Facility Management and Safety (FMS)

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
FMS.01.00	FMS.1	Renumbered standard with four measurable elements focused on leadership and planning for facility use.		
FMS.01.01	FMS.2	Renumbered standard with three measurable elements focused on oversight of the FMS structure.		
FMS.02.00	FMS.3 FMS.4	Combined into one standard with four measurable elements focused on risk assessment, reporting, and action by the governing entity.		
FMS.03.00	FMS.5	Renumbered standard with five measurable elements focused on the safety program.		
		ME 4 focuses on safety incidents within the facility.		X
		ME 5 focuses on safety incidents related to workplace violence.		X
FMS.04.00	FMS.6	Renumbered standard with nine measurable elements focused on a secure environment.		
		ME 4 focuses on equipment inspection.		X
		ME 5 focuses on education related to a safety event.		X
		ME 6 focuses on safety exercises.		X
		ME 7 focuses on an annual analysis of workplace violence.		X
		ME 8 focuses on investigation of security incidents.		X
		ME 9 focuses on investigation of workplace violence incidents.		X
FMS.05.00	FMS.7 FMS.7.1 FMS.7.2	Combined into one standard with seven measurable elements focused on hazardous materials and waste.		
		ME 7 focuses on staff demonstration of procedures.		X
FMS.06.00	FMS.8	Renumbered standard with three measurable elements focused on fire safety measures.		
FMS.06.01	FMS.8.1 FMS.8.2	Combined into one standard with six measurable elements focused on maintenance of fire safety equipment/building features.		
FMS.06.02	FMS.8.3	Renumbered standard with three measurable elements similar to the 7th Edition.		
FMS.06.03	FMS.8.4	Renumbered standard with three measurable elements similar to the 7th Edition.		
FMS.06.04	FMS.8.5	Renumbered standard with three measurable elements focused on patient and staff smoking habits.		

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
FMS.07.00	FMS.9 FMS.9.1	Combined into one standard with three measurable elements focused on medical equipment.		
		ME 2 combined concepts of previous FMS.9.1, MEs 2–4.		
FMS.07.01	FMS.9.2	Renumbered standard with three measurable elements similar to the 7th Edition.		
FMS.08.00	FMS.10 FMS.10.1	Combined into one standard with five measurable elements focused on utility systems management.		
FMS.08.01	FMS.10.2	Renumbered standard with three measurable elements focused on testing and evaluation of utility systems.		
FMS.08.02	FMS.10.3	Renumbered standard with four measurable elements focused on monitoring water quality.		
FMS.08.03	FMS.10.3.1	Renumbered standard with five measurable elements similar to the 7th Edition.		
FMS.08.04	PCI.10	Renumbered standard with three measurable elements focused on reducing the risk of infection through engineering controls.	X	
FMS.09.00	FMS.11	Renumbered standard with four measurable elements focused on the emergency management program.		
FMS.09.01	PCI.12.1 PCI.12.2	New standard with six measurable elements focused on emergency management for global communicable diseases.	X	
FMS.10.00	FMS.12 PCI.11	Renumbered standard with three measurable elements similar to the 7th Edition.		

Governance, Leadership, and Direction (GLD)

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
GLD.01.00	GLD.1 GLD.1.1 GLD.1.2	Combined into one standard with five measurable elements focused on structure and oversight responsibilities of the governing entity.		
GLD.02.00	GLD.2	Renumbered standard with five measurable elements focused on the chief executive's qualifications and responsibilities.		
GLD.03.00	GLD.3	Renumbered standard with three measurable elements focused on hospital leaders' responsibility to carry out the hospital's mission.		

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
GLD.03.01	GLD.3.1	Renumbered standard with four measurable elements focused on hospital departments' planning of services, providing data, and communication to staff.		
		ME 4 focuses on implementing policies to provide uniform care to patients.		X
GLD.03.02	GLD.3.2	Renumbered standard with three measurable elements similar to the 7th Edition.		
GLD.04.00	GLD.4	Renumbered standard with seven measurable elements focused on implementation of hospitalwide quality and patient safety program.		
		ME 5 focuses on definition of patient safety events and reporting of sentinel events.		X
		Moved QPS.7, ME 2 (7th Edition) to GLD.04.00, ME 6 (8th Edition).		
		ME 7 focuses on supporting staff involved in an adverse event or a sentinel event.		X
GLD.04.01	GLD.4.1	Renumbered standard with three measurable elements similar to the 7th Edition.		
GLD.04.02	GLD.5	Renumbered standard with four measurable elements focused on hospital leaders' use of data when identifying hospitalwide priorities and compliance to IPSGs.		
		ME 3 focuses on data collection and assessment of diagnostic error factors.		X
		ME 4 focuses on interventions to mitigate diagnostic errors.		X
GLD.05.00	GLD.6 GLD.6.1	Combined into one standard with six measurable elements focused on oversight of contract services and integration of contract management to the hospital's quality monitoring program.		
GLD.05.01	GLD.6.2	Renumbered standard with four measurable elements similar to the 7th Edition.		
GLD.05.02	GLD.7	Renumbered standard with four measurable elements focused on using data in resource decision-making.		
GLD.05.03	GLD.7.1	Renumbered standard with three measurable elements focused on establishing the hospital's supply chain strategy.		
		ME 1 combines the concepts of GLD.7.1, MEs 1–3 (7th Edition).		
GLD.06.00	GLD.8 GLD.9	Combined into one standard with four measurable elements focused on hospital department oversight, direction, and structure.		

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
GLD.06.01	GLD.11	Renumbered standard with four measurable elements similar to the 7th Edition.		
GLD.06.02	GLD.11.2	Renumbered standard with four measurable elements similar to the 7th Edition.		
GLD.07.00	GLD.12	Renumbered standard with six measurable elements focused on the hospital's ethical framework and conflict of interest disclosure.		
GLD.07.01	GLD.13 GLD.13.1	Renumbered standard with six measurable elements focused on culture of safety in the organization.		
		Moved GLD.13, ME 1 (7th Edition) to GLD.07.01, ME 4 (8th Edition).		
		Moved GLD.13.1, ME 5 (7th Edition) to GLD.07.01, ME 5 (8th Edition).		
		Moved GLD.13.1, ME 3 (7th Edition) to GLD.07.01, ME 6 (8th Edition).		
GLD.07.02	N/A	New standard with five measurable elements focused on workplace violence prevention program.	X	
GLD.08.00	GLD.14	Renumbered standard with five measurable elements similar to the 7th Edition.		
GLD.09.00	GLD.15	Renumbered standard with five measurable elements focused on human subjects research policies, patient information, consent forms, and indemnity insurance.		

Health Care Technology (HCT)

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
HCT.01.00	MOI.11	Renumbered standard from MOI with four measurable elements similar to the 7th Edition.		
HCT.01.01	MOI.12	Renumbered standard from MOI with five measurable elements similar to the 7th Edition.		
HCT.01.02	N/A	New standard with four measurable elements focused on telehealth services.	X	
HCT.01.03	N/A	New standard with three measurable elements focused on clinical decision support tools and artificial intelligence.	X	
HCT.01.04	MOI.13	Renumbered standard from MOI with six measurable elements similar to the 7th Edition.		
HCT.01.05	N/A	New standard with three measurable elements focused on cybersecurity and cyber risk management.	X	
HCT.02.00	COP.4	Renumbered standard from COP with six measurable elements similar to the 7th Edition.		

Management of Information (MOI)

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
MOI.01.00	MOI.1	Renumbered standard with three measurable elements focused on managing information.		
MOI.01.01	MOI.2	Renumbered standard with six measurable elements similar to the 7th Edition.		
MOI.01.02	MOI.2.1	Renumbered standard with five measurable elements focused on safety and security of information.		
		ME 5 focuses on cyberattacks.		X
MOI.01.03	MOI.3	Renumbered standard with three measurable elements similar to the 7th Edition.		
MOI.01.04	MOI.6	Renumbered standard with four measurable elements focused on information systems training.		
		ME 3 focuses on cybersecurity education.		X
MOI.02.00	MOI.7	Renumbered standard with four measurable elements focused on management of documents.		
		Split 7th Edition ME 1 into 8th Edition MEs 1 and 2.		
MOI.02.01	MOI.7.1	Renumbered standard with four measurable elements similar to the 7th Edition.		
MOI.02.02	MOI.4	Renumbered standard with four measurable elements focused on use of abbreviations.		
MOI.02.03	MOI.5	Renumbered standard with three measurable elements focused on dissemination of data.		
MOI.03.00	MOI.8 MOI.8.1 MOI.9	Combined into one standard with five measurable elements focused on the integrity of the patient health record.		
MOI.03.01	MOI.10	Renumbered standard with five measurable elements similar to the 7th Edition.		

Prevention and Control of Infections (PCI)

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
PCI.01.00	PCI.1	Renumbered standard with five measurable elements focused on qualifications of infection prevention and control leaders and oversight of the infection prevention and control program.		
PCI.01.01	PCI.2	Renumbered standard with five measurable elements focused on integration of the infection prevention and control program with all departments and services, and with the quality and patient safety program.		

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
PCI.01.02	PCI.3	Renumbered standard with three measurable elements focused on provision of adequate resources for the infection prevention and control program.		
PCI.02.00	PCI.5 PCI.5.1 IPSG.5.1	Combined into one standard with five measurable elements focused on risk assessments and evidence-based strategies for infection prevention and control.		
PCI.02.01	AOP.5.3.1	Renumbered standard moved to PCI chapter with four measurable elements similar to the 7th Edition.		
PCI.03.00	PCI.6	Renumbered standard with eight measurable elements similar to the 7th Edition.		
PCI.03.01	PCI.6	New standard with five measurable elements focused on a process to manage reuse of single-use devices.	X	
PCI.03.02	PCI.6	New standard with three measurable elements focused on a process to manage expired and damaged devices and supplies.	X	
PCI.04.00	PCI.7	Renumbered standard with four measurable elements similar to the 7th Edition.		
PCI.04.01	PCI.7.1	Renumbered standard with four measurable elements similar to the 7th Edition.		
PCI.05.00	PCI.8	Renumbered standard with seven measurable elements focused on proper disposal and handling of infectious waste, sharps, and needles.		
		ME 7 focuses on a policy to direct chain of custody for all bodies and body parts handled by pathology, mortuary, and other postmortem areas.		X
PCI.05.01	PCI.8.1	Renumbered standard with seven measurable elements focused on protection from and response to blood and body fluid exposures.		
		ME 2 focuses on implementation of practices to reduce risk of exposures to blood and body fluids.		X
PCI.06.00	PCI.9	Renumbered standard with five measurable elements similar to the 7th Edition.		
PCI.07.00	PCI.12	Renumbered standard with five measurable elements focused on isolation precautions for communicable diseases and protection of immunosuppressed patients.		
		ME 2 focuses on staff education on management of infectious patients when negative air pressure rooms are not available.		X

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
PCI.07.01	PCI.13	Renumbered standard with six measurable elements focused on personal protective equipment and hand hygiene resources.		
		ME 2 focuses on ensuring that personal protective equipment and hand hygiene resources are readily available.		X
PCI.07.02	N/A	New standard with five measurable elements focused on preparedness and response for epidemiologically significant or high-impact pathogens, including novel pathogens.	X	
PCI.08.00	PCI.14	Renumbered standard with five measurable elements similar to the 7th Edition.		
PCI.08.01	PCI.15	Renumbered standard with five measurable elements focused on infection prevention and control education for staff and infection prevention and control program communication with leaders and governing board.		
		ME 5 focuses on communicating data and information from infection prevention and control program to governing board.		X

Quality and Patient Safety (QPS)

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
QPS.01.00	QPS.1	Renumbered standard with six measurable elements focused on implementation of quality and patient safety program and quality and patient safety program leaders/staff qualifications.		
		ME 6 focuses on defining qualifications of quality and patient safety program leaders and staff.		X
QPS.02.00	QPS.2	Renumbered standard with four measurable elements similar to the 7th Edition.		
QPS.03.00	QPS.4	Renumbered standard with five measurable elements similar to the 7th Edition.		
QPS.03.01	QPS.6	Renumbered standard with three measurable elements focused on data validation.		
QPS.03.02	QPS.4.1	Renumbered standard with five measurable elements similar to the 7th Edition.		
QPS.03.03	QPS.5	Renumbered standard with three measurable elements similar to the 7th Edition.		

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
QPS.03.04	QPS.8	Renumbered standard with six measurable elements focused on mandatory data collection, intensive analysis when adverse events or trends occur, and reporting of data analyses.		
		ME 6 focuses on implementing measures intended to increase patient safety event reporting.		X
QPS.04.00	QPS.9	Renumbered standard with four measurable elements similar to the 7th Edition.		
QPS.04.01	QPS.10	Renumbered standard with six measurable elements focused on requirements for risk management programs.		
		ME 6 focuses on defining qualifications of risk management personnel.		X

Staff Qualifications and Education (SQE)

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
SQE.01.00	SQE.1	Renumbered standard with three measurable elements similar to the 7th Edition.		
SQE.01.01	SQE.1.1	Renumbered standard with four measurable elements focused on staff member responsibilities in the job description.		
		ME 2 focuses on requiring the job description to include defined staff member responsibilities.		X
SQE.01.02	SQE.2	Renumbered standard with four measurable elements similar to the 7th Edition.		
SQE.01.03	SQE.3 SQE.4	Combined into one standard with six measurable elements focused on staff qualifications and performance.		
		ME 2 focuses on performance-based staff evaluations.		X
		ME 5 focuses on a qualified individual conducting staff evaluations.		X
SQE.01.04	SQE.5	Renumbered standard with three measurable elements similar to the 7th Edition.		
SQE.01.05	SQE.6 SQE.6.1	Combined into one standard with seven measurable elements focused on hospital staffing process.		
		ME 4 focuses on staffing process compliance with laws and regulations.		X

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
SQE.01.06	SQE.7	Renumbered standard with five measurable elements focused on staff orientation.		
		ME 5 focuses on documentation of completed orientation.		X
SQE.01.07	SQE.8	Renumbered standard with seven measurable elements focused on education and training.		
		ME 7 focuses on documentation of completed education and training.		X
SQE.01.08	SQE.8.1 SQE.8.1.1	Combined into one standard with seven measurable elements focused on staff competence in resuscitative techniques.		
SQE.02.00	SQE.8.2	Renumbered standard with five measurable elements focused on staff mental health.		
		ME 3 focuses on the evaluation and resources for elements of staff mental health.		X
		ME 5 focuses on actions taken for staff mental health prevention.		X
SQE.02.01	SQE.8.3	Renumbered standard with five measurable elements focused on a staff vaccination and immunization program.		
		ME 3 focuses on a process for staff vaccinations and immunizations.		X
SQE.02.02	N/A	New standard with three measurable elements focused on workplace violence prevention training.	X	
SQE.03.00	SQE.13	Renumbered standard with six measurable elements similar to the 7th Edition.		
SQE.03.01	SQE.14	Renumbered standard with five measurable elements focused on nursing staff credentials.		
		ME 1 focuses on nursing staff experience, training, and education applicability to their role.		X
		ME 2 focuses on nursing staff evaluation criteria.		X
SQE.03.02	SQE.14.1	Renumbered standard with three measurable elements similar to the 7th Edition.		
SQE.04.00	SQE.15	Renumbered standard with five measurable elements similar to the 7th Edition.		
SQE.04.01	SQE.16	Renumbered standard with three measurable elements similar to the 7th Edition.		
SQE.04.02	SQE.16.1	Renumbered standard with three measurable elements similar to the 7th Edition.		
SQE.05.00	SQE.9	Renumbered standard with four measurable elements similar to the 7th Edition.		

