02.03.01, EP 25
DMEPOS: The organization evaluates the patient’s understanding of the education and training it provided.

PC.02.03.01, EP 27
DMEPOS: The organization provides the patient education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.

Standard PC.04.01.01
DMEPOS: The organization follows a process that addresses the patient’s need for continuing care, treatment, or services after discharge or transfer.

PC.04.01.01, EP 1
DMEPOS: The organization describes the following:
- The reason(s) for and conditions under which the patient is discharged or transferred

- The method for shifting responsibility for a patient’s care from one licensed practitioner, organization, program, or service to another

PC.04.01.01, EP 10
DMEPOS: The organization’s staff has access to information about community resources that are relevant to the care, treatment, or services it provides.

PC.04.01.01, EP 15
DMEPOS: The organization coordinates the patient’s discharge or transfer with the patient, the patient’s family, the physician or other licensed practitioner primarily responsible for the patient, and the organization's staff.

Standard PC.04.01.03
DMEPOS: The organization discharges or transfers the patient based on the patient's assessed needs and the organization’s ability to meet those needs.

PC.04.01.03, EP 1
DMEPOS: The organization begins planning for the patient’s discharge early in the patient’s care, treatment, or services.

PC.04.01.03, EP 2
DMEPOS: The organization identifies any needs the patient may have for psychosocial or physical care, treatment, or services after discharge or transfer.

PC.04.01.03, EP 3
DMEPOS: The patient, the patient’s family or caregivers, physicians or other licensed practitioners, and staff involved in the patient’s care, treatment, or services participate in planning the patient’s discharge or transfer.

PC.04.01.03, EP 4
DMEPOS: Prior to discharge, the organization arranges or assists in arranging the services required by the patient after discharge in order to meet the patient's ongoing needs for care and services.

Standard PC.04.01.05
DMEPOS: Before the organization discharges or transfers a patient, it informs and educates the patient about their follow-up care, treatment, or services.

PC.04.01.05, EP 1
DMEPOS: When the organization determines the patient’s discharge or transfer needs, it promptly shares this information with the patient.

PC.04.01.05, EP 2
DMEPOS: Before the patient is discharged, the organization informs the patient of the kinds of continuing care, treatment, or services the patient will need.

PC.04.01.05, EP 7
DMEPOS: The organization educates the patient about how to obtain any continuing care, treatment, or services the patient will need.

Standard PC.04.02.01
DMEPOS: When a patient is discharged or transferred, the organization gives information about the care, treatment, or services provided to the patient to other service providers who will provide the patient with care, treatment, or services.

PC.04.02.01, EP 1
DMEPOS: At the time of the patient's discharge or transfer, the organization informs other service providers who will provide care, treatment, or services to the patient about the following:
- The reason for the patient's discharge or transfer
- A summary of care, treatment, or services it provided to the patient
- The patient's progress toward goals
- A list of community resources or referrals made or provided to the patient

PC.04.02.01, EP 3
DMEPOS: The organization provides a written discharge summary to the patient's physician or other licensed practitioner in accordance with law and regulation.

Performance Improvement

Overview
DMEPOS: All organizations want better patient outcomes and, therefore, are concerned about improving the safety and quality of the care, treatment, or services they provide. The best way to achieve better care is by first measuring the performance of processes that support care and then using that data to make improvements. The standards in this chapter stress the importance of using data to inform positive change.

About This Chapter
DMEPOS: The standards in this chapter address the fundamental principles of performance improvement: collecting data, analyzing data, and taking action to improve and monitor performance. Leaders have ultimate responsibility for performance improvement. They set performance improvement priorities and provide the resources needed to achieve improvement. They make sure that all individuals who work in the organization participate in performance improvement activities. The leaders' responsibilities are more fully described in the "Leadership" (LD) chapter. (Standards LD.03.01.01 through LD.03.06.01 describe the management of important organizationwide systems that support safety and quality. Standard LD.03.07.01 addresses the need for leaders to establish performance improvement priorities.)