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
SQE.05.01	SQE.9.1	Renumbered standard with three measurable elements similar to the 7th Edition.		
SQE.05.02	SQE.9.2	Renumbered standard with three measurable elements similar to the 7th Edition.		
SQE.06.00	SQE.10	Renumbered standard with five measurable elements focused on the process to grant medical staff membership and clinical privileges.		
		ME 2 focuses on criteria that determine scope of medical staff privileges.		X
		Moved PCC.4.3, ME 4 (7th Edition) to SQE.06.00, ME 5 (8th Edition).		X
SQE.06.01	N/A	New standard with six measurable elements focused on medical staff temporary clinical privileges.	X	
SQE.06.02	SQE.12	Renumbered standard with six measurable elements focused on medical staff membership and clinical privileges.		
		ME 4 focuses on notification of staff regarding the decision to grant privileges.		X
		ME 5 focuses on the process to disseminate all granting-related decisions to applicable parties.		X
SQE.07.00	SQE.11	Renumbered standard with five measurable elements focused on process for evaluating the care provided by the medical staff.		
		ME 4 focuses on hospitalwide and department/service data sources criteria used in medical staff ongoing evaluations.		X
SQE.07.01	N/A	New standard with five measurable elements focused on monitoring and evaluating medical staff professional performance.	X	

Global Health Impact (GHI)

All-new chapter and requirements. Did not exist in 7th Edition.

Human Subjects Research Programs (HRP)

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
HRP.01.00	HRP.1 HRP.1.1	Renumbered standard with four measurable elements similar to the 7th Edition.		
		Moved HRP.1.1, ME 2 (7th Edition) to HRP.01.00, ME 4 (8th Edition).		

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
HRP.01.01	HRP.2	Renumbered standard with five measurable elements similar to the 7th Edition.		
HRP.01.02	HRP.3 HRP.3.1	Renumbered standard with three measurable elements focused on a policy for sponsors of research.		
		Moved HRP.3, MEs 1–5 (7th Edition) to elements under HRP.01.02, ME 1 (8th Edition).		
		ME 2 focuses on leaders verifying sponsor qualifications.		X
		ME 3 focuses on documentation confirming sponsor responsibility and accountability.		X
HRP.01.03	HRP.3.1	Renumbered standard with four measurable elements similar to the 7th Edition.		
HRP.01.04	HRP.4	Renumbered standard with six measurable elements similar to the 7th Edition.		
HRP.02.00	HRP.5	Renumbered standard with four measurable elements focused on managing conflict of interest with research conducted in hospitals.		
		ME 1 focuses on a conflict of interest policy for research in hospitals.		X
HRP.02.01	HRP.6	Renumbered standard with three measurable elements similar to the 7th Edition.		
HRP.02.02	HRP.7 HRP.7.1	Renumbered standard with four measurable elements similar to the 7th Edition.		
		Moved Standard HRP.7 (7th Edition) to HRP.02.02, ME 1 (8th Edition).		

Medical Professional Education (MPE)

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
MPE.01.00	MPE.1	Renumbered standard with five measurable elements similar to the 7th Edition.		
MPE.01.01	MPE.2	Renumbered standard with three measurable elements similar to the 7th Edition.		
MPE.01.02	MPE.3	Renumbered standard with three measurable elements similar to the 7th Edition.		
MPE.02.00	MPE.4	Renumbered standard with five measurable elements focused on the supervision of medical students and trainees.		
		ME 2 focuses on the participant roles and responsibilities of the professional education programs.		X

8th Edition Standard Number(s)	7th Edition (Previous) Standard Number(s)	Description of Changes	New Standard	New ME
MPE.02.01	MPE.5	Renumbered standard with four measurable elements similar to the 7th Edition.		
MPE.02.02	MPE.6	Renumbered standard with five measurable elements similar to the 7th Edition.		
MPE.02.03	MPE.7	Renumbered standard with three measurable elements similar to the 7th Edition.		

Introduction

This introduction presents Joint Commission International (JCI) and explains how *Joint Commission International Accreditation Standards for Hospitals*, 8th Edition, is organized. Like each of the seven previous editions, we have sought to reflect the most current thinking in patient safety practices and concepts to help accredited and nonaccredited organizations uncover their most pressing safety risks and advance their goals for continuous quality improvement. We hope to support your work of making health care as safe as possible.

Read this chapter first to understand the structure and the content of this manual. This introduction provides information on the following topics:

- The value of JCI accreditation
- The standards development process
- How the manual is organized
- Applying the standards in your organization
- How to use the standards manual
- General eligibility requirements

After you have a better understanding of how to use this manual, read the "General Eligibility Requirements" section of this introduction to check whether your organization is eligible for JCI accreditation. Then become familiar with the JCI standards chapters and how the standards make health care safer.

If you have questions about the standards or the accreditation process, please contact JCI at JCIAccreditation@jcrinc.com.

The Value of JCI Accreditation

JCI's Gold Seal of Approval® is a widely recognized benchmark representing the most comprehensive evaluation process in the health care industry. Joint Commission accreditation benefits your organization in the following ways:

- *Gives you a competitive advantage:* Achieving accreditation and specialty certification is a visible demonstration to patients and the community that your hospital is committed to providing the highest-quality services. It also sets you apart from other hospitals offering the same types of care, treatment, and services.
- *Assists with recognition from insurers, associations, and other third parties:* Many payers, regulatory agencies, government agencies, and managed care contractors require JCI accreditation for reimbursement, for certification or licensure, and as a key element of their participation agreements and reimbursement practices.
- *Helps organize and strengthen performance improvement efforts:* Accreditation encompasses state-of-the-art performance improvement concepts that help you continuously improve quality and standardize your processes of care, treatment, and services.
- *Helps health care organizations become high reliability organizations:* JCI offers numerous resources and information to help hospitals move toward high reliability—that is, to consistently perform at high levels of quality and safety across all services and to maintain these levels over long periods.

These resources help leaders commit to high reliability by making it a priority, establishing a safety culture throughout the organization that emphasizes trust and the reporting of unsafe conditions and opportunities for improvement.

- *Enhances staff education:* The accreditation process is designed to be educational. JCI surveyors share best practice approaches and strategies that may help your hospital better meet the intent of the standards and, more important, improve performance of day-to-day operations.
- *Provides access to experts in quality and safety:* JCI is committed to helping your hospital move toward highly reliable care, treatment, and services. Through JCI your hospital has access to a range of professionals eager to see you succeed. It starts with the assignment of an account manager specializing in hospitals to help in day-to-day accreditation activities. You also have ready access to the clinical and engineering experts in our Standards Interpretation Group (SIG) as well as professional surveyors who visit your organization for surveys.

Standards Development Process

The JCI standards development process represents a collaboration between JCI, accredited organizations, and global subject matter experts in patient quality and safety. This 8th edition considers developments in the science of quality improvement and patient safety as well as the experiences of the organizations that used the 7th edition hospital and academic medical center standards to improve the safety and quality of care in their organizations.

The JCI standards development team took the following actions in revising the standards for this edition:

- Conducted focus groups with leaders from JCI–accredited organizations and other health care experts representing a broad range of perspectives from around the world.
- Reviewed the literature for current evidence-based practice and processes, and authoritative sources for industry guidelines to support new and revised standards.
- Gathered input from experts and others with specific and relevant content knowledge, including JCI surveyors and consultants.
- Received guidance on the development and revision of the standards from the Technical Advisory Panel, an international panel composed of experts with extensive experience in various health care fields.
- Sent an online field review of the revised standards to all accredited hospitals and promoted public participation in the field review through social media and the JCI website.
- Overall, the standards revisions were influenced and guided by the following sources:
    - Suggestions identified in the focus groups, advisory panels and subject matter experts, and field review
    - Requests to clarify requirements and expectations for specific standards
    - Evolving health care practices, evidence-based guidelines, and the changing health care environment

Keep Current with Standard Changes

JCI gathers information and experience related to the standards on an ongoing basis. If a standard no longer reflects evidence-based health care practice, commonly available technology, and quality management practices, JCI will revise or delete the requirements. New and revised standards are published at least six months in advance of the effective date to provide time for organizations to come into full compliance with the revised standards by the time they are effective.

JCI Insight provides critical information about changes to standards and policies that are made throughout the year. Reading *JCI Insight* allows you to learn about initiatives underway to support your efforts to achieve and sustain performance excellence. **Note the changes because your organization is responsible for complying with all applicable JCI standards (new and revised), including any changes published in *JCI Insight*.**

Current and recent editions of *JCI Insight* are available on your organization's extranet (*JCI Direct Connect*) site, made available to organizations that are accredited or have applied for accreditation. Staff who don't have access to their organization's secure extranet site can "Request Guest Access" on JCI's website at https://www.jointcommissioninternational.org/resources/jcinsight-newsletter.

Effective Date of Standards

The *Joint Commission International Accreditation Standards for Hospitals*, 8th Edition, is effective 1 January 2025:

1. For currently accredited hospitals, this is the date by which you now must be in full compliance with all new and revised standards in the 8th edition.
2. For hospitals seeking accreditation for the first time, this is the date after which all surveys and accreditation decisions will be based on the standards of the 8th edition. If you apply for survey and are surveyed before 1 January 2025, the survey will assess compliance with the standards of the 7th edition.

How This Manual Is Organized

This manual includes all the hospital and academic medical center Accreditation Participation Requirements (APRs), standards, intents, and measurable elements (MEs). The standards are organized around the important functions common to all health care organizations—an approach widely used around the world, which has been validated by scientific study, testing, and application.

This manual contains five major sections:

1. Accreditation Participation Requirements (Section I) that outline specific requirements for participating in accreditation and maintaining an accreditation award
2. Standards related to providing patient care (Section II)
3. Standards related to providing a safe, effective, and well-managed organization (Section III)
4. Standards related to environmental, social, and governance that impacts health care organizations (Section IV)
5. For academic medical centers only, standards related to medical professional education and human subjects research programs (Section V)

The standards apply to the entire organization as well as to each department, unit, or service within the organization.

In addition to the accreditation requirements, this manual includes the following appendices:

- **Interim Measures:** Interim measures are actions taken to ensure the safety of the building's occupants during times when features and systems for fire safety are defective, compromised, or inoperable due to construction, maintenance, a breakdown, or repair. Interim measures may need to be implemented to ensure the safety of occupants until improvements or repairs can be completed.
- **Patient Safety Systems:** Informs and educates leaders about the importance and structure of an integrated patient safety system. This chapter is designed to clarify the relationship between JCI accreditation and patient safety. It does not contain new standards or requirements. Rather, the chapter describes how existing requirements can be applied to continually improve patient safety. It also provides approaches and methods that may be adapted to remove risk of patient harm.
- **Sentinel Event Policy:** Contains information on JCI's Sentinel Event Policy, including the definition of a sentinel event, the goals of the policy, the adverse events that constitute sentinel events, sentinel event–related standards, and the various activities that surround the policy.

The manual also includes "Summary of Changes to the Manual," "Introduction," a chapter describing the key accreditation policies, and a glossary.

The companion *Joint Commission International Survey Process Guide for Hospitals Including Academic Medical Centers*, 8th Edition, helps hospitals and academic medical centers learn about and prepare for the JCI accreditation survey. During the survey, surveyors gather standards compliance information throughout the entire organization. The accreditation decision is based on the organization's overall level of compliance with the standards in this manual.

Elements of a Standards Chapter

Each standards chapter in Sections II, III, IV, and V contains the following elements:

- *Overview:* The overview is located at the beginning of each chapter. The overview explains the chapter's purpose and the principles on which the standards were built.
- *Standards list:* This part shows how the chapter is laid out and provides a frame of reference for the numbering of standards.
- *Standards:* Standards (also known as requirements) are statements that define the performance expectations and/or structures or functions that must be in place for an organization to be accredited by JCI and to provide safe, high-quality care, treatment, and services. Standards are evaluated for compliance during the on-site survey.
- *Intent:* An intent helps explain the full meaning of a standard by providing additional background, justification, or other information. The intent describes the purpose or reason for the standard and how it fits into the overall program, setting parameters for what is required by the standard. The intent is considered advisory, and it is not scored.
- *Measurable elements (MEs):* MEs are statements that detail the specific performance expectations, structures, functions, or processes that must be in place for an organization to meet the standard and provide high-quality care, treatment, and services. MEs are reviewed during the on-site survey and assigned a score that determines an organization's overall compliance with a standard. Organizations can use MEs to bring clarity to standards, help the organization fully understand the requirements, guide the organization in accreditation preparation, and educate executive leaders, department/service leaders, health care practitioners, and staff about the standards.
- *Examples:* Examples are included in many standards' intents and MEs to better illustrate expectations for compliance. Examples are considered advisory and are not required or scored.
- *Notes:* Occasionally, notes are used to provide organizations and surveyors with additional or clarifying information. A note may provide applicability information, define a term, or explain a concept. (All key terms are defined in the "Glossary" in the back of this manual.)

Required Written Documentation

Joint Commission International's focus is on performance and implementation rather than documentation. The standards, consequently, require documentation only when it is essential. The documentation icon—Ⓓ—is used to identify data collection and documentation requirements that are in addition to information found in the medical record. For example, the documentation icon is applied to an ME that requires a written procedure, but the icon is not applied to an ME that lists the required components of the medical record. Other examples in which the documentation icon is applied are MEs that require a policy, a written plan, bylaws, a license, evidence of testing, data, performance improvement reports, medication labels, safety data sheets, and meeting minutes.

Documentation can be on paper or in an electronic format. Although documentation is important, the primary emphasis of the survey will be on how your hospital carries out the functions described in the standards. The surveyors may use a combination of data sources, including interviews with leaders of the hospital, staff, patients, and patients' family members; visits to patient care settings; and review of documentation to arrive at an assessment of your hospital's compliance with a standard.

The documentation icon is meant to be a guide. The names and format of specific documents may vary from organization to organization.

JCI Standards in the Public Domain

To help individual health care organizations and public agencies seeking to improve the quality of patient care, JCI hospital standards (but not the intent statements and MEs) are in the international public domain for viewing. A listing of JCI hospital standards can be downloaded at no cost from the JCI website at https://www.jointcommissioninternational.org. Organizations with questions about translating or using the JCI standards must request written permission by contacting permissions@jcrinc.com.

Applying the Standards in Your Organization

Although each standard in Sections II, III, and IV apply to all applicant hospitals, there are three special circumstances when considering how to apply standards in an individual hospital:

Adhering to the Stricter Standard

A hospital must establish policies and procedures that conform to national, regional, and local laws or regulations as well as JCI standards. When a concept is addressed by the JCI standards and by the laws or regulations of a national or local authority, JCI requires that an organization follow whichever body has set the *higher* or *stricter* requirement. For example, JCI requires that organizations use two patient identifiers in a variety of processes. If the hospital's national standard requires the use of three identifiers, the hospital must use three identifiers to meet the national standard, which is stricter than JCI's standard. However, if that same national standard allows the use of bed number as an identifier—a practice JCI explicitly prohibits—the organization is prohibited from doing so. In this case, the organization would need to use three identifiers (the stricter national requirement) and would be prohibited from using bed number as an identifier (the stricter JCI requirement).

Global Health Impact (GHI) Standards

The *Joint Commission International Accreditation Standards for Hospitals,* 8th Edition, introduces a new chapter on Global Health Impact (GHI) that focuses on environmental sustainability in health care organizations. Standards in the GHI chapter are developed in collaboration with the International Hospital Federation's Geneva Sustainability Centre.

Understanding that hospitals are in different stages of their environmental sustainability journey, this chapter will serve as a resource to standardize practices in the environmental sustainability initiatives of JCI-accredited hospitals. Standards in the GHI chapter will be scored but will not factor into the organization's JCI accreditation decision for organizations surveyed before 1 January 2026.

Academic Medical Center Standards

Although community medical centers, often called hospitals or acute care centers, provide a wide range of basic and specialized services for patients in their local communities, academic medical centers are also primary sites for medical education and health care research. JCI developed the academic medical center standards to recognize the unique resource such organizations represent for health professional education and human subjects research in their community and country.

JCI standards in Section V, the "Medical Professional Education" (MPE) and "Human Subjects Research Programs" (HRP) chapters, present a framework for including medical education and research into the quality and patient safety activities of academic medical centers.

Many health care organizations may consider themselves to be an academic medical center, but only organizations that meet JCI's definition are required to comply with the MPE and HRP standards presented in Section V of this manual.