Collecting data is the foundation of performance improvement (see Standard IM.01.01.01 addressing the planning of managing information, and Standard IM.02.02.03, regarding retrieving, disseminating, and transmitting health information in usable formats). Based on its setting, scope, and services, the organization selects measures that are meaningful to the organization and that address the needs of the patients it serves. In addition, Joint Commission has identified important processes (see Standard PI.01.01.01) that should always be measured because they involve risk and can harm patients.

Regardless of how much data the organization collects, data are not useful if not analyzed. Analysis identifies trends, patterns, and performance levels that suggest opportunities for improvement. The organization can then make improvements based on the analysis. Of course, there is always the chance that analysis may reveal that more opportunities for improvement exist than an organization can manage at one time. In this case, leaders need to set priorities for improvement.

After a change has been made, the organization monitors that change by collecting and analyzing data to make sure the desired improvement is achieved and sustained. Organizations should identify the results that will signify sustained improvement. If the improvement does not meet expectations, the organization makes additional changes, and the cycle starts again. These principles of performance improvement also apply whenever the organization wants to design new processes, such as a new patient care service or an information management system (see Standard LD.03.08.01).

Introduction to Standard PI.01.01.01
DMEPOS: Data provide organizations with important information that can be used in a variety of ways. Collecting and analyzing data on performance, outcomes, and other activities can help an organization improve its ability to provide

quality care, treatment, or services. The organization can collect data from many areas, including internal data obtained from staff, patients, records, and observations. Data are also available from quality control, risk management activities, and research studies. Other valuable data can be obtained from external sources, such as regulators, insurers, and community. Joint Commission has identified important areas that should be measured regularly. In addition, the organization should establish data priorities particular to its needs.

Organizations should proactively seek to identify and reduce risks to the safety of patients by examining high-risk or problem-prone processes related to care, treatment, or services. In most home care settings the patient is not continuously monitored by the organization; therefore, the patient and the patient's family are important partners in improving patient safety. It is critical that the patient and their family are provided with sufficient and appropriate information about the risks related to the patient's condition or the care or services provided, instructions on minimizing these risks, and the consequences of not following such risk-reduction instructions.

Note: The organization also collects data on evaluation and improvement of conditions in the environment, infection control, and the medication management system. Standards addressing this data collection are located in the "Environment of Care" (EC), "Infection Prevention and Control" (IC), and "Medication Management" (MM) chapters.

Standard PI.01.01.01
DMEPOS: The organization collects data to monitor its performance.

PI.01.01.01, EP 2
DMEPOS: The organization collects data on the following: Performance improvement priorities identified by leaders.

PI.01.01.01, EP 12
DMEPOS: The organization collects data on the following: Significant medication errors.

PI.01.01.01, EP 13
DMEPOS: The organization collects data on the following: Significant adverse drug reactions.

PI.01.01.01, EP 14
DMEPOS: The organization collects data on the following: Patient perception of the safety and quality of care, treatment, or services delivered by the organization.

PI.01.01.01, EP 15
DMEPOS: The organization collects data on the following:
- Patient satisfaction with and complaints about products and services
- Timeliness of response to patient questions, problems, and concerns
- Impact of the organization's business practices on the adequacy of patient access to equipment, items, services, and information
- Adverse events involving patients due to inadequate or malfunctioning equipment, supplies, or services (for example, injuries, accidents, signs and symptoms of infection, and hospitalizations)

PI.01.01.01, EP 16
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization collects data on the following: The frequency of billing and coding errors.

PI.01.01.01, EP 25
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization seeks input from employees, beneficiaries, and referral sources when assessing the quality of its operations and services.

Standard PI.02.01.01
DMEPOS: The organization has a performance improvement plan.

Rationale for Standard PI.02.01.01
DMEPOS: Planning is essential to achieving and sustaining improved performance. Leaders who monitor data related to organizational processes and outcomes have a better awareness of how well they are performing and where opportunities for improvement exist. When leaders identify the processes and outcomes that will be the focus for improvement, a detailed plan will communicate to staff the goals, expectations, data to collect, and timelines for activity. This detailed plan provides structure and focus for both leaders and staff that will lead to meaningful and sustainable change.