JCI will consider an applicant hospital an eligible academic medical center if it meets the following three criteria:

1. It is *integrated* (by organization or administration) with a medical school.
2. It is the principal site for the *education* of both (a) medical students (that is, undergraduates) and (b) postgraduate medical specialty trainees (for example, residents or interns) from such medical school.
3. At the time of application, it conducts *medical research* with approval and oversight by an Institutional Review Board (IRB) or research ethics committee.

All hospitals meeting the academic medical center eligibility criteria must comply with the requirements in Section V (as well as the requirements detailed in Sections II and III) to achieve JCI accreditation.

Organizations with questions about their eligibility for academic medical center accreditation should contact JCI Accreditation's Central Office at JCIAccreditation@jcrinc.com.

Using the Standards Manual

Joint Commission International Accreditation Standards for Hospitals, 8th Edition, when paired with its companion book *Joint Commission International Survey Process Guide for Hospitals Including Academic Medical Centers*, 8th Edition, along with information on the organization's *JCI Direct Connect* extranet site, together contain all the information a hospital needs to achieve and maintain continuous compliance with JCI hospital accreditation standards.

Communicating critical information to staff and maintaining continuous compliance with JCI standards are keys to ensuring that safe, high-quality care is provided to patients—yet these goals present a real challenge for many organizations. Following are some helpful suggestions for successfully achieving continuous compliance with accreditation standards outlined in this accreditation manual:

- *Become familiar with the standards.* Review the important functions of a health care organization identified in the titles of the standards chapters. Become aware of those standards that all organizations must meet to be accredited by JCI and review the compliance expectations of the standards as well as those of the additional requirements found in the associated intents and MEs. Become familiar with the terminology used in the manual. Identify those standards that require documentation (also outlined in the *Joint Commission International Survey Process Guide for Hospitals Including Academic Medical Centers*, 8th Edition) and make sure you have the needed documentation to maintain compliance.
- *Visit your organization's extranet site.* Become aware of the accreditation policies and procedures and the accreditation process. Discover how to find the information you need about an upcoming survey or a revised requirement.
- *Use the standards to improve care, treatment, and services.* Hospitals should not view accreditation standards as rules that must be followed just for the JCI survey. Instead, incorporate tasks and processes that help integrate these concepts into your daily operations because they directly affect the safety of patients and the quality of care, treatment, and services you provide. As you self-assess your compliance with JCI surveys, identify follow-up actions needed to bring your organization into compliance and meet the needs of your patients for safe, high-quality care.

JCI's accreditation policies and procedures, as well as information about JCI's hospital accreditation process—including the presurvey, on-site survey, and postsurvey activities—can be found in their entirety on an accredited organization's secure *JCI Direct Connect* extranet site. They are also summarized in this manual.

General Eligibility Requirements

Any hospital may apply for JCI accreditation if it meets all the following criteria:

- The hospital is located outside of the United States and its territories.
- If required by law, the organization has a facility license or registration to conduct its scope of services.
- The hospital is currently operating as a health care provider in the country, is licensed to provide care and treatment as a hospital (if required), and, at minimum, does the following:
  - Provides a complete range of acute care clinical services—diagnostic, curative, and rehabilitative.
  - Provides services that are available 365 days per year; ensures that all direct patient care services are operational 24 hours per day, 7 days per week; and provides ancillary and support services as needed for emergent, urgent, and/or emergency needs of patients 24 hours per day, 7 days per week (such as diagnostic testing, laboratory, and operating theatre, as appropriate to the type of acute care hospital).
  - In the case of a specialty hospital, provides a defined set of services, such as pediatric, eye, dental, and psychiatry, among others.
- The hospital meets parameters for the minimum number of inpatients/volume of services required for organizations seeking initial or continued Joint Commission accreditation; that is, 10 inpatients served, with 1 active at the time of survey.
- The hospital provides services that can be evaluated by JCI accreditation standards for hospitals.
- The hospital assumes, or is willing to assume, responsibility for improving the quality of its care and services.
- The hospital is open and in *full operation*, admitting and discharging a volume of patients that will permit the complete evaluation of the implementation and sustained compliance with all current JCI accreditation standards for hospitals.
- The hospital meets the conditions described in the "Accreditation Participation Requirements" (APR) chapter.

In addition, academic medical center applicants must meet the additional following criteria:

- The applicant hospital is integrated (by organization or administration) with a medical school.
- The applicant hospital is the *principal site* for the education of both (1) *medical students* (undergraduates) and (2) postgraduate medical specialty *trainees* (for example, residents or interns) from such medical school.
- At the time of application, the applicant hospital is conducting *medical research* with approval and oversight by an Institutional Review Board (IRB) or research ethics committee.

Contact JCI at JCIAccrediation@jcrinc.com prior to submitting an electronic application (that is, E-App) to discuss the criteria and validate whether the hospital meets the above criteria as well as the definition for "in full operation" (in the sidebar "Understanding Terms" on page 8) at least six months or more prior to submitting its E-App and at its initial survey. JCI may request documentation of the hospital's utilization statistics prior to accepting the E-App or conducting the on-site survey. In addition, JCI will not begin a survey, may discontinue a survey, or may cancel a scheduled survey when it determines the hospital is not "in full operation."

Note: If in its reasonable discretion JCI determines that the applicant does not meet the eligibility criteria for the hospital/academic medical center accreditation program JCI will not accept or process the E-App and will notify the hospital of its decision.

Understanding Terms

Full Operation

Criteria indicating the organization's readiness for comprehensive evaluation against all relevant JCI standards, based on identification of the following in the organization's electronic application for survey (E-App):

1. A list of all clinical services currently provided for inpatients and outpatients. (Those clinical services that are planned, and thus not identified in the E-App, and begin operations at a later time will require a separate extension survey to evaluate those services.)
2. Utilization statistics for clinical services showing consistent inpatient and outpatient activity levels and types of services provided for at least four months or more prior to submission of the organization's electronic application.
3. All inpatient and outpatient clinical services, units, and departments. These locations must be available for a comprehensive evaluation against all relevant JCI standards for hospitals currently in effect, consistent with JCI's normal survey process for the size and type of organization, such as the following:
   - Patient tracer activities, including individual patient and system tracers
   - Open and closed medical record review
   - Direct observation of patient care processes
   - Interviews with patients
   - Interviews with medical students/trainees

Principal site

The location at which the hospital provides the majority of medical specialty programs for postgraduate medical trainees (for example, residents or interns) and not just one specialty, as in a single-specialty organization (for example, an ophthalmologic hospital, a dental hospital, or an orthopedic hospital).

Medical research

Basic, clinical, and health services research that includes many types of research studies, such as clinical trials, therapeutic interventions, development of new medical technologies, and outcomes research, among others. (Hospitals that primarily conduct non–human subjects research and/or research exempt from review by an Institutional Review Board or research ethics committee, such as medical record review studies, case studies, and research involving data/specimens without individually identifiable information, do not meet criterion 3 of the academic medical center eligibility criteria.)

Section I: Accreditation Participation Requirements

Accreditation Participation Requirements (APR)

Overview

This section consists of specific requirements for participation in the Joint Commission International (JCI) accreditation process and for maintaining an accreditation award.

For a hospital seeking accreditation for the first time, compliance with many of the APRs is assessed during the initial survey. For the already-accredited hospital, compliance with the APRs is assessed throughout the accreditation cycle, through surveys, the Strategic Improvement Plan (SIP), and periodic updates of hospital-specific data and information.

When a hospital does not comply with certain APRs, the hospital may be asked to submit an SIP, go through a for-cause survey, or be placed in Preliminary Denial of Accreditation. Refusal to permit performance of survey activities, such as limiting or denying access to authorized JCI staff (APR.04.00) will lead to immediate Denial of Accreditation. Consequences of noncompliance with the requirement are noted with each APR.

Requirements

The following is a list of all accreditation participation requirements. They are presented here for your convenience without their rationales, consequences of noncompliance, and measurable elements. For more information about these standards, please see the next section in this chapter, Requirements, Rationales, and Measurable Elements. JCI reserves the right to update its Accreditation Participation Requirements (APRs) and recognizes the *JCI Direct Connect* website as the official location for the posting of all current APRs.

APR.01.00 The hospital submits information to Joint Commission International (JCI) as required.

APR.02.00 The hospital provides accurate information throughout the accreditation process.

APR.03.00 The hospital reports any changes in the information provided in the application for accreditation and any changes made between surveys.

APR.04.00 The hospital permits the performance of a survey at JCI's discretion.

APR.05.00 The hospital allows JCI to request (from the hospital or outside agency) and review an original or authenticated copy of the results and reports of external evaluations from publicly recognized bodies.

APR.06.00 The hospital selects and uses measures as part of its quality improvement measurement system.

APR.07.00 The hospital accurately represents its accreditation status and the programs and services to which JCI accreditation applies. Only hospitals with current JCI accreditation may display the Gold Seal.

APR.08.00 Any individual hospital staff member (clinical or administrative) can report concerns about patient safety and quality of care to JCI without retaliatory action from the hospital.

APR.09.00 The hospital notifies the public it serves about how to contact its hospital management and JCI to report concerns about patient safety and quality of care.

APR.10.00 Translation and interpretation services arranged by the hospital for an accreditation survey and any related activities are provided by qualified translation and interpretation professionals who have no relationship to the hospital.

APR.11.00 The hospital provides patient care, treatment, services, and an environment that pose no risk of an "Immediate Threat to Health or Safety."

Requirements, Rationales, and Measurable Elements

JCI reserves the right to update its Accreditation Participation Requirements (APRs) and recognizes the *JCI Direct Connect* website as the official location for the posting of all current APRs.

Requirement APR.01.00

The hospital submits information to Joint Commission International (JCI) as required.

Rationale for APR.01.00

There are many points in the accreditation process at which data and information are required. Some examples include the completion of the electronic application (E-App); annual updates to the E-App; submission of a Strategic Improvement Plan (SIP); any changes in hospital executive leadership, such as a change in ownership; Office of Quality and Patient Safety (OQPS) requests for information; JCI Accreditation requests for verification of information received from a regulatory or other authority; or timely notification of intent to appeal an accreditation decision. Relevant accreditation policies and procedures inform the hospital of what data and/or information are required and the time frame for submission.

Consequences of Noncompliance with APR.01.00

If the hospital consistently fails to meet the requirements for the timely submission of data and information to Joint Commission International, the hospital will be required to undergo a follow-up survey. Failure to resolve this issue at the time of the follow-up survey may result in an accreditation decision change.

These consequences address only compliance with the requirement itself and not the content of the hospital's submissions to JCI. For example, if information in a hospital's E-App leads to inaccuracies in the appropriate length of the survey and a longer survey is required, the hospital will incur the additional costs of the longer survey. In addition, if there is evidence that the hospital has falsified or withheld the information or intentionally deleted information submitted to JCI, the requirement at APR.02.00 and its consequences will apply.

Measurable Elements of APR.01.00

1. The hospital meets all requirements for timely submissions of data and information to Joint Commission International. (*See also* APR.02.00, ME 1)

Requirement APR.02.00

The hospital provides accurate information throughout the accreditation process.

Rationale for APR.02.00

JCI requires each hospital seeking accreditation or already accredited to engage in the accreditation process with honesty, integrity, and transparency. This type of engagement in the accreditation process is evident by providing complete and accurate information during all phases of the three-year cycle of the accreditation process.

Hospitals provide information to JCI in any of the following ways:

- Verbally
- Direct observation by, or in an interview or any other type of communication with, a JCI employee
- Electronic or hard-copy documents submitted to JCI or through a third party, such as the media, or a government report

For the purpose of this requirement, *falsification of information* is defined as the fabrication, in whole or in part, of any information provided by an applicant or accredited organization to JCI. Falsification may include redrafting, reformatting, or deleting document content or submitting false information, reports, data, or other materials.

Consequences of Noncompliance with APR.02.00

If JCI is reasonably convinced that the hospital has submitted inaccurate or falsified information to JCI or has presented inaccurate or falsified information to surveyors, the hospital may be required to undergo a for-cause survey. Failure to resolve this issue in a timely manner or at the time of the for-cause survey may result in Denial of Accreditation.

Measurable Elements of APR.02.00

1. The hospital provides accurate and complete information throughout the accreditation process. (*See also* APR.01.00, ME 1)

Requirement APR.03.00

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

Rationale for APR.03.00

JCI collects core information regarding each hospital's profile in its E-App to understand ownership, licensure, scope and volume of patient services, and types of patient care facilities, among other factors. When any of these factors change, JCI must evaluate the change to determine if the change is within or outside of the scope of a planned initial survey or the scope of a current accreditation award.

Thus, the hospital notifies JCI within 30 days of the effective date of the change for the following:

- A change in the organization's ownership
- Requesting to change hospital accreditation to academic medical center accreditation
- A merger or acquisition; the organization has merged with, consolidated with, or acquired an unaccredited site, service, or program for which there are applicable JCI standards.
- The revocation or restriction of operational licenses or permits, any limitations or closure of patient care services, any sanctions of professional or other staff, or other actions under laws and regulations brought by relevant health authorities
- New biomedical equipment for patient care that are used to expand the types and volume of patient care services 25% or more than was stated in the most recent E-App
- Changes in use of patient care buildings, construction of new or expansion of patient care buildings, or the occupation of buildings that are used to expand the types and volume of patient care services 25% or more than was stated in the most recent E-App, or was not reported as a patient care location, or was not included in the scope of the previous accreditation survey

- Temporary cessation of services and/or significant reduction of patient care services/volume due to extenuating circumstances
- Intentional expansion of the organization's capacity to provide services in the absence of new, renovated, or expanded facilities by 25% or greater, as measured by patient volume, scope of services, or other relevant measures
- The addition of one or more types of health care services (for example, addition of a dialysis unit)
- Implementation of a higher level of service (for example, adding inpatient invasive diagnostic cardiology when originally providing only outpatient cardiac rehabilitation)

JCI does not automatically extend accreditation to new services and facilities. Based on the change, JCI may request additional information or documents; for example, policies, floor plans, fire safety plan, credentials of new staff for a new service. When JCI is unable to fully evaluate the changes with the additional information or documents provided, an extension survey may be necessary for all or a portion of the hospital again or for the first time in the case of new facilities or services.

Consequences of Noncompliance with APR.03.00

If the hospital does not provide notification to JCI within 30 days of the effective date of any change(s), the hospital may be denied accreditation.

Measurable Elements of APR.03.00

1. Ⓓ The hospital reports within 30 days of the effective date of any change(s) in the hospital's profile (electronic database) or information provided to JCI via the E-App before and between surveys.

Requirement APR.04.00

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

Rationale for APR.04.00

Achieving JCI accreditation implies to the public, governmental agencies, and payment sources, among others, that the hospital is in compliance with JCI standards and accreditation policies at all times. Thus, it is important that JCI has the right to enter all or any portion of the hospital on an announced or unannounced basis to confirm standards and accreditation policy compliance and/or evaluate patient safety and quality concerns at any time during all phases of accreditation. Surveyors will always present an official letter of introduction and at least one other form of identification as a JCI representative when the visit is unannounced.

Consequences of Noncompliance with APR.04.00

JCI will deny or withdraw the accreditation of a hospital that refuses or limits access to authorized JCI staff to perform an evaluation.

Measurable Elements of APR.04.00

1. The hospital permits evaluations of standards and policy compliance or verification of quality and safety concerns, reports, or regulatory authority sanctions at the discretion of JCI.

Requirement APR.05.00

The hospital allows JCI to request (from the hospital or outside agency) and review an original or authenticated copy of the results and reports of external evaluations from publicly recognized bodies.

Rationale for APR.05.00

In order to conduct a thorough accreditation survey, JCI collects information on many aspects of hospital operations. External bodies other than JCI evaluate areas related to safety and quality—for example, fire safety inspections, staff working conditions inspections, and evaluation of safety incidents or quality complaints by local authorities. These evaluations complement accreditation reviews but may have a different focus or emphasis. These evaluations may produce information JCI needs to make accreditation decisions.