The regularity and visibility of leadership review and updates to the plan affirm the commitment being made to quality and improvement throughout the organization. Leaders can use this opportunity to recognize staff achievement of successful changes and identify new priorities to include in the next round of planning. The message this sends is one that ongoing attention and vigilance at all levels of the organization are critical in the quest for health care high reliability.

PI.02.01.01, EP 1
DMEPOS: Performance improvement priorities established by organization leaders are described in a written plan that includes the following:
- The defined process(es) needing improvement, along with any stakeholder (for example, patient, staff, regulatory) requirements, project goals, and improvement activities
- Method(s) for measuring performance of the process(es) identified for improvement
- Analysis method(s) for identifying causes of variation and poor performance in the process(es)
- Methods implemented to address process deficiencies and improve performance
- Methods for monitoring and sustaining the improved process(es)

PI.02.01.01, EP 2
DMEPOS: Leaders review the plan for addressing performance improvement priorities at least annually and updates it to reflect any changes in strategic priorities and in response to changes in the internal or external environment.

Introduction to Standard PI.03.01.01
DMEPOS: When data are collected, they are analyzed using statistical tools and techniques. When the organization analyzes data over time, it transforms raw data into useful information. Analysis of data from internal sources allows the organization to identify patterns and trends and monitor its performance. The organization may also have access to external databases that allow it to compare its performance with other organizations on a specific topic, such as a procedure or outcome.

Standard PI.03.01.01
DMEPOS: The organization compiles and analyzes data.

PI.03.01.01, EP 4
DMEPOS: The organization analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.

PI.03.01.01, EP 8
DMEPOS: The organization uses the results of data analysis to identify improvement opportunities.

Standard PI.04.01.01
DMEPOS: The organization improves performance.

Rationale for Standard PI.04.01.01
DMEPOS: Data have been collected, monitoring is underway, and data analysis has revealed an opportunity for improvement. Some opportunities are resolved with minimal work and immediate acceptance, but many are more

complex, involve and impact more people, and require more careful efforts to achieve improvement and make it last. Tested and proven improvement tools and methodologies can make the difference between an actual improvement with lasting change versus a quick fix that is just as quickly forgotten. Knowing that highly reliable processes provide for a zero-harm environment for patients, organizations must explore available tools and methodologies and determine what will best facilitate and sustain their improvement successes.

PI.04.01.01, EP 2
DMEPOS: The organization acts on improvement priorities.

PI.04.01.01, EP 3
DMEPOS: The organization uses improvement tools or methodologies to improve its performance.

PI.04.01.01, EP 4
DMEPOS: The organization evaluates actions to confirm that they resulted in improvements.

PI.04.01.01, EP 5
DMEPOS: The organization acts when it does not achieve or sustain planned improvements.

Record of Care, Treatment, and Services

Overview
DMEPOS: The “Record of Care, Treatment, and Services” (RC) chapter contains a wealth of information about the components of a complete patient record. A highly detailed document when seen in its entirety, the patient record comprises all data and information gathered about a patient from the moment they begin receiving services to the moment of discharge or transfer. As such, the patient record functions not only as a historical record of a patient’s episode(s) of care but also as a method of communication between staff that can facilitate the continuity of care and aid in clinical decision making.

Whether the organization keeps paper records, electronic records, or both, the contents of the record remain the same. Special care should be taken, however, by organizations that are transitioning from paper to electronic systems, as the period of transition can present increased opportunity for errors in recordkeeping that can affect the delivery of safe quality care.

About This Chapter
DMEPOS: Within this chapter is a comprehensive set of requirements for compiling and maintaining the patient record. The separate components of a complete patient record are listed and arranged within common groups (demographic, clinical, and additional information). This chapter also contains documentation requirements for screenings, assessments, and reassessments; the care, treatment, or services provided; and discharge. The standards provide a structure that guides the compilation, completion, authentication, retention, and release of records.

Standard RC.01.01.01
DMEPOS: The organization maintains complete and accurate patient records.

RC.01.01.01, EP 1
DMEPOS: The organization defines the components of a complete patient record.

RC.01.01.01, EP 5
DMEPOS: The patient record includes the following:
- Information needed to support the patient's diagnosis and condition
- Information needed to justify the patient’s care, treatment, or services
- Information that documents the course and result of the patient's care, treatment, or services

- Information about the patient's care, treatment, or services that promotes continuity of care among providers
- Information that documents the patient's response to care, treatment, or services provided

RC.01.01.01, EP 7
DMEPOS: All entries in the patient record are dated.

RC.01.01.01, EP 10
DMEPOS: The organization maintains accurate, pertinent, and accessible patient records, in accordance with law and regulation.

Standard RC.01.02.01
DMEPOS: Entries in the patient record are authenticated.

RC.01.02.01, EP 1
DMEPOS: Only authorized individuals make entries in the patient record.

RC.01.02.01, EP 2
DMEPOS: The organization defines the types of entries in the patient record made by licensed practitioners that require countersigning, in accordance with law and regulation.

RC.01.02.01, EP 3
DMEPOS: The author of each patient record entry is identified in the patient record.

RC.01.02.01, EP 4
DMEPOS: Entries in the patient record are authenticated by the author. Information introduced into the patient record through transcription or dictation is authenticated by the author.
Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. The Centers for Medicare & Medicaid Services (CMS) permits the use of rubber-stamp signatures in accordance with the Rehabilitation Act of 1973 for authors with a physical disability who can provide proof of their inability to sign their signature due to a disability.
Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for physician or allowed practitioner verbal orders are dated when required by law or regulation or organization policy. For electronic records, electronic signatures will be date-stamped.

Standard RC.01.03.01
DMEPOS: Documentation in the patient record is entered in a timely manner.

RC.01.03.01, EP 1
DMEPOS: The organization defines the time frame for completion of the patient record.

RC.01.03.01, EP 2
DMEPOS: The organization documents entries into the patient's record within its defined time frames.
(See also PC.01.02.03, EP 1)

Standard RC.01.04.01
DMEPOS: The organization audits its patient records.

RC.01.04.01, EP 1
DMEPOS: According to a time frame it defines, the organization reviews its patient records to confirm that the required information is present, accurate, legible, authenticated, and completed on time.

Standard RC.01.05.01

DMEPOS: The organization retains its patient records.

RC.01.05.01, EP 1
DMEPOS: The retention time of the patient record is determined by its use and organization policy, in accordance with law and regulation.

Standard RC.02.01.01
DMEPOS: The patient record contains information that reflects the patient's care, treatment, or services.

RC.02.01.01, EP 1
DMEPOS: The patient record contains the following demographic information:
- The patient’s name, address, phone number, and date of birth and the name and phone number of any legally authorized representative
- The patient’s sex
- The patient’s language and communication needs
- The name and telephone number of the person to be contacted in the event of emergency or death

RC.02.01.01, EP 2
DMEPOS: The patient record contains the following clinical information:
- Any medications administered, including dose
- Any activity restrictions
- Any changes in the patient's condition
- Any summaries of the patient's care, treatment, or services furnished to the patient’s physician or allowed practitioner
- The patient's medical history
- Any allergies to medications
- Any adverse drug reactions
- The patient's functional status
- Any diet information or any dietary restrictions
- Diagnostic and therapeutic tests, procedures, and treatments, and their results
- Any specific notes on care, treatment, or services
- The patient's response to care, treatment, or services
- Any assessments relevant to care, treatment, or services
- Physician or allowed practitioner orders
- Any information required by organization policy, in accordance with law and regulation
- A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services
- The plan(s) of care
- For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner.

RC.02.01.01, EP 4
DMEPOS: When applicable to the patient’s care, treatment, or services, the organization documents the following additional information:
- Informed consent, as required by organization policy
- Any wishes the patient has regarding advance directives
- Any medical equipment either provided by the organization or used for the patient's care, treatment, or services
- Any documents that record the suitability of the patient's home for, or the adaptation of the patient's home to, the care, treatment, or services ordered
- Any safety measures employed to protect the patient from harm
- Any education provided to the patient and their family

- Any communication with the patient's physician or other licensed practitioner(s)
- Any names of individuals and organizations involved in the patient's care, treatment, or services
- Any information received about the patient from transferring organizations
- Any information that is provided to a receiving organization when a patient is transferred
- Any patient referrals made to internal and external health care professionals, including community agencies
- Any communication with the patient

RC.02.01.01, EP 14
DMEPOS: The organization documents in the patient record that the patient received training and instructions on the use of items supplied by mail order at the time of their initial delivery.