When requested, the hospital provides JCI with all official records, reports, and recommendations of outside agencies, such as licensing, examining, reviewing, government, or planning bodies. JCI may also request such reports directly from the outside agency. The reports can be requested during any phase of accreditation, including during an accreditation survey or as part of the evaluation of a quality concern or incident.

Consequences of Noncompliance with APR.05.00

When the hospital fails to provide an official report when requested during an on-site survey, relevant standards will be scored out of compliance and the hospital may be required to undergo a for-cause survey to review the report and the relevant standards. When the hospital fails to provide a requested report during other phases of accreditation, a for-cause survey may be required.

Measurable Elements of APR.05.00

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

Requirement APR.06.00

The hospital selects and uses measures as part of its quality improvement measurement system.

Rationale for APR.06.00

Collection, analysis, and use of data are important for any quality improvement system and are at the core of the JCI accreditation process. Many JCI standards specify that organizations must collect data as part of their quality improvement system. To comply with these standards, the organization's leaders select well-defined, evidence-based measures that are applicable to the organization's patient populations and services. The organization analyzes measurement data, and the data are used to inform and propel quality improvement activities in the organization.

Organizations may choose any well-defined, evidence-based measures and measurement approaches that address process and outcomes for which the data will guide improvement in the delivery of patient care. Acceptable measures are those developed by any one or combination of the following:

- The organization's quality leaders and team
- A municipal, regional, or national health authority
- Internationally recognized health care quality authorities, such as Joint Commission International, the Institute for Healthcare Improvement, or the US-based Agency for Healthcare Research and Quality

Consequences of Noncompliance with APR.06.00

A Strategic Improvement Plan (SIP) will be required when a hospital is found to be not compliant with this requirement.

Measurable Elements of APR.06.00

1. Ⓓ The hospital selects and uses performance measures from among those available that are relevant to the service(s) it provides to the population(s) it serves.

Requirement APR.07.00

The hospital accurately represents its accreditation status and the programs and services to which JCI accreditation applies. Only hospitals with current JCI accreditation may display the Gold Seal.

Rationale for APR.07.00

The hospital's website, advertising and promotion, and other information made available to the public accurately reflect the scope of programs and services that are accredited by JCI.

The hospital does not engage in any false or misleading advertising about its accreditation award. For example, the organization's website displaying the JCI Gold Seal of Approval® may not include the contracted clinics and/or services that were not included in the accreditation survey or services that will be offered in the future but that the organization is not currently providing or acquisition of an unaccredited site, service, or program for which there are applicable JCI standards.

Consequences of Noncompliance with APR.07.00

When the hospital fails to correct inaccurate information, a for-cause survey may be required.

Measurable Elements of APR.07.00

1. The hospital's advertising accurately reflects the scope of programs and services that are accredited by JCI.
2. The hospital does not engage in any false or misleading advertising about its accreditation award.

Requirement APR.08.00

Any individual hospital staff member (clinical or administrative) can report concerns about patient safety and quality of care to JCI without retaliatory action from the hospital.

Rationale for APR.08.00

To create a "safe" reporting environment, the hospital educates all staff that concerns about the safety or quality of patient care provided in the hospital may be reported to JCI. The hospital also informs its staff that it will take no disciplinary (for example, demotions, reassignments, or change in working conditions or hours) or punitive (for example, harassment, isolation, or abuse) actions because a staff member reports safety or quality-of-care concerns to JCI. (*See also* GLD.07.01)

Methods of notice may include distribution of information about JCI, including contact information in published materials such as brochures and/or posting this information on the hospital's website.

Consequences of Noncompliance with APR.08.00

Confirmed reports of retaliatory actions to staff who reported a quality and patient safety issue to JCI may cause a Denial of Accreditation and a for-cause survey may be conducted.

Measurable Elements of APR.08.00

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

Requirement APR.09.00

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

Rationale for APR.09.00

Methods of notice may include but are not limited to distribution of information about JCI, including contact information in published materials such as brochures and/or posting this information on the hospital's website.

The following link is provided to report a patient safety or quality-of-care concern to JCI: https://www.jointcommissioninternational.org/contact-us/report-a-quality-and-safety-issue/.

Hospitals seeking initial accreditation should be prepared to discuss their plan on how compliance with this APR will be achieved when accredited. JCI standards require hospitals to have a mechanism to receive and respond to complaints, conflicts, and other patient care quality and safety concerns in a timely manner. The hospital needs to inform the public it serves about how to access this process. (*See also* PCC.02.03)

The hospital also needs to inform the public about how to report concerns about patient safety and quality of care to JCI, in particular when the hospital process has not been effective in resolving the concern.

Consequences of Noncompliance with APR.09.00

A Strategic Improvement Plan (SIP) will be required when a hospital is found to not meet this requirement.

Measurable Elements of APR.09.00

1. Ⓓ The hospital informs the public it serves about how to contact its management to report concerns about patient safety and quality of care. (*See also* GLD.07.01, ME 1)
2. Ⓓ The hospital informs the public it serves about how to contact JCI to report concerns about patient safety and quality of care.

Requirement APR.10.00

Translation and interpretation services arranged by the hospital for an accreditation survey and any related activities are provided by qualified translation and interpretation professionals who have no relationship to the hospital.

Rationale for APR.10.00

The integrity of the on-site evaluation process, as well as the integrity of the outcome, depend on the surveyor(s) obtaining an unbiased, accurate understanding of their conversations with staff; and the hospital's staff communicating effectively in their language with the surveyor(s). To ensure this accurate, unbiased exchange, translation and interpretation is provided by individuals qualified to provide translation and interpretation services, with evidence of experience in health care translation and/or interpretation services. Individuals providing translation and interpretation services are not current or former staff of the hospital and do not have any conflicts of interest, such as immediate family members or staff of an affiliated hospital. Individuals providing translation and interpretation services have not served in any consultation capacity to the hospital in relation to accreditation or accreditation preparation, with the possible exception of assistance in translating the documents required by JCI to be in English or providing translation and interpretation services at a previous survey.

Qualified translators and interpreters provide to the hospital and JCI documentation of their experience in translation and interpretation. The documentation may include but is not limited to the following:

- Evidence of advanced education in English and in the language of the host hospital
- Evidence of translation and interpretation experience, preferably in the medical field

- Evidence of employment as a professional translator or interpreter, preferably full-time
- Evidence of continuing education in translation and interpretation, preferably in the medical field
- Translation and interpretation certifications, when applicable
- Other relevant translation and interpretation credentials

In some cases, JCI can provide organizations with a list of translators and interpreters who meet the requirements listed above.

JCI Accreditation staff will obtain a signed conflict of interest statement from each translator. For unannounced surveys, the surveyor and/or JCI Accreditation staff will evaluate the credentials of the translators.

Consequences of Noncompliance with APR.10.00

When translators are found to be unqualified due to lack of professional experience and/or other qualifications, or no signed conflict of interest statement is provided, the survey will be stopped until a suitable replacement can be found. The hospital is responsible for any additional costs related to the delay, including rescheduling of survey team members when necessary.

Measurable Elements of APR.10.00

1. Ⓓ When applicable, the hospital submits the résumés of the selected translators no later than eight (8) weeks prior to the start of any JCI survey.

Requirement APR.11.00

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

Rationale for APR.11.00

Patients, staff, and the public trust hospitals to be low-risk, safe places. Thus, hospitals maintain that trust with ongoing vigilant review and supervision of safety practices.

Consequences of Noncompliance with APR.11.00

Immediate threats discovered during a survey interrupt the survey until the threat can be resolved or until the hospital, survey team, and JCI Accreditation staff can mediate the issue. Until the issue is resolved, the hospital is placed in Preliminary Denial of Accreditation and a follow-up survey is conducted.

Measurable Elements of APR.11.00

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

Section II: Patient-Centered Standards

Access to Care and Continuity of Care (ACC)

Overview

Health care organizations are pursuing a more comprehensive and integrated approach toward delivering health care. This approach is characterized by a high degree of collaboration and communication among health care practitioners. Hospitals need to consider the care provided as part of an integrated provider system of services, health care practitioners, and levels of care, which make up a continuum of care. The goal is to correctly match the patient's health care needs with the services available, to coordinate timely and high-quality services provided to the patient in the organization, and then to plan for referral, transfer, or discharge and follow-up. The result is improved patient care outcomes and more efficient use of available resources.

Information is essential for making correct decisions about the following:

- Which patient needs can be met by the health care organization
- Prioritization for patients presenting with urgent or immediate needs
- Efficient flow of services to the patient
- Access to intensive care or specialized services
- Coordination and continuity of care
- Referral, transfer, or discharge of the patient to their home or to another care setting
- Safe patient transportation

Standards

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

Admission to the Hospital

ACC.01.00 Patients admitted to the hospital or who seek outpatient services are screened to identify if their health care needs match the hospital's mission, scope of care, and resources.

ACC.01.01 Patients with emergent, urgent, or immediate needs are given priority for assessment and treatment.

ACC.01.02 The hospital considers the clinical needs of patients and informs patients when there are unusual delays for diagnostic and/or treatment services.

Patient Flow

ACC.02.00 The hospital has a process for managing the flow of patients throughout the hospital that includes the admission and registration of patients, as applicable to the patient care setting.

ACC.02.01 At the time of admission, the patient and family receive education and orientation to the patient care area, information on the proposed care and any expected costs for care, and the expected outcomes of care.

ACC.02.02 The hospital establishes criteria for admission to and discharge from units or departments providing specialized services.

Continuity of Care

ACC.03.00 The hospital provides continuous patient care services and coordination among health care providers.

ACC.03.01 There is a qualified individual responsible for the patient's care.

Discharge, Referral, and Follow-Up

ACC.04.00 The hospital develops and implements a discharge planning and referral process based on the patient's readiness for discharge.

ACC.04.01 The hospital's discharge process includes patient and family education related to the patient's ongoing need for continuing care, treatment, and services.

ACC.04.02 The complete discharge summary is prepared for all patients and is included in the patient's medical record.

ACC.04.03 Emergency care is documented.

ACC.04.04 Medical records contain patient profiles.

ACC.04.05 The hospital has a process for the management of patients who leave against medical advice.

Transfer of Patients

ACC.05.00 The hospital has a process to transfer patients to other health care organizations based on the patient's status and the hospital's ability to meet those needs.

ACC.05.01 The receiving organization is given a written summary of the patient's clinical condition and the interventions provided by the hospital, and the process is documented in the patient's medical record.

Transportation

ACC.06.00 The hospital's transportation services comply with relevant laws and regulations and meet requirements for high-quality, safe transport.

Standards, Intents, and Measurable Elements

Admission to the Hospital

Standard ACC.01.00

Patients admitted to the hospital or who seek outpatient services are screened to identify if their health care needs match the hospital's mission, scope of care, and resources.

Intent of ACC.01.00

Matching patient needs with the hospital's mission, scope of care, and available resources depends on obtaining information on the patient's needs and condition through screening. Decisions to treat, to transfer, or to refer are made only after the results of screening evaluations are available.

Screening for patient needs and condition may be conducted through various means, including the following:

- Triage criteria in the emergency department or outpatient urgent/immediate care clinic
- Visual evaluation

- Physical examination
- Previous physical, psychological, clinical laboratory, or diagnostic imaging evaluations

The screening may occur at various points of contact, including the following:

- At a referring source (for example, primary care visit)
- During emergency transport
- Upon arrival at the hospital

If patients qualify for admission, their care needs are identified and prioritized. These needs may include the following:

- Preventive services
- Diagnostics services
- Curative or treatment services
- Rehabilitative services
- Palliative services

The patient is admitted to the service or unit that meets the patient's most urgent needs.

When the hospital does not have the clinical capability to provide the needed services, the patient is transferred, referred to, or assisted in identifying sources of services to meet their needs. The transferring hospital must provide and document stabilizing treatment within its capacity prior to transfer.

Measurable Elements of ACC.01.00

1. Screening results determine if patients are accepted or admitted to the hospital, dependent on patient needs matching the hospital's mission, scope of care, and available resources.
2. Patients outside of the hospital's mission, scope of care, or available resources are assessed and stabilized within the capacity of the hospital prior to transfer.
3. The hospital transfers, refers, or assists the patient or family in identifying and/or obtaining appropriate sources of care if their needs do not match the hospital's mission, scope of care, or available resources.
4. Patients are admitted to the service or unit that meets their most urgent needs.
5. Ⓓ Assessments and treatments completed prior to transfer are documented in a record maintained by the transferring hospital. (*See also* ACC.03.00, ME 4)
6. There is a process to provide the results of diagnostic tests to those responsible for determining if the patient is to be admitted, transferred, or referred.

Standard ACC.01.01

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

Intent of ACC.01.01

The hospital identifies which patients need emergent, urgent, or immediate care and prioritizes care.

Patients with emergent, urgent, and immediate care needs are identified and prioritized through the use of a recognized triage process, such as Emergency Severity Index or Canadian Triage and Acuity Scale. Staff responsible for identifying and prioritizing patient needs are trained in the selected triage process.

The triage process includes early recognition of the signs and symptoms of communicable diseases. Patients identified as having, or suspected of having, potential communicable diseases are segregated and/or isolated.

The triage process includes identifying patients who require clinical observation. The clinical observation period allows appropriate clinicians to determine whether a patient requires admission or is safe to discharge from the hospital. There is a defined process for clinical observation prior to admission to or discharge from the hospital.

Certain screenings or diagnostic tests may be required for every patient being admitted, or the hospital may identify specific screenings and tests for particular patient populations based on risk. Examples include the following:

- Screening patients with active diarrhea for *Clostridioides difficile* (*C. diff*)
- Screening patients from other health care organizations for methicillin-resistant *Staphylococcus aureus* (MRSA)

The triage process used by the hospital organization meets the following criteria:

- Is based on evidence or established by a professional organization.
- Is appropriate for the patient population (for example, pediatric vs. adult triage tools, obstetric tools).

The clinical observation process includes the following:

- Criteria for admission to or discharge from the hospital
- A time limit on the observation period
- Identification of who determines whether the patient is admitted or discharged from the hospital

Screenings and diagnostic tests required for admission are based on the following:

- Current trends in health care and current scientific evidence
- Risks specific to patient population cared for by the organization
- Risks specific to the environment and geographic region

Measurable Elements of ACC.01.01

1. Ⓓ The hospital selects and uses an evidence-based triage process, appropriate to its patient population, to identify and prioritize patients with emergent, urgent, and immediate needs.
2. The hospital has identified which specific screenings or diagnostic tests must be completed prior to admitting or registering patients.
3. The triage process includes early recognition of communicable diseases.
4. Staff are trained to use the triage process, including the early recognition of communicable diseases.
5. There is a process for holding patients for observation when clinically indicated.

Standard ACC.01.02

The hospital considers the clinical needs of patients and informs patients when there are unusual delays for diagnostic and/or treatment services.

Intent of ACC.01.02

Delays for diagnostic services and treatment may negatively impact patient condition, particularly when a patient's condition or treatment is time sensitive. Patients have a right to know and understand the potential impact of these delays on their health.

Patients are informed when there are known long delays for diagnostic and/or treatment services or when obtaining planned care may require placement on a waiting list. Examples of such delays include the following:

- Waiting for an organ transplant
- A delay in obtaining a diagnostic test due to limited appointments
- Waiting for an elective surgical procedure due to limited availability of operating theatres

Patients are informed of the associated reasons for the delay and are informed of alternatives, if available.

This requirement applies to inpatient and outpatient care and/or diagnostic services. This requirement does not apply to minor, usual, or expected waiting periods for outpatient care or inpatient care. Examples of such delays include the following:

- When a provider is behind schedule in a clinic
- When the emergency department and its waiting room are full

- When a delay is consistent with regional norms for specialized services, such as oncology treatment or organ transplant

These are reasonable examples for delays, but patients and/or their families should still be informed of delays and the reason for them. Appropriate and timely communication is essential to address anxiety and demonstrate genuine empathy for patients and/or their families.