RC.02.01.01, EP 15
DMEPOS: For suppliers of complex rehabilitation and assistive technology services: The organization documents in the patient record all information obtained during the assessment.

RC.02.01.01, EP 16
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization collects pre-treatment photographic documentation when needed for custom orthotics and prosthetics to be provided to the beneficiary.

RC.02.01.01, EP 20
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization documents in the patient record the make and model or any other identifier of the noncustom equipment provided.

RC.02.01.01, EP 21
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization documents in the patient record the evaluation of the seating, positioning, and specialty assistive technology to be provided to the beneficiary.

Standard RC.02.03.07
DMEPOS: Qualified staff receive and record verbal orders.

RC.02.03.07, EP 2
DMEPOS: Only authorized staff receive and record verbal orders.

Rights and Responsibilities of the Individual

Overview
DMEPOS: When the organization recognizes and respects patient rights, it is providing an important aspect of care that has been shown to encourage patients to become more informed and involved in their care. These empowered patients ask questions and develop better relationships with their caregivers. This acknowledgement of patient rights also helps patients feel supported by the organization and those people directly involved in their care, treatment, or services. In a climate of respect and trust, communication is enhanced, and issues that could lead to problems in safety or quality can be prevented or addressed.

Recognizing and respecting patient rights are, however, only part of the story. Patients also have the obligation to take on certain responsibilities. The organization defines these responsibilities and then relays them to the patient. When patients understand and accept their responsibilities, the concept of the patient as a partner in care becomes a dynamic component of the patient’s episode of care.

In summary, the standards in this chapter address the following processes and activities as they relate to patient rights:
- Informing patients of their rights
- Helping patients understand and exercise their rights

- Respecting patients' values, beliefs, and preferences
- Informing patients of their responsibilities regarding their care, treatment, or services

About This Chapter
DMEPOS: This chapter presents a series of requirements that help organizations to recognize and respect patient rights. These requirements address the following:
- Identification of fundamental, overarching patient rights
- The right to effective communication
- The right to participate in care decisions
- The right to informed consent
- The right to know the staff providing care
- The right to participate in end-of-life decisions
- Individual rights of patients
- Patient responsibilities

Note: This chapter talks about the role of a surrogate decision-maker who may participate in circumstances in which the patient cannot or chooses not to make decisions. Instead of stating "patient or surrogate decision-maker" in each occurrence where the surrogate decision-maker may need to play a role, "patient" is used with the understanding that if the patient is unable to make decisions, the surrogate decision-maker will do so.

Introduction to Standard RI.01.01.01
DMEPOS: This standard focuses on how the organization respects the rights of the patient during their encounter with the organization. Rights such as treating the patient in a dignified and respectful manner, providing effective communication, and respecting the patient's cultural and personal values are covered in this standard. An organization puts its respect for the patient's rights into action by showing its support of these rights through the way, that staff interact with the patient and involve the patient in care, treatment, or services.

Standard RI.01.01.01
DMEPOS: The organization respects, protects, and promotes patients' rights.

RI.01.01.01, EP 1
DMEPOS: The organization has written policies on patient rights.

RI.01.01.01, EP 2
DMEPOS: The organization informs the patient of the patient's rights prior to beginning care, treatment, or services or during the initial evaluation visit before beginning care, treatment, or services.
(See also RI.01.01.03, EPs 1, 2, 3)

RI.01.01.01, EP 4
DMEPOS: The organization treats the patient in a dignified and respectful manner that supports the patient's dignity.

RI.01.01.01, EP 5
DMEPOS: The organization respects the patient's right to and need for effective communication.
(See also RI.01.01.03, EPs 1, 2, 3)

RI.01.01.01, EP 6
DMEPOS: The organization respects the patient's cultural and personal values, beliefs, and preferences.

RI.01.01.01, EP 7
DMEPOS: The organization respects the patient's right to privacy.
Note: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a

patient's health information, please refer to Standard IM.02.01.01.
(See also IM.02.01.01, EPs 1, 3, 4, 6)

RI.01.01.01, EP 10
DMEPOS: The organization allows the patient to access, request amendment to, and obtain information on disclosures of the patient's health information, in accordance with law and regulation.

RI.01.01.01, EP 37
DMEPOS: The organization considers patients' privacy and complies with law and regulation when making and using recordings, films, or other images of patients.
Note: The term "recordings, films, or other images" refers to photographic, video, digital, electronic, or audio media.

Introduction to Standard RI.01.01.03
DMEPOS: Because communication is a cornerstone of patient safety and quality care, every patient has the right to receive information in a manner they understand. Effective communication allows patients to participate more fully in their care. When a patient understands what is being said about their care, treatment, or services, that patient is more likely to fulfill critical health care responsibilities. Communicating effectively with patients is also critical to the informed consent process and helps organizations give the best possible care. For communication to be effective, the information provided must be complete, accurate, timely, unambiguous, and understood by the patient.

Many patients of varying circumstances require alternative communication methods: patients who speak and/or read languages other than English; patients who have limited literacy in any language; patients who have visual or hearing impairments; patients on ventilators; patients with cognitive impairments; and children. The organization has many options available to assist in communication with these individuals, such as interpreters, translated written materials, pen and paper, communication boards, and speech therapy. It is up to the organization to determine which method is the best for each patient.

There are laws, regulations, and a body of literature that are relevant to the use of interpreters. These include Title VI of the Civil Rights Act, 1964; Executive Order 13166; policy guidance from the Office of Civil Rights regarding compliance with Title VI, 2004; Title III of the Americans with Disabilities Act, 1990; state laws (many states have laws and regulations that require the provision of language assistance); and the American Medical Association Office Guide to Limited English Proficiency (LEP) Patient Care. Organizations may wish to reference these sources for additional information on providing interpreting and translation services to their patients.

Standard RI.01.01.03
DMEPOS: The organization respects the patient's right to receive information in a manner the patient understands.

RI.01.01.03, EP 1
DMEPOS: The organization provides information in a manner tailored to the patient's age, language, and ability to understand.
(See also PC.02.03.01, EP 3; RI.01.01.01, EPs 2, 5)

RI.01.01.03, EP 2
DMEPOS: The organization provides interpreting and translation services, as necessary.
(See also RI.01.01.01, EPs 2, 5)

RI.01.01.03, EP 3
DMEPOS: The organization communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.
(See also RI.01.01.01, EPs 2, 5)

Standard RI.01.02.01

DMEPOS: The organization respects the patient's right to participate in decisions about their care, treatment, or services.

Rationale for Standard RI.01.02.01
DMEPOS: The organization that recognizes the patient's right to participate in care decisions and involves the patient in making those decisions validates patient rights as a key aspect of care. Involving patients in care decisions helps the patient develop a better understanding of their care, which can lead to safer care and better care outcomes. This involvement includes informing the patient of outcomes of care, treatment, or services, including those outcomes that may have been unanticipated.

RI.01.02.01, EP 1
DMEPOS: The organization involves the patient in making decisions about their care, treatment, or services.

RI.01.02.01, EP 2
DMEPOS: When a patient is unable to make decisions about their care, treatment, or services, the organization involves a surrogate decision-maker in making these decisions.

RI.01.02.01, EP 4
DMEPOS: The organization respects the right of the patient, authorized decision-maker, or legal representative to refuse care, treatment, or services in accordance with law and regulation.

RI.01.02.01, EP 8
DMEPOS: The organization involves the patient's family in care, treatment, or services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.

RI.01.02.01, EP 17
DMEPOS: The organization provides its contact information when the patient receives rental equipment.

RI.01.02.01, EP 18
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization provides the patient with options for renting or purchasing equipment and items.

RI.01.02.01, EP 19
DMEPOS: For custom orthotics and prosthetics services: The organization asks the patient for comments to determine the effectiveness of the custom orthotics and prosthetics provided.
Note: Based on the type of custom orthotic or prosthetic, the patient might be asked about their wear schedule or tolerance of the orthotic or prosthetic, comfort, perceived benefits, ability to don and doff, satisfaction with the usefulness and function of the orthotic or prosthetic.