Unusual delays require documentation in the patient's medical record. Documentation of unusual delays includes the reason for the delay, so the hospital and health care provider understand how it impacted patient care. Examples of unusual delays include the following:

- Insufficient staffing
- Miscommunication
- Rejected laboratory specimen

Measurable Elements of ACC.01.02

1. Patients are informed when there will be a delay in care and/or treatment.
2. Patients are informed of the reasons for the delay and provided with information on available alternatives consistent with their clinical needs.
3. The information on unusual delays and reasons for the delay are documented in the patient's medical record.

Patient Flow

Standard ACC.02.00

The hospital has a process for managing the flow of patients throughout the hospital that includes the admission and registration of patients, as applicable to the patient care setting.

Intent of ACC.02.00

Managing the flow of patients throughout the hospital improves the coordination of care, patient safety, and health outcomes. It is essential to minimize boarding of patients in the emergency department or other temporary areas in the hospital.

Patient flow is the movement of patients throughout the hospital from the point of admission to the point of discharge or from the point of registration to the point of disposition. Effective management of processes that support patient flow can minimize delays in the delivery of care. Patient flow includes the following:

- Admission and discharge of patients
- Scheduled, elective, and emergent admissions
- Assessment and treatment of patients
- Patient transfers between units or other levels of care
- Availability of staff and resources

The hospital has a process to manage patient flow. Components of the process include the following:

- Available inpatient beds in appropriate care areas
- Availability of appropriately trained and credentialed staff
- Expected patient progression and movement through all care areas, including the following:
  - Emergency department
  - Inpatient units
  - Operating theatres and procedure areas
  - Diagnostic testing areas
- Availability and efficiency of nonclinical services that support patient care, including housekeeping and transportation

Hospitals must prepare for patient overflow when patient flow does not progress as expected, and when there is an influx of patients. Preparation plans address patient and staff requirements to provide safe care to patients boarding in the emergency department or held in other temporary locations.

The hospital has a process to manage overflow patients boarding in the emergency department and other temporary areas. This process includes the following:

- Facility plans for allocation of space, utilities, equipment, medical equipment, and supplies
- Staffing plans
- Clinical resource availability and access, including the following:
  - Overflow or boarded patients receive the same level of care as admitted patients.
  - Overflow or boarded patients have the same access to clinical services as admitted patients.
  - Overflow or boarded patients have the same access to nonclinical services as admitted patients.
- An established timeline for transferring patients from temporary holding areas or the emergency department to appropriate inpatient beds

Staff from throughout the hospital can contribute to understanding and resolving problems in patient flow. The hospital establishes measures and goals to review the effectiveness of the patient flow process. These measures and goals are monitored and inform strategies to improve patient flow. The effectiveness of process improvements to patient flow is evaluated.

Measurable Elements of ACC.02.00

1. The hospital implements a patient flow process, including the following:
   - Availability of appropriate beds
   - Properly trained staff
   - Expected movement and progression throughout care areas
   - Availability of nonclinical services
2. The hospital has an admission process for patients, regardless of their origin of arrival, including a registration process for patients who do not require admission.
3. The hospital plans and provides for the care of patients who are boarded in the emergency department and other temporary holding areas, including the following:
   - Allocation of space, utilities, equipment, medical equipment, and supplies
   - Staffing plans
   - Availability of clinical resources
   - Availability of nonclinical resources
   - Provision of timely and equivalent care to meet patient needs
   - A time limit on boarding patients in the emergency department and other temporary holding areas and a process for managing patients when temporary boarding periods exceed this time limit
4. Ⓓ The patient flow processes are reviewed for effectiveness, and process improvements are identified and implemented.

Standard ACC.02.01

At the time of admission, the patient and family receive education and orientation to the patient care area, information on the proposed care and any expected costs for care, and the expected outcomes of care.

Intent of ACC.02.01

Orientation to the care environment, including equipment related to the care and services provided, is an essential component of patient safety. Patients and their families receive sufficient information to make knowledgeable decisions. Patients and clinical staff understand the scope and limits of the general consent (if used by the hospital) to protect patient autonomy and rights.

The patient and their family receive information about the proposed care, the expected outcomes of care, and any expected cost for the care when not paid for by a public or private source. This information can be provided as a written document or through verbal explanation. It must also be noted in the patient's medical record.

The hospital seeks ways to minimize any financial barriers for the patient. Examples include the following:

- Providing applications for financial aid
- Identifying sources of charitable funding for health care
- Providing prescriptions for generic rather than branded medications

When used, general consents include the following:

- The scope of the general consent (for example, which tests and treatments are covered by the general consent)
- What tests and treatments require additional informed consent
- How patients receive information (for example, via patient portal or text messaging)

The hospital specifies how the general consent is documented in the patient's medical record.

The hospital may rely on implied consent or obtain a general consent for treatment when the patient is admitted or registered for the first time. Hospitals are not required to use a general consent unless required by laws and regulations. Regardless of whether general consent is obtained, all patients are informed about what tests and treatments require additional informed consent.

All patients are informed about the likelihood of students participating in their care; for example, medical students, nursing students, physical therapy students, respiratory therapy students.

Measurable Elements of ACC.02.01

1. The patient and family receive education and orientation to the patient care area.
2. The patient and family receive information on the proposed care, treatment, and services, including expected outcomes.
3. The patient and family receive information on any expected costs related to the proposed care, treatment, and services.
4. Patients and families are informed as to the scope of a general consent, if used by the hospital. (*See also* PCC.03.00, ME 3)
5. Ⓓ The hospital defines, in writing, how a general consent is documented in the patient's medical record, if used by the hospital. (*See also* PCC.03.00, ME 1)
6. All patients receive information about the likelihood of students and trainees participating in care processes.

Standard ACC.02.02

The hospital establishes criteria for admission to and discharge from units or departments providing specialized services.

Intent of ACC.02.02

Specific criteria for admission to and discharge from intensive care or specialized units or departments ensures that patients are receiving an appropriate level or type of care and encourages the efficient use of these limited resources.

Units or departments that provide intensive or specialized care are costly, use many resources, and usually are limited in space and staffing. Hospitals should restrict admission to these units or departments to ensure the appropriate use of these areas and resources. The hospital must establish criteria regarding which patients require the level and type of care provided by these specialized units or departments. Criteria must be

consistently implemented throughout the hospital and among clinical staff determining patient disposition. Examples of these units or departments and their admission criteria include the following:

- Criteria for admission to a burn unit may include a specific percentage of the burned body surface and/or whether the burn is a second- or third-degree burn.
- Criteria for admission to an intensive care unit may require that patients are intubated, need close monitoring for critical changes, or require additional equipment (for example, IV lines and pumps, feeding tubes, drains and catheters).
- Admission to a postanesthesia care unit vs. surgical intensive care unit may be determined by whether the patient remains intubated, is on vasopressors, or requires complex wound care.

The criteria are used to determine direct admission to the unit or department (for example, directly from the emergency department). The criteria are also used to determine admission into the unit or department from another clinical area within the hospital or transferred from another hospital.

Patients admitted to a specialized unit or department require periodic reassessment to determine when a patient continues to meet criteria for specialized services. Examples of patients no longer meeting criteria include the following:

- A patient admitted to an intensive care unit whose physiological status has stabilized and no longer requires continuous monitoring
- A patient whose physiological status has deteriorated, and care goals are redirected to comfort or palliative care, requiring less intensive monitoring

Whenever possible, criteria for intensive or specialized units and departments meet the following requirements:

- Use prioritization or severity-of-illness criteria.
- Are based on diagnostic and/or objective parameters.
- Use physiologic-based criteria for medical and surgical services.
- Use psychological-based criteria for psychiatric services.
- Include required lifesaving or life-sustaining technology, interventions, and medications. Examples of such technology, interventions, and medications include the following:
  - Ventilators or other respiratory support
  - Vasopressors or other medications requiring frequent or continuous monitoring
  - Frequency of direct observation of the patient
  - Frequency and complexity of wound care

Intensive or specialized units or departments establish criteria for reassessment of admitted patients, which include the following:

- When and how often patients should be reassessed for continued care or transfer to a different level of care
- Diagnostic and/or objective parameters for safe transfer to a different level of care
- Physiologic-based and/or psychological-based criteria
- Frequency and type of technology, interventions, and medications for de-escalation of treatment

Measurable Elements of ACC.02.02

1. Ⓓ The hospital has established written admission criteria, based on prioritization, diagnostic, and/or objective parameters, for specialized units or departments.
2. Ⓓ The hospital has established written discharge and/or transfer criteria from specialized units or departments to a different level of care.
3. The medical records of patients who are admitted to specialized units or departments contain evidence that they meet the criteria for care, treatment, and services. (*See also* GLD.06.00, ME 3)
4. The medical records of patients who are transferred or discharged from specialized units or departments contain evidence that they meet criteria for discharge. (*See also* ACC.03.00, ME 1; ACC.05.00, ME 1; GLD.06.00, ME 4)

Continuity of Care

Standard ACC.03.00

The hospital provides continuous patient care services and coordination among health care providers.

Intent of ACC.03.00

Care coordination and continuity among health care practitioners improves patient safety and outcomes. Coordination is accomplished through access to patient information that is imperative to these processes. Therefore, health care practitioners who are part of the patient's care, treatment, and services are provided access to relevant information.

Patients are transferred within the hospital between various services and units or departments. The hospital identifies individuals for coordinating patient care and services. Many health care practitioners care for patients throughout the hospital. Throughout all phases of care, patient needs are matched with required level of care and resources for care. When necessary, patients are transferred or referred to resources or services outside the hospital. The hospital establishes criteria or policies to determine appropriateness of transfers within and from the hospital.

Continuity is enhanced when all health care practitioners have the information needed from the patient's current and past medical experiences to make decisions about the patient's care. When multiple decision-makers are providing care, these decision-makers agree on the care and services to be provided.

The hospital implements processes for continuity and coordination of care among physicians, nurses, and other health care practitioners in all settings, including the following:

- Emergency services and inpatient admission
- Diagnostic services
- Surgical and nonsurgical treatment services
- Outpatient care programs
- Other organizations and other care settings

The patient's medical record is a primary source of information for patient care and is an essential communication tool. The medical record must contain current information and be available during inpatient care and for outpatient visits. Medical, nursing, and other patient care notes are available to all the patient's health care practitioners who need them for patient care.

The patient's complete health care record is transferred with the patient when changing care teams or settings within the hospital so treatments, medications, and other interventions may continue without interruption. When a patient is transferred to an outside organization, the hospital provides the care team receiving the patient with a copy of the patient's medical record or a summary of essential information from the patient's health care record.

When transferring a patient to an outside organization, the hospital may transfer a copy of the patient's medical record or send a transfer summary with the patient. The transfer summary contains the following information from the patient's health care record:

- Chief complaint(s)
- Significant findings
- Diagnosis
- Procedures performed
- Medications
- Other treatments
- Patient condition at time of transfer

Care coordination and continuity processes are supported by the following:

- Guidelines
- Clinical pathways
- Referral forms
- Checklists

Measurable Elements of ACC.03.00

1. Ⓓ Hospital leaders implement processes that support the continuity and coordination of care across all care settings. (*See also* ACC.02.02, ME 4; ACC.05.00, ME 1; GLD.06.00, ME 4)
2. The patient's medical record is available to those practitioners who are authorized to have access and need it for the care of the patient. (*See also* MOI.01.01, ME 4)
3. The patient's medical record is up to date with the patient's latest information.
4. The patient's medical record or a summary of patient care information is transferred with the patient to another service or unit in the hospital. (*See also* ACC.01.00, ME 5)
5. Ⓓ The written transfer summary of the patient's medical record contains, at minimum, the following:
   - The reason for admission
   - Significant findings and test results
   - Diagnosis
   - Procedures performed
   - Medications administered during hospitalization, including last time of administration and current medications (*See also* MMU.04.02, ME 2)
   - Other treatments
   - Patient condition at time of transfer
6. Care coordination and continuity are supported using various tools, such as care plans, guidelines, or protocols.

Standard ACC.03.01

There is a qualified individual responsible for the patient's care.

Intent of ACC.03.01

A clearly identified individual overseeing a patient's entire hospital stay improves continuity, coordination, patient satisfaction, quality, and clinical care outcomes.

The individual with responsibility for the patient's overall care coordination is clearly identified, for all the different phases of patient care. This individual may be a physician or another qualified individual. The individual responsible is identified in the patient's medical record. This individual collaborates and communicates with the other health care practitioners. When more than one individual is responsible for coordination of care, there is a higher likelihood of uncertainty and a lack of effective coordination. Hospital policy defines the process for the transfer of responsibility to another individual during vacations, holidays, and other periods.

The hospital creates a policy that guides the process for patient oversight, including the following:

- Identifying the individual overseeing all phases of patient care; for example, a physician or other advanced provider
- Defining the process for transfer of oversight responsibility during off days; for example, vacations, sick days, holidays
- Identifying consultants, on-call physicians, locum tenentes, or others who take responsibility
- Defining how transfer of responsibility occurs and what documentation is required to ensure coordination and documentation of their participation or coverage; for example, when a patient moves from one phase of care to another

Measurable Elements of ACC.03.01

1. A qualified individual responsible for the coordination of the patient's care is available through all phases of inpatient care and is identified in the patient's medical record.
2. There is a process for transferring the responsibility for coordination of care.
3. Ⓓ The process identifies how transferred responsibility is assumed, and the participation or coverage is documented.

Discharge, Referral, and Follow-Up

Standard ACC.04.00

The hospital develops and implements a discharge planning and referral process based on the patient's readiness for discharge.

Intent of ACC.04.00

Effective and early discharge planning can decrease the risk of hospital readmission, improve recovery, ensure safe medication practices, and help prepare patients and/or families in having safe, posthospital care.

Discharge planning is a process used to help determine what types of continued care and services a patient may need after leaving the hospital. Improvements in hospital discharge planning significantly improve outcomes for patients as they move to the next level of care. Early initiation of the discharge planning process is paramount to maximizing outcomes. The discharge planning process includes assessing and identifying the patient's need for continuing care or services. The patient's principal health care provider determines readiness for referral or discharge.

Referring or discharging a patient to a health care provider outside the hospital, another care setting, home, or family is based on the patient's health status and readiness for discharge. The hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. An organized process is required to ensure that any continuing needs are met.

Patients not directly referred or transferred to another health care practitioner receive clear instructions on where and how to receive continuing care. This is essential to ensure that all care needs are met. The instructions include the name and location of sites for continuing care, any return to the hospital for follow-up, and when urgent care should be obtained. The process includes referring patients to sources of care outside the region when required.

The hospital begins to plan for the continuing needs as early in the care process as possible. The discharge planning process begins with the initial assessment and is updated throughout the care process as the patient's discharge needs become clearer. Discharge planning includes any special education the patient may require related to continuing care outside of the hospital. The patient, the patient's family, health care practitioners, and others involved in the patient's care participate in planning the patient's discharge or transfer.

The hospital establishes a method to determine a patient's readiness for discharge. This includes the use of the following:

- Relevant criteria
- Clinical indications
- Clinical guidelines/protocols

The hospital establishes a process to ensure that patients receive any continuing care or support services they need following discharge. Continuing care needs include the following:

- Referral to a medical specialist
- Rehabilitation services

- Admission to a long-term care facility
- Home care services
- Psychological services
- Social services
- Home medical supplies or equipment
- Education related to continuing care needs

Patients discharged home are provided with at least the following information:

- Name and location of a site(s) for continuing care; for example, ambulatory care clinic, rehabilitation center, nearest emergency department
- Written instructions regarding any follow-up visits or care
- When and how to obtain urgent or emergent care

Discharge planning and instruction are documented in the patient's medical record and provided to the patient in writing.

Measurable Elements of ACC.04.00

1. The patient's discharge and/or referral is consistent with relevant criteria, indications, or guidelines.
2. The discharge planning process begins with the initial assessment and includes care, treatment, equipment, and services that meet the continuing needs of the patient.
3. Patients not directly referred or transferred are provided with the name and location of a site(s) for continuing care.
4. Patients not directly referred or transferred are provided instructions, in writing, on when to return to the hospital for continued care, treatment, and service, and when and how to obtain urgent care.
5. Patients, family as appropriate, and staff involved in the patient's care participate in the discharge planning process.
6. Discharge planning and instructions are documented in the patient's medical record and provided to the patient in writing.