RI.01.02.01, EP 20
DMEPOS: The organization provides the patient or surrogate decision-maker with information about the following:
- Outcomes of the patient's care, treatment, or services that they need in order to participate in current and future health care decisions
- A sentinel event (either an incident or an unanticipated outcome) of the patient's care, treatment, or service (Refer to the Glossary for a definition of sentinel event.)

Standard RI.01.03.01
DMEPOS: The organization honors the patient's right to give or withhold informed consent.

Rationale for Standard RI.01.03.01
DMEPOS: Obtaining informed consent presents an opportunity to establish a mutual understanding between the patient and the organization about the care, treatment, or services that the patient will receive. Unlike the consent to

receive care, which acknowledges the patient's agreement to receive care from the organization, informed consent is not merely a signed document. It is a process that considers patient values and preferences, complies with law and regulation, and includes patient education about the risks, benefits, and alternatives of a proposed treatment. Utilizing the informed consent process helps the patient to participate fully in decisions about their care, treatment, or services.

RI.01.03.01, EP 1
DMEPOS: The organization follows a written policy on informed consent that describes the following:
- The specific care, treatment, or services that require informed consent
- Circumstances that would allow for exceptions to obtaining informed consent
- The physician or other licensed practitioner permitted to conduct the informed consent discussion in accordance with law and regulation
- How informed consent is documented in the patient record
Note 1: Documentation may be recorded in a form, in progress notes, or elsewhere in the record.
Note 2: For organizations that provide personal care and support services: An informed consent can be a separate document, or included as part of the service agreement or service contract.
- When a surrogate decision-maker may give informed consent

RI.01.03.01, EP 2
DMEPOS: The informed consent process includes a discussion about the following:
- The patient's proposed care, treatment, or services.
- Potential benefits, risks, and side effects of the patient's proposed care, treatment, or services, and the likelihood of the patient achieving their goals.
- Reasonable alternatives to the patient's proposed care, treatment, or services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, or services.

RI.01.03.01, EP 4
DMEPOS: For custom orthotics and prosthetics services: The organization informs the patient about the potential risks, benefits, and precautions of the recommended treatment plan and any optional plans.

RI.01.03.01, EP 5
DMEPOS: For custom orthotics and prosthetics services: The organization informs the patient of the recommended treatment plan.

Standard RI.01.03.05
DMEPOS: The organization protects the patient and respects the patient's rights during research, investigation, and clinical trials.

RI.01.03.05, EP 2
DMEPOS: To help the patient determine whether or not to participate in research, investigation, or clinical trials, the organization provides the patient with all of the following information:
- An explanation of the purpose of the research
- The expected duration of the patient's participation
- A clear description of the procedures to be followed
- A statement of the potential benefits, risks, discomforts, and side effects
- Alternative care, treatment, or services available to the patient that might prove advantageous to the patient

RI.01.03.05, EP 3
DMEPOS: The organization informs the patient that refusing to participate in research, investigation, or clinical trials or discontinuing participation at any time will not jeopardize the patient's access to care, treatment, or services unrelated to the research.

RI.01.03.05, EP 4
DMEPOS: The organization documents the following in the research consent form:
- That the patient received information to help determine whether or not to participate in the research, investigation, or clinical trials
- That the patient was informed that refusing to participate in research, investigation, or clinical trials or discontinuing participation at any time will not jeopardize their access to care, treatment, or services unrelated to the research
- The name of the person who provided the information and the date the form was signed
- The patient's right to privacy, confidentiality, and safety

Standard RI.01.04.01
DMEPOS: The organization respects the patient's right to receive information about the individual(s) providing the patient's care, treatment, or services.

RI.01.04.01, EP 2
DMEPOS: The organization provides the patient with information about the identity and role of the staff member(s) who will provide care, treatment, or services.

Standard RI.01.05.01
DMEPOS: The organization addresses patient decisions about care, treatment, or services received at the end of life.

RI.01.05.01, EP 1
DMEPOS: The organization follows written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services that address the following:
- Which patients the organization will ask about advance directives.
- Limitations the organization has in respecting the patient’s advance directives.
- Staff knowledge of the patient’s advance directives and any updates made to the advance directives.
- How the organization will honor the patient’s advance directives.

RI.01.05.01, EP 17
DMEPOS: The existence or lack of an advance directive does not determine the patient’s right to access care, treatment, or services.

Standard RI.01.06.03
DMEPOS: The patient has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.

Rationale for Standard RI.01.06.03
DMEPOS: All patients should be protected from neglect, exploitation, and abuse. Home care organizations need to proactively decide what they will do to make sure that patients are protected. This includes doing whatever the organization can to make sure that the patient is safe while under the care of the organization. This standard differs from Standard PC.01.02.09 in that it addresses what the organization does to make sure that neglect, exploitation, and abuse do not happen, while Standard PC.01.02.09 addresses what an organization does if it suspects that a patient may be a victim of neglect, exploitation, or abuse.

RI.01.06.03, EP 1
DMEPOS: The organization determines how it will protect the patient from neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, or services from the organization.

RI.01.06.03, EP 2
DMEPOS: The organization evaluates all allegations, observations, and suspected cases of neglect, exploitation, and abuse that occur during the time that the patient is receiving care, treatment, or services from the organization. (See also PC.01.02.09, EP 1)

RI.01.06.03, EP 3
DMEPOS: The organization reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events.
(See also PC.01.02.09, EPs 6, 7)

Standard RI.01.07.01
DMEPOS: The patient and their family have the right to have complaints reviewed by the organization.

RI.01.07.01, EP 1
DMEPOS: The organization establishes a complaint resolution process and informs the patient and the patient's family about it.

RI.01.07.01, EP 4
DMEPOS: The organization investigates and, when possible, resolves complaints from the patient and the patient's family.

RI.01.07.01, EP 6
DMEPOS: When a patient submits a complaint that the organization recognizes as significant, the organization acknowledges receipt of the complaint and notifies the patient of follow-up to the complaint.

RI.01.07.01, EP 10
DMEPOS: The organization allows the patient to voice complaints and recommend changes freely without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care.

RI.01.07.01, EP 14
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: Within five calendar days of receiving a patient’s complaint, the organization notifies the patient by telephone, e-mail, fax, letter, or in person that it has received the complaint and that it is being investigated.

RI.01.07.01, EP 15
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: Within 14 calendar days of receiving a patient's complaint, the organization provides written notification to the patient of the results of its investigation and its response to those results.

RI.01.07.01, EP 16
DMEPOS: For DMEPOS suppliers serving Medicare beneficiaries: The organization maintains documentation of all complaints, copies of investigations, and responses to patients.

Introduction to Standard RI.02.01.01
DMEPOS: The safety of patients is enhanced when patients are partners in the health care process. In addition, organizations are entitled to reasonable and responsible behavior on the part of patients and their families. When organizations inform patients and their families about their responsibilities, some of the topics that are discussed could include the following:
- Providing information. Patients should provide, to the best of their knowledge, accurate information about present complaints, past illnesses, hospitalizations, medications, and other matters related to their health.
- Sharing expectations. Patients should provide the organization with information about their expectations of and satisfaction with the organization.
- Asking questions. Patients should ask questions when they do not understand their care, treatment, or services or what they are expected to do.
- Following instructions. Patients should follow instructions about their care, treatment, or services. They should also express any concerns about their ability to follow the instructions.

- Accepting consequences. Patients should accept their share of responsibility for the outcomes of care, treatment, or services if they do not follow the instructions about their care, treatment, or services.
- Following policies and procedures. Patients should follow the organization’s policies and procedures.
- Showing respect and consideration. Patients should be considerate of the organization’s staff and property, as well as other patients and their property.
- Meeting financial commitments. Patients should meet any financial obligation agreed to with the organization.

Standard RI.02.01.01
DMEPOS: The organization informs the patient about the patient's responsibilities related to their care, treatment, or services.

RI.02.01.01, EP 1
DMEPOS: The organization has a written policy that defines patient responsibilities.

RI.02.01.01, EP 2
DMEPOS: The organization 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.