Standard ACC.04.01

The hospital's discharge process includes patient and family education related to the patient's ongoing need for continuing care, treatment, and services.

Intent of ACC.04.01

Patient and family education is an important component of the discharge plan and supports the patient's return to previous functional levels and maintenance of optimal health.

The discharge process addresses the patient's and family's need for education on how to manage the patient's continuing care needs at home or for education on how to support the patient's continuing care needs in another setting. Standardized materials and processes are used to educate patients on topics related to their ongoing care and treatment after discharge. Patient education and follow-up instructions are provided to the patient in a form and language the patient understands.

Based on the patient's identified continuing care needs, discharge education and instructions may include but are not limited to the following topics:

- Review of all medications to be taken at home
- Safe and effective use of all medications, including potential medication side effects
- Potential interactions between prescribed medications and other medications (including over-the-counter preparations) and food
- Diet and nutrition
- Pain management

- Safe and effective use of medical equipment
- Rehabilitation activities and services

Patient education and follow-up instructions are provided to the patient in a form and language the patient understands. It is recommended that education and instructions are provided in writing to the patient and family, so they can refer to these materials as needed. However, not all patients and families have even basic reading skills. If education and instructions are provided in other forms, this must be documented in the patient's medical record. Education and instructions may be provided in the following forms:

- In writing (recommended method)
- Verbally
- Media (for example, videos, photographs, pictograms)

Measurable Elements of ACC.04.01

1. Ⓓ Patients and families are provided with a complete written list of medications to be taken at home and are educated on their safe use, including the following:
   - Potential side effects
   - Potential interactions between medications
   - Potential interactions between medications and foods
2. Patients and families are educated about proper diet and nutrition.
3. Patients and families are educated about pain management. (*See also* COP.07.00, ME 3)
4. Patients and families are educated about safe and effective use of medical equipment and rehabilitation activities and services.
5. Patient and family education is documented in the patient's medical record and includes the following:
   - What information and education were provided
   - How the information and education was delivered (for example, in writing, verbally, by demonstration)
   - Confirmation that the patient and/or family understood the information and education provided

   (*See also* PCC.04.01, MEs 2 and 3)

Standard ACC.04.02

The complete discharge summary is prepared for all patients and is included in the patient's medical record.

Intent of ACC.04.02

The discharge summary provides an overview of the patient's care and is intended to be used by the health care provider(s) caring for the patient following discharge.

A summary of the patient's care is prepared prior to discharge from the hospital. Any qualified individual can compile the discharge summary, such as the patient's physician or a house officer. A copy of the discharge summary is provided to the practitioner who will be responsible for the continuing or follow-up care of the patient.

A copy is to be given to the patient when indicated by hospital policy or when required by local laws or regulations. When the provider responsible for follow-up care is unknown (for example, patients who are visiting from a different region or country), a copy of the discharge summary is given to the patient or family. The expectation is that the patient provides the copy of their discharge summary to their primary care or general practitioner responsible for their care.

A copy of the discharge summary is included in the patient's medical record.

The hospital has a process to provide a copy of the discharge summary to the health care provider responsible for the patient's continuing or follow-up care.

The hospital has defined situations when a patient will be given a copy of the discharge summary. Examples include the following:

- When required by hospital policy
- When required by local laws or regulations
- When the health care provider responsible for the patient's follow-up care is unknown

The summary includes the following:

- Reason for admission, diagnoses, and comorbidities
- Significant physical and other findings
- Diagnostic and therapeutic procedures performed
- Medications at time of discharge, including last date/time administered
- All medications to be taken at home
- Therapeutic equipment at time of discharge (for example, nebulizers, glucometer, ambulation devices)
- The patient's condition at the time of discharge (examples include "condition improved," "patient at baseline condition")
- Follow-up instructions

Measurable Elements of ACC.04.02

1. A discharge summary is prepared by a qualified individual.
2. The discharge summary contains at least the following:
   - Reason for admission, diagnoses, and comorbidities
   - Significant physical and other findings
   - Diagnostic and therapeutic procedures performed
   - Medications at time of discharge, including date/time of last dose given while hospitalized
   - All medications to be taken at home
   - Therapeutic equipment at time of discharge
   - The patient's condition at the time of discharge
   - Follow-up instructions
3. A copy of the discharge summary is provided to the health care provider responsible for the patient's continuing or follow-up care.
4. The patient or caregiver is provided with a copy of the discharge summary.
5. A copy of the completed discharge summary is included in the patient's medical record at the time of discharge.

Standard ACC.04.03

Emergency care is documented.

Intent of ACC.04.03

Emergency care is documented to ensure continuity of care and to permit providers at the next level of care to understand the emergency services provided.

The record of each patient receiving emergency care includes the arrival and departure times. This information is captured for all emergency department patients, including those who are discharged from the hospital, transferred to another facility, or admitted as inpatients. Departure time may be when the patient physically leaves the emergency department to go home or to another facility, or the time at which the patient is moved to another unit as an inpatient. For patients discharged from the emergency department, the medical record includes conclusions following completion of emergency treatment, the patient's condition at discharge, and follow-up care instructions.

Measurable Elements of ACC.04.03

1. The medical records of all emergency patients include arrival and departure times.
2. The medical records of patients discharged from the emergency department include conclusions following completion of treatment.
3. The medical records of patients discharged from the emergency department include the patient's condition at discharge.
4. The medical records of patients discharged from the emergency department include any follow-up care instructions.

Standard ACC.04.04

Medical records contain patient profiles.

Intent of ACC.04.04

Patient profiles provide a summary of a patient's condition and treatments and are available to all members of the patient's health care team across the continuum of care. Patient profiles provide a "snapshot" of the patient and their care.

The hospital creates patient profiles or similar brief overviews for all patients, including inpatients and outpatients, as part of the patient medical record. A profile makes updated critical information quickly and easily available to health care providers, particularly when there are multiple providers involved in the patient's care. Patient profiles are particularly helpful when patients have complex diagnoses and care, multiple problems, or multiple care teams. Because a health care occurrence is dynamic, the patient profile must be kept up to date and current with patient information as any changes occur. The profile summary should be available within one document for efficient access by any health care provider.

A patient profile is required for both electronic and hard-copy medical records.

The process for creating patient profiles includes defining what information is part of the patient profile. Examples of such information include the following:

- Patient age, weight, height
- Active problem list
- Past medical and surgical history
- Current treatment information
- Allergies

Additional considerations include creating a format that is easy for clinicians to retrieve and review and evaluating the process to verify that the profile meets the needs of the clinicians.

The patient profile may be structured differently or contain different information between care areas to meet clinician needs; however, the profile must be consistent within care areas, as in the following examples:

- Inpatient and outpatient profiles may be structured differently, but all inpatient and outpatient profiles are consistent.
- Medical and surgical patient profiles may be structured differently but all medical and surgical patient profiles are consistent.
- Psychiatric and physical rehabilitation patient profiles may be structured differently, but all psychiatric patient physical rehabilitation profiles are consistent.

Measurable Elements of ACC.04.04

1. All patient medical records contain a patient profile or similar overview.
2. Ⓓ The hospital identifies necessary information to be included in the profiles.
3. The patient profile is easy to access and review and is consistent within care areas.
4. The process is evaluated to ensure that the implementation is consistent with the policy and provides clinicians with an accurate overview of the patient.

Standard ACC.04.05

The hospital has a process for the management of patients who leave against medical advice.

Intent of ACC.04.05

Patients leaving against medical advice are at risk of inadequate treatment, which may result in permanent harm or death. The hospital must have a process to manage patients leaving against medical advice and to inform them of the risks related to this decision.

"Leaving against medical advice" means leaving the hospital after an examination has been completed and a treatment plan has been recommended. Leaving against medical advice also includes patients who do not complete or return for complex or lifesaving treatments in the outpatient setting.

Inpatients and outpatients, including patients from the emergency department, have the right to refuse medical treatment and to leave the hospital against medical advice. However, these patients may be at risk of inadequate treatment, which may result in permanent harm or death.

When a competent patient requests to leave the hospital without medical approval, the risks must be explained by the provider recommending the treatment plan or their designee, and the conversation should be documented in the medical record. If the patient allows it, normal discharge procedures should be followed. Patients leaving against medical advice do not leave the facility without receiving information on their medical care. Health care providers attempt to identify why the patient is choosing to leave against medical advice to improve communication and identify potential process improvements. When a patient leaves the hospital against medical advice without notifying anyone or does not return for treatment, the hospital must try to contact the patient to inform them of potential risks.

If the patient has a documented primary care provider, they must be notified of the patient's decision to leave against medical advice. When applicable, the hospital reports cases of infectious disease and provides information regarding patients who may harm themselves or others to local and national health authorities as required.

If the patient is at risk of self-harm or harming others, the hospital should restrain the patient from leaving if allowed by local laws and regulations.

The hospital may develop a process to allow patients to leave the hospital for a defined period (such as on a weekend "pass") if approved by the patient's attending physicians and permitted by local laws and regulations. Such a temporary absence is not considered leaving against medical advice.

The hospital designs this process to be consistent with applicable laws and regulations. The process for managing patients who leave against medical advice includes the following:

- Inpatients who leave with or without informing hospital staff
- Patients who have absconded
- Patients receiving complex treatment who do not complete or do not return for treatment ("no shows")

The process includes contacting the following individuals:

- The patient (if possible) to inform them of the potential risks of leaving against medical advice
- The patient's family or caregivers, as applicable
- The patient's primary care provider if one is known
- Local and national health authorities, as required, if the patient has a known or suspected reportable infectious disease
- Local authorities, as required, if the patient is at risk for harming themselves or others

The process defines expectations for documenting "leaving against medical advice," patient absconded, and no shows.

The process includes the following:

- Permitting patients to leave for a defined period of time during the planned course of treatment
- Identifying clinical criteria for patients to leave. Examples of criteria include the following:
  - Physical status
  - Mental status
  - Patient's ability to care for themselves or the family's ability to care for the patient
- Including the treatment team, the patient, and the patient's family (if applicable) in the decision

Measurable Elements of ACC.04.05

1. Ⓓ There is a written process for managing patients who leave against medical advice; this process includes the following:
   - Inpatients who leave with and without informing hospital staff
   - Patients who have absconded
   - Patients receiving complex treatment who do not complete or do not return for treatment ("no shows")
   - Documentation requirements
2. There is a process to inform the patient of the medical risks of inadequate treatment.
3. The patient is discharged according to the hospital discharge process.
4. There is a process to notify the patient's primary care provider if a patient leaves against medical advice.
5. The process is consistent with applicable laws and regulations, including requirements for reporting cases of infectious disease and when patients may be a threat to themselves or others.
6. When consistent with regional laws and regulations, the hospital develops a process for allowing patients to leave the hospital during the planned course of treatment for a defined period of time.

Transfer of Patients

Standard ACC.05.00

The hospital has a process to transfer patients to other health care organizations based on the patient's status and the hospital's ability to meet those needs.

Intent of ACC.05.00

Transferring a patient to an outside organization is based on the patient's status and need for continuing health care services. Criteria help to identify when a transfer is necessary to ensure that the patient's needs are met.

Transfer may be in response to a patient's needs. Examples of needs include the following:

- Specialized consultation and treatment
- Urgent services
- Less intensive services (such as subacute care or long-term rehabilitation)
- Patient or family request

The hospital must determine if the receiving organization provides services to meet the patient's needs and has the capacity to receive the patient. This advance determination ensures continuity of care and that the patient's care needs will be met. Transfer requirements are described in formal or informal affiliations or agreements. However, transfers may occur to other specialized treatment or services without formal or informal agreements.

A consistent process for patients is required to ensure that patients are transferred between health care organizations safely.

The condition and status of the patient determine the required qualifications of the staff member monitoring the patient and the type of medical equipment needed during transfer.

The hospital evaluates the quality and safety of the transfer process to ensure that patients are transferred with qualified staff and the correct medical equipment for the patient's condition.

The patient transfer process specifies the following:

- How and when responsibility is transferred between providers and organizations
- Criteria for when transfer is necessary to meet the patient's needs
- Who is responsible for the patient during transfer
- Qualifications of the staff caring for the patient during transfer
- What medications, supplies, and medical equipment are required during transport
- Follow-up mechanism that provides information regarding the condition of the patient during transfer and upon arrival to the receiving organization
- What is done when transfer to another source of care is not possible

Measurable Elements of ACC.05.00

1. Ⓓ The hospital develops a written transfer process based on patients' needs for continuing care and ensures that the receiving organization meets the needs of the patient to be transferred. (*See also* ACC.02.02, ME 4; ACC.03.00, ME1; GLD.06.00, ME 4)
2. The transfer process addresses how and when responsibility for continuing care is moved to another provider.
3. The transfer process identifies who is responsible for monitoring the patient during transfer and the staff qualifications required for the type of patient being transferred.
4. The transfer process identifies the medications, supplies, and medical equipment required during transport.
5. The transfer process addresses a follow-up mechanism that provides information about the patient's condition upon arrival to the receiving organization.
6. The transfer process addresses the situations in which transfer is not possible.

Standard ACC.05.01

The receiving organization is given a written summary of the patient's clinical condition and the interventions provided by the hospital, and the process is documented in the patient's medical record.

Intent of ACC.05.01

To ensure continuity of care, patient information is transferred with the patient.

The receiving organization needs to understand any patient care provided before and during transfer. Without this information, there is a risk that vital patient information will not be communicated or that interventions, treatments, or medications are repeated or omitted. A copy of the written clinical or discharge summary is provided to the receiving organization with the patient. The patient's medical record contains documentation of the transfer.

The written clinical or discharge summary includes at least the following:

- Patient's clinical condition or status
- Procedures and other interventions provided
- Patient's continuing needs and reason for transfer

The transfer documentation includes the following:

- Name of the health care organization and the name of the individual agreeing to receive the patient
- Reason(s) for the transfer

- Any serious changes in the patient's condition or status during transfer
- Any other documentation required by hospital policy (for example, a signature of the receiving nurse or physician, the name of the individual who monitored the patient during transport)

Measurable Elements of ACC.05.01

1. Ⓓ A written clinical summary is transferred with the patient and includes at least the following:
   - Patient's condition or status
   - Procedures and other interventions provided
   - Patient's continuing needs and reason for transfer
2. Ⓓ The transfer documentation includes at least the following:
   - Name of the service provider and the name of the individual agreeing to receive the patient
   - Reason(s) for the transfer
   - Changes in the patient's condition or status
   - Other documentation required by hospital policy

Transportation

Standard ACC.06.00

The hospital's transportation services comply with relevant laws and regulations and meet requirements for high-quality, safe transport.

Intent of ACC.06.00

Patients may require transportation at the time of discharge or transfer; the hospital is responsible for assessing patients' transportation needs and arranging safe transportation when necessary.

Assessing patients' transportation needs and ensuring safe transportation for those patients who require assistance is the hospital's responsibility. Transportation services may be provided by the following:

- Hospital-owned service
- A contracted transportation service
- The Ministry of Health
- Other entity

The hospital has a process for assessing patients' transportation needs at the time of discharge or transfer. A patient's transportation needs may change from admission to discharge. Examples of these changes may include change in their physical or mental condition or use of sedation during a same-day procedure.

The required equipment, supplies, and medications for transport are determined by the type of patient and the patient's condition at the time of transport. The hospital determines the staff qualifications and level of monitoring required based on the type of patient and the patient's condition at the time of transport.

The hospital identifies transportation situations that have a risk of infection and implements strategies to reduce infection risk.

The hospital ensures that transportation services meet all applicable laws and regulations related to their operation, condition, and maintenance. The hospital evaluates the quality and safety of transportation, including complaints about the transportation services.

Depending on hospital policy and the laws and regulations of the region, the cost of the transportation may or may not be the responsibility of the hospital.

The hospital has a process to evaluate transportation needs of its patients. This includes the following:

- Identifying which patients require transportation

- Identifying which type of transportation is needed (for example, ambulance, air transfer, another vehicle)
- Defining staff qualifications for transportation
- Defining what equipment, supplies, and medications are needed for transportation
- Defining criteria for patient monitoring during transportation

The hospital has a process to ensure the safety and quality of transportation services. This includes the following:

- Ensuring that transportation services comply with local and regional laws and regulations
- Identifying infection risks and implementing strategies to reduce the infection risks (transportation services are part of the hospital's infection prevention and control program)
- Evaluating the quality and safety of services provided by the hospital or others, including receiving, evaluating, and responding to complaints about the transportation services provided or arranged

Note: If transportation services are not provided by the hospital, the hospital has a process to provide feedback about safety and quality to the responsible organization.

Measurable Elements of ACC.06.00

1. The process for discharging or transferring patients includes an assessment of patient transportation needs.
2. Transportation services, including contracted services, and transport vehicles owned by the hospital meet relevant laws and regulations and the hospital's requirements for high-quality and safe transport.
3. All vehicles used for transportation, contracted or hospital owned, comply with the hospital's infection prevention and control program.
4. All vehicles used for transportation, contracted or hospital owned, have appropriate medical equipment, supplies, and medications to meet the needs of the patient being transported.
5. The transportation provided or arranged is appropriate to the needs and condition of the patient.
6. There is a process in place to monitor the quality and safety of transportation provided or arranged by the hospital, including a complaint process.

Assessment of Patients (AOP)

Overview

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

1. Collecting information and data on the patient's physical, psychological, and social status, and health history
2. Analyzing the data and information, including the results of laboratory testing, diagnostic imaging, and physiologic monitoring, to identify the patient's health care needs
3. Developing a plan of care to meet the patient's identified needs

Patient needs must be reassessed throughout the course of care, treatment, and services. Reassessment is key to understanding the patient's response to the care, treatment, and services provided and is essential in identifying whether care decisions are appropriate and effective.

Assessment activities may vary between settings, as defined by the hospital'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, and services sought and the patient's presenting condition(s).

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

Standards

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

Patient Assessment

AOP.01.00 All patients have their health care needs identified through an assessment process that has been defined by the hospital.

AOP.01.01 Each patient's initial assessment includes a health history and an assessment of the patient's physical, psychological, spiritual/cultural, social, and economic needs.

AOP.01.02 The hospital has a process for accepting initial assessments from outside sources.

AOP.01.03 Patients are screened for nutritional, functional, and other special needs and are further assessed when indicated by the screening.

AOP.01.04 All patients are screened for pain and assessed when pain is present.

AOP.01.05 All patients are reassessed at intervals based on their condition and treatment.

Patient Falls

AOP.02.00 The hospital develops and implements a process to reduce the risk of falls, and patient harm resulting from falls.

Laboratory Services

AOP.03.00 Laboratory services are available to meet patient needs, and all laboratory services meet applicable local and national standards, laws, and regulations.

AOP.03.01 A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service, and all laboratory staff are qualified to perform the tests and interpret the results.

AOP.03.02 The hospital has defined requirements for the oversight and supervision of the point-of-care testing program.

AOP.03.03 Laboratory results are reported within time frames defined by hospital policy.

AOP.03.04 All laboratory testing equipment is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.

AOP.03.05 Essential reagents and supplies are available, and all reagents are evaluated to ensure accuracy and precision of results.

AOP.03.06 Procedures for collecting, identifying, handling, safely transporting, and disposing of specimens are established and implemented.

AOP.03.07 Established norms and ranges are used to interpret and to report clinical laboratory results.

AOP.03.08 The hospital has implemented processes for quality control and proficiency testing of laboratory services.

AOP.03.09 The hospital ensures the quality of services provided by contracted laboratories.

Blood Bank and/or Transfusion Services

AOP.04.00 A qualified individual(s) is responsible for blood bank and/or transfusion services and ensures that services adhere to laws and regulations and recognized standards of practice.

AOP.04.01 Clinical guidelines and procedures are implemented for the handling and administration of blood and blood products.

Radiology and Diagnostic Imaging Services

AOP.05.00 Radiology and diagnostic imaging services are available to meet patient needs, and all services meet applicable local and national standards, laws, and regulations.

AOP.05.01 A qualified individual(s) is responsible for managing the radiology and diagnostic imaging services, and individuals with proper qualifications and experience perform diagnostic imaging studies, interpret the results, and report the results.

AOP.05.02 A radiation and/or diagnostic imaging safety program for patients, staff, and visitors is implemented and is compliant with applicable professional standards, laws, and regulations.

AOP.05.03 Radiology and diagnostic imaging study results are available in a timely way as defined by hospital policy.

AOP.05.04 All equipment used to conduct radiology and diagnostic imaging studies is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.

AOP.05.05 The hospital has implemented quality control procedures for radiology and diagnostic imaging services.

AOP.05.06 The hospital ensures the quality of services provided by all outside contracted sources of radiology and diagnostic imaging services.

Nuclear Medicine Services

AOP.06.00 When applicable, the hospital establishes and implements a nuclear medicine safety program that complies with applicable professional standards, laws, and regulations.

Standards, Intents, and Measurable Elements

Patient Assessment

Standard AOP.01.00

All patients have their health care needs identified through an assessment process that has been defined by the hospital.

Intent of AOP.01.00

The effective assessment process drives decisions about the patient's needs for care, treatment, and services. Because decisions are made based on assessments, the assessment process is dynamic and ongoing throughout the patient care continuum.

Patient assessments determine care needs, even when the patient's condition changes. Patient assessment includes three primary processes:

- Collecting information and data on the patient's health history and their physical, psychological, and social needs
- Analyzing the assessment data, including any diagnostic tests, to identify the patient's health care needs
- Using the information to develop a plan of care specific to the patient's needs

When a patient is admitted to or registered for care, whether inpatient or outpatient care/treatment, a complete assessment needs to be performed related to the reason for care. The information required depends on the patient's needs and the setting in which care is being provided (for example, inpatient or outpatient care). Hospital policies define the minimum content of assessments for clinical staff to include in their assessments and in all care settings. The hospital identifies any specific assessment data that must be included by various clinical staff.

Assessments are performed by each discipline within its scope of practice, licensure, applicable laws and regulations, or certification. Only qualified individuals conduct the assessments.

All the content from assessments must be available when treatment is initiated.

Measurable Elements of AOP.01.00

1. Ⓓ Hospital policy defines, in writing, the minimum content of assessments for inpatients for each clinical discipline that performs assessments. (*See also* AOP.01.01, ME 2)
2. Ⓓ Hospital policy defines, in writing, the minimum content of assessments for outpatients for each clinical discipline that performs assessments. (*See also* AOP.01.01, ME 2)
3. Only qualified individuals permitted by licensure, applicable laws and regulations, or certification perform the assessments. (*See also* AOP.01.01, ME 3)
4. The hospital identifies the information to be documented for the assessments.

Standard AOP.01.01

Each patient's initial assessment includes a health history and an evaluation of the patient's physical, psychological, spiritual/cultural, social, and economic needs.

Intent of AOP.01.01

The initial patient assessment is critical to identifying patient needs and planning the patient's care.

A complete assessment is performed related to the chief complaint at the time of admission or registration. Hospital policies define what information is needed at the time of admission or registration, who is responsible for obtaining and documenting this information, and how this information is documented.

The initial assessment provides information to do the following:

- Understand the care the patient is seeking.
- Select the best care setting for the patient.
- Form an initial diagnosis.
- Understand the patient's response to any previous care.

Hospital policy outlines what assessments and history are required as part of the initial assessment.

Common elements of an initial assessment include the following:

- Physical evaluation
- Health history
- Medication history and allergies
- Psychological assessment
- Social and economic assessment
- Cultural and spiritual assessment

The psychological assessment determines the patient's perception, thought processes, and emotional status. The social and economic assessment is not intended to "classify" the patient; it is used to identify possible barriers to access and paying for care.

A patient's social, cultural, spiritual, family, and economic factors can influence their response to illness and treatment. Families can be very helpful in these areas of assessment and in understanding the patient's wishes and preferences.

Hospital policy also states the following:

- What parts of the initial assessment each discipline is responsible for completing
- The minimum content for the initial medical assessment
- The minimum content for the initial nursing assessment
- The minimum content for other assessments (for example, physical therapy, speech therapy)
- The time frame for completion of the initial assessment
- The documentation requirements for the initial assessment

The initial assessment of the patient does not need to be completed by one person. Hospital policies define which disciplines are responsible for which parts of the initial assessment. Hospital policies outline the minimum content of the initial medical and nursing and other assessments, the time frame for completion of assessments, and the documentation requirements for assessments.

The initial assessment of some patient populations requires that the assessment process be modified. The modification is based on the unique characteristics or needs of each patient population. Each hospital identifies those special patient populations and modifies the assessment process to meet their special needs. The assessment of these patients responds to their needs and condition in a culturally acceptable and confidential manner. The assessment of special populations is modified to be consistent with local laws and regulations and professional standards.

The assessment is complete, available to those caring for the patient, and results in an initial diagnosis and an understanding of the patient's medical and nursing needs so care and treatment can begin.

In an emergency, the initial medical and nursing assessments may be limited to the patient's apparent needs and condition. In cases in which an emergency patient requires surgery, a brief note and the preoperative diagnosis are documented before surgery.

The hospital must identify, in writing, special populations that it serves and require a modified assessment process. Examples of special patient populations include the following:

- Infants, children, and adolescents
- Frail elderly
- Terminally ill/dying patients
- Patients with intense or chronic pain
- Women in labor or experiencing terminations in pregnancy
- Patients with emotional or psychiatric disorders
- Patients suspected of drug and/or alcohol dependency
- Victims of abuse or neglect
- Patients with infectious or communicable diseases
- Patients whose immune systems are compromised

The hospital requires the patient's initial assessment be completed and documented within 24 hours of admission. The hospital may identify situations in which an assessment may be needed sooner, or a limited assessment is acceptable. These situations include the following:

- When a patient's condition indicates, for example, an unstable patient, a patient scheduled for surgery in less than 24 hours after admission, or when a transfer is imminent
- Immediate assessment of emergency patients or other groups identified by the hospital
- When an emergency patient is sent for emergent surgery

Measurable Elements of AOP.01.01

1. Ⓓ All patients have an initial assessment that is consistent with the requirements defined in hospital policy.
2. The assessment includes the following:
   - Physical examination
   - Health history
   - Medication history and known allergies
   - Initial psychological assessment as indicated by the patient's condition
   - Initial social and economic assessment, when indicated by the patient's needs
   - Initial spiritual and cultural assessment, when indicated by the patient's needs

   (*See also* AOP.01.00, MEs 1 and 2)
3. Ⓓ The hospital outlines requirements about who is responsible for the initial assessment and the timeliness of the assessment, including the following:
   - What parts of the initial assessment each discipline is responsible for completing
   - Minimum content for the initial medical assessment
   - Minimum content for the initial nursing assessment
   - Minimum content for other assessments (for example, physical therapy, speech therapy, social services)
   - Time frame for completion of the initial assessment
   - Documentation requirements for the initial assessment

   (*See also* AOP.01.00, ME 3)
4. Ⓓ The hospital identifies, in writing, those patient groups and populations it serves that require modifications to their initial assessment.
5. The initial assessment for special patient populations is modified to reflect their needs.
6. The initial nursing assessment is completed within 8 hours, and the medical assessment is completed within 24 hours of admission to the hospital.
7. The initial assessment results in an initial diagnosis or diagnoses that require treatment and monitoring.
8. The initial nursing assessment results in a list of specific nursing needs or conditions that require nursing care, interventions, or monitoring.
9. Preoperative diagnosis is documented for patients requiring emergency surgery.

Standard AOP.01.02

The hospital has a process for accepting initial assessments from outside sources.

Intent of AOP.01.02

There must be a process to accept initial assessments from outside sources that includes validation of the information included in the assessment because correct and current information is needed to provide safe patient care.

An initial assessment may be conducted by an outside source. Examples of outside sources include the following:

- Health care practitioner's office
- Primary care or ambulatory care center
- Consulting or referring practitioner

Common reasons for initial assessments by outside sources include the following:

- Referral to a specialist employed by the hospital
- Direct or scheduled admissions to the hospital
- Referral for a scheduled outpatient or same-day procedure

The initial assessment completed by an outside source must be within the previous 30 days.

When an assessment is partially or entirely completed by an outside source, the information in the assessment is reviewed and verified by a qualified individual. If there are any changes to the assessment, the medical record is updated and identifies any additional testing that may be needed related to the change.

If the initial assessment is greater than 30 days old at the time of admission or registration, the medical history must be updated and the physical examination repeated.

For initial assessments performed and documented 30 days or less prior to admission or registration, the information in the history and assessment is reviewed and verified. This review includes the following:

- Patient's medical history and assessment findings
- Laboratory and other diagnostic test results
- Proposed plan of care and treatments

Any changes in the patient's condition since the assessment, or "no change" if appropriate, are documented at admission.

Measurable Elements of AOP.01.02

1. Initial medical assessments accepted are less than or equal to 30 days old.
2. For initial assessments less than or equal to 30 days old, the assessment is reviewed and validated; any changes in the patient's condition since the assessment or "no change" are documented in the patient's medical record at the time of admission or registration.
3. If the initial assessment is greater than 30 days old at the time of admission or registration, the medical history is updated and the initial assessment is repeated in accordance with the hospital's initial assessment policy.

Standard AOP.01.03

Patients are screened for nutritional, functional, and other special needs and are further assessed when indicated by the screening.

Intent of AOP.01.03

Initial screenings for nutritional, functional, and other special needs identify patients who may require additional interventions for safe, high-quality care.

These screenings may be conducted at the initial medical or nursing assessment. The hospital uses a screening tool to screen patients for nutritional, functional, and other special needs. The information gathered through the screening determines if the patient needs further assessment.

The screening process is very simple and high level and identifies whether a risk or problem exists. If the screening identifies a risk or a problem, an assessment is then completed. The hospital refers the patient for further assessments, either within the hospital or through the community, to address risks or problems identified by the screening.

The screening tools are implemented consistently throughout the hospital and are used by trained clinical staff.

The screening tools are developed by qualified individuals able to further assess any identified risks. Various clinical staff may be trained on how to use the tools and complete screenings with patients. When indicated by the screening, qualified individuals complete the assessment and identify interventions or a plan to address the patient's needs. Examples include the following:

- Nutritional risk
  - An evidence-based screening tool for nutritional risk may be developed by the hospital's nurses.
  - Nurses, physicians, and dietitians are trained to use the tools.

  - Dietitians then complete a nutritional assessment and supply the recommended dietary intervention.
  - Nutritionists integrate nutritional needs identified by the assessment with the other needs of the patient.
- Functional status
  - An evidence-based functional screening tool, including physical ability, vision, and hearing, may be developed by the hospital's occupational therapists.
  - Nurses and occupational, physical, and speech therapists are trained use the screening tool.
  - Occupational, physical, and speech therapists complete a functional assessment.
  - Physical medicine and rehabilitation physician orders functional therapy to address the needs identified in the assessment.

Other specialized needs may be identified through routine care; for example, clinical staff may observe that a patient has difficulty seeing or hearing and refer the patient for the necessary assessments.

Assessments are completed using evidence-based tools and used by trained clinical staff to determine the level of risk or severity of a problem and to develop specific interventions to address the risk or problem.

A screening tool is used to evaluate for the presence of a risk or a problem and generally results in a "yes or no" response.

Screening tools can be developed by a qualified individual to screen for a risk or problem. Creating a brief questionnaire for the patient is a useful screening tool, as in the following examples:

- Asking a patient "Have you lost or gained more than 2 kg in the past 30 days?" to screen for nutritional risk
- Asking a patient "Are you able to complete daily hygiene tasks without difficulty or assistance?" to screen for functional risk
- Asking a patient to complete a brief whisper test to screen for hearing deficits

Assessment tools are used to complete an in-depth assessment of patient risk or problems and are used to develop specific interventions to address the risk or problem.

Assessment tools meet the following criteria:

- Are appropriate to the risk or problem being evaluated.
- Are appropriate to the patient population being evaluated (for example, pediatric, adult, geriatric).
- Are based on evidence and validated in the population being evaluated.

Measurable Elements of AOP.01.03

1. Evidence-based screening tools are used to identify patients who require further nutritional assessment, and the tools are implemented consistently throughout the hospital.
2. Patients whose screening indicates a nutritional risk or problem receive a nutritional assessment.
3. Screening tools are used to identify patients who require further functional assessment, and the tools are implemented consistently throughout the hospital.
4. Patients whose screening indicates a functional risk or problem receive a functional assessment.
5. When the need for additional specialized assessments is identified, patients are referred within the hospital or outside the hospital.

Standard AOP.01.04

All patients are screened for pain and assessed when pain is present.

Intent of AOP.01.04

Pain greatly impacts a patient's quality of life, affects healing, and can impact physical, psychological, and social well-being.

Screening identifies those at risk or potentially in need of a further, more specialized assessment. The screening has a narrow scope, whereas the scope of assessment is more comprehensive. An assessment is a systemic process done to evaluate needs that can then be fulfilled, or a plan made around them on how to meet those needs, thus the individual conducting the assessment should have an expertise or specialty in the field being assessed.

Screening tools have a more narrow, superficial scope and are beneficial for identifying those at risk. A screening tool is used to identify patients with pain. The screening process is simple, is high level, and identifies whether a risk or problem related to pain exists. If the screening identifies a risk or a problem, an assessment is then completed. A screening for pain may consist of one or more simple questions that can be asked by trained clinical staff. The results of the pain screening are documented in the patient's medical record.

The information gathered through the screening determines if the patient needs further assessment. The assessment is then used to match the individual's needs with the appropriate type and level of care, treatment, or services.

If the planned care, treatment, or services may result in pain, this would also indicate the need for a pain assessment.

The pain assessment is appropriate to the patient, including the following:

- Patient age
- Patient condition (for example, sedated or alert)
- Any barriers (for example, inability to speak or hear or developmental delays)

The pain assessment is a more in-depth evaluation of the patient's pain and is used to develop specific interventions to address the pain. The pain assessment is documented in the patient's medical record.

The patient's pain is addressed immediately and may include referral or transfer to a different care setting. For example, an outpatient with severe pain may be admitted as an inpatient to further assess and treat their pain, or an inpatient in the general medical unit may need to be transferred to an intensive care unit for monitoring if an epidural is needed to treat their pain.

A screening tool is used to evaluate for the presence of a risk or a problem and generally results in a "yes or no" response. Examples of questions that may be used in a screening include the following:

- Are you having pain right now?
- Does pain keep you from sleeping at night?
- Does pain keep you from participating in activities?
- Do you experience pain every day?

Evidence-based tools are used to measure the severity of the patient's pain. Examples of pain severity scales include the following:

- Wong-Baker Faces Scale
- FLACC (Face, Legs, Activity, Cry, Consolability)
- COMFORT Scale
- Behavior Pain Scale
- Newborn Infant Pain Scale

The pain assessment also evaluates pain intensity and quality, including the following:

- Pain character (for example, sharp, dull, or burning)
- Frequency
- Location
- Duration

- Pain history (for example, when did the pain start, what activities cause the pain, what treatments has the patient tried to relieve the pain)
- What makes pain better or worse
- What are the patient's goals for pain relief (for example, zero pain or enough relief to complete or participate in specific activities)

Pain assessments, including which assessment tool is used, are documented in the patient's medical record to allow the care team to easily identify trends in the patient's pain and pain relief interventions.

Measurable Elements of AOP.01.04

1. All inpatients are screened for pain, and the screening is documented.
2. Outpatients whose condition, diagnosis, or situation may indicate that they are at risk for pain are screened for pain.
3. Ⓓ When pain is identified by the screening, a pain assessment is performed and documented. (*See also* COP.07.00, ME 1)
4. Patients are reassessed for pain following any pain management interventions.
5. If needed, the patient is referred or transferred to a care setting that has the capabilities and resources to treat the patient's pain.

Standard AOP.01.05

All patients are reassessed at intervals based on their condition and treatment.

Intent of AOP.01.05

Reassessment is key to understanding how patients respond to treatment and to understand if care decisions are effective.

Patients are reassessed throughout the care process at intervals based on their condition and treatment as defined in hospital policies. The results of these reassessments are documented in the patient's medical record.

Hospital policy defines how often reassessments occur by various members of the health care team. A physician must assess patients with acute care needs at least daily, including weekends, and when there is a significant change in the patient's condition.

Hospital policy defines how often patients are reassessed by a nurse. This will vary greatly based on the patient's needs, condition, and treatment. For example, newly intubated patients may require a nursing reassessment every hour, whereas a stable, chronically ill patient with an established airway may require a nursing reassessment every four hours.

Hospital policy defines how often patients are reassessed by other members of the care team, including the following:

- Respiratory therapists
- Physical, occupational, and speech therapists
- Social workers or other social services

Reassessments occur in accordance with hospital policy. Reassessments are completed and results are documented in the patient's medical record in the following instances:

- At defined intervals by various members of the care team, including physicians, nurses, and others
- Daily by a physician for acute care patients
- In response to a significant change in the patient's condition
- If the patient's diagnosis has changed and the care needs require revised planning
- To determine if medications and other treatments have been successful and the patient can be transferred or discharged

Some nonacute patients may not need daily physician assessments (for example, a stable psychiatric patient receiving group therapy sessions, or a patient who is past the acute phase of illness or surgery and who is receiving only rehabilitative treatment). Hospital policy identifies patients who do not require daily physician assessments.

Measurable Elements of AOP.01.05

1. Ⓓ Hospital policy defines, in writing, how often patients are reassessed by various members of the health care team and other circumstances when a reassessment is required, including the following:
   - Defined intervals by various members of the care team, including physicians, nurses, and other clinical staff (for example, therapists, social workers)
   - When there has been a significant change in patient condition
   - When the diagnosis has changed and plan of care needs to be revised (*See also* COP.01.01, ME 3)
   - To determine if the patient is ready for transfer or discharge
2. A physician reassesses patients at least daily, including weekends, during the acute phase of their care and treatment.
3. Ⓓ Hospital policy identifies, in writing, patient populations who may not require a daily assessment and defines the minimum reassessment interval for these patients.
4. Reassessments are documented in the patient's medical record.

Patient Falls

Standard AOP.02.00

The hospital develops and implements a process to reduce the risk of falls, and patient harm resulting from falls.

Intent of AOP.02.00

Many injuries in hospitals to both inpatients and outpatients are a result of falls, so a comprehensive falls prevention program is needed to prevent injuries to patients.

The risk for falls is related to the patient, the situation, and/or the location. Risks associated with patients include but are not limited to the following:

- Age
- Medical history
- Patient history of falls
- Medication use
- Substance consumption
- Other comorbidities
- Gait or balance disturbances
- Visual impairments
- Altered mental status
- Environmental hazards (for example, slippery floors, poor lighting, cluttered rooms)

Patient falls are a significant safety concern and can result in serious injuries such as fractures, head injuries, lacerations, and death.

Patients who have been initially assessed to be at low risk for falls may have a change in fall risk during hospitalization or between outpatient visits. Reasons for change in fall risk include the following:

- Surgery and/or anesthesia
- Sudden changes in patient condition
- Adjustment in medications

Many patients require reassessment during their hospitalization due to these changes in condition and fall risk. Fall risk criteria screenings and assessments identify the patients who are considered at high risk for falls. Screenings, assessments, and any interventions applied are documented in the patient's medical record.

The hospital establishes a fall risk reduction program based on appropriate policies and/or procedures. If a fall occurs, the hospital evaluates the fall, takes action to reduce the risk of future falls, and reduces the risk of injury. A fall risk reduction program includes risk assessment and periodic reassessment of a particular patient population and/or of the environment in which care and services are provided (such as those conducted during periodic safety tours). Measures and interventions are implemented to reduce fall risk for patients, situations, and locations assessed to be at risk.

Specific situations can pose a risk for falls. For example, a patient arriving at the outpatient department from a long-term care facility by ambulance for a radiologic examination may be at risk for falls in that situation when transferring from ambulance cart to exam table or when changing positions while lying on the narrow exam table.

Specific locations may present higher fall risks because of the services provided. For example, a physical therapy department (inpatient or outpatient) has many types of specialized equipment used by patients that may increase the risk for falls, such as parallel bars, freestanding staircases, and exercise equipment. When specific locations are identified as areas at higher risk for falls, hospitals may determine that all patients visiting those locations are considered at risk for falls and implement general measures to mitigate fall risks that are applicable to all patients.

All inpatients are assessed for fall risk using evidence-based assessment tools and/or methods appropriate for the hospital's patient population(s). For example, pediatric patients require a pediatric fall risk assessment tool, such as the Humpty Dumpty Score or GRAF-PIF tool. Specialized units may prefer tools that are geared toward their specific populations (for example, the Obstetric Fall Risk Assessment System for women on a maternity ward or the Edmonson Psychiatric Fall Risk Assessment Tool (EPFRAT) for psychiatric patients.

Hospital leaders conduct a risk assessment to identify high-risk services and patient populations to screen for fall risk in the outpatient department(s). However, the hospital may either choose to screen all outpatients, or those in departments that are inherently higher risk for fall, based on condition, diagnosis, situation, and/or location. Examples could include the following:

- All patients in a physical therapy outpatient department
- All patients arriving from long-term care facilities by ambulance for outpatient procedures
- Patients scheduled for outpatient surgery involving procedural sedation or anesthesia
- Patients with gait or balance disturbances or who use an ambulation device
- Patients with visual impairments
- Pediatric patients under the age of 2

If fall risk is indicated from the screening, evidence-based interventions are implemented to reduce fall risk for those patients.

Screening generally involves performing a simple evaluation of the patient to determine if they are at risk for a fall. Screening tools are commonly used and include questions or items that are used to identify fall risk patients. For example, the questions may require a simple yes/no answer, or the tool may involve assigning a score to each item based on the patient's responses. Hospitals may determine how the screening process occurs. For example, screening may be performed by registration clerks, or patients may be allowed to self-screen, such as at a kiosk upon entering the outpatient department. Examples of simple screening questions may include "Do you feel unsteady when standing or walking?"; "Do you worry about falling?"; and "Have you fallen in the past year?"

Measurable Elements of AOP.02.00

1. The hospital screens all inpatients for fall risk and uses evidence-based screening tools appropriate for the patient population.
2. The hospital screens all outpatients whose condition, diagnosis, situation, or location may put them at risk for falls and uses screening tools appropriate for the patients being served.
3. The hospital implements a process for the assessment and, when applicable, reassessment of patients who may become at risk for falls due to a change in condition or are already at risk for falls based on the documented assessment.
4. Interventions to reduce fall risk are implemented for those identified patients, situations, and locations within the hospital assessed to be at risk, and the interventions are documented.

Laboratory Services

Note: Laboratories that are required to have specific recognition by local laws and regulations (for example, ISO 15189) may present verification of this recognition as evidence of compliance with relevant requirements to surveyors during the JCI hospital accreditation survey. Evidence of compliance must include all specialties and subspecialties provided by the hospital laboratory. JCI survey includes laboratory specialties and subspecialties (for example, blood bank) that are not within the scope of the existing laboratory recognition.

Standard AOP.03.00

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

Intent of AOP.03.00

Laboratory services are essential to the diagnostic and treatment process and therefore must meet requirements to ensure the quality of data from laboratory tests.

The hospital has a system for providing laboratory services based on patient needs.

The laboratory services are organized and provided in a way that meets applicable local and national standards, laws, and regulations. Laboratory services are available after normal hours for emergencies.

Laboratory services may be provided within the hospital, by agreement with another organization (for example, contracted laboratory), or both. The hospital identifies and contacts experts in specialized diagnostic areas, such as parasitology, virology, or toxicology, when needed.

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

Measurable Elements of AOP.03.00

1. Laboratory services, including outside sources of laboratory services, meet applicable local and national standards, laws, and regulations.
2. Ⓓ Laboratory services meet the needs of the patients and other services the hospital provides, including a process to access laboratory services after hours and for emergency needs.
3. Experts in specialized diagnostic areas are contacted when needed. (*See also* GLD.05.00, ME 1)

Standard AOP.03.01

A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service, and all laboratory staff are qualified to perform the tests and interpret the results.

Intent of AOP.03.01

Clinical laboratory services are managed by an individual who is qualified to ensure that the laboratory and its services meet patient needs, laws, and regulations. Qualified laboratory staff perform tests and interpret results to ensure that the data collected through laboratory services are accurate.

Clinical laboratory services are under the direction of an individual who is qualified through documented education, training, experience, and the requirements of laws and regulations. This individual is responsible for the laboratory facility, the services provided in the laboratory, and tests performed outside the laboratory, including point-of-care testing.

The oversight of services outside the laboratory does not include daily supervision of those activities. Daily supervision remains the responsibility of the leaders of the department or unit in which the testing is conducted. When this individual provides clinical consultation or medical opinion, they are a physician, preferably a pathologist. Specialty and subspecialty laboratory services are under the direction of appropriately qualified individuals.

Laboratory staff are oriented to their work and are given work assignments consistent with their training and experience. The laboratory implements a staffing program that allows staff to perform tests promptly and to ensure laboratory staffing during all hours of operation and for emergencies.

The hospital identifies a qualified laboratory leader to oversee laboratory services. Oversight responsibilities include those services that are provided within and outside the laboratory.

The oversight of services outside the laboratory includes ensuring consistent hospitalwide policies and practices, including the following:

- Training
- Supply management
- Inspection and maintenance of equipment
- Oversight of the point-of-care-testing program

Laboratory staffing requirements include the following:

- Education, training, qualifications, and experience of laboratory staff members performing and interpreting laboratory tests
- Identifying staff approved to perform point-of-care testing
- Identifying staff who direct or supervise other staff who perform testing

Measurable Elements of AOP.03.01

1. The clinical laboratory, and other laboratory services throughout the hospital, are under the direction and oversight of one or more qualified individuals. (*See also* GLD.06.00, ME 1)
2. Responsibilities of the qualified laboratory leader include the following:
   - Developing, implementing, and maintaining policies and procedures
   - Administrative oversight of laboratory services
   - Maintaining any necessary quality control programs
   - Developing and implementing a staffing program
   - Recommending outside sources of laboratory services
   - Monitoring and reviewing all laboratory services
3. All laboratory staff have the required qualifications to perform and interpret tests.
4. Ⓓ A laboratory staffing program is implemented so staff can perform tests promptly and provide staffing during all hours of operation and during emergencies.
5. Laboratory supervisory staff are identified and have the proper qualifications and experience for the role.

Standard AOP.03.02

The hospital has defined requirements for the oversight and supervision of the point-of-care testing program.

Intent of AOP.03.02

The hospital must have a clearly defined and well-structured approach to point-of-care testing to ensure that it is performed safely and correctly and that the results generated are accurate and reliable.

Point-of-care testing (POCT) is testing performed at sites outside the traditional laboratory environment, usually at or near where care is delivered to the patient.

The individual responsible for laboratory services or other qualified designee is responsible for the oversight and supervision of POCT.

The hospital develops a program for POCT that includes the following:

- Selecting tests to be performed
- Identifying staff who perform the test(s)
- Establishing a protocol for reporting abnormal test results
- Determining a process for reporting critical results
- Defining a process to include representatives of clinical staff in developing and evaluating the POCT program

Staff performing POCT require training for each test being performed. Staff must complete a competency evaluation for each test to confirm that they know how to perform the test and to ensure that results are accurate. Staff performing POCT understand the process to report abnormal and critical results.

Quality control tests and their documentation are required to be performed according to manufacturers' guidelines. All staff performing POCT adhere to quality control procedures and know what actions to take if a quality control sample is out of the test range specified by the manufacturer. The results of the quality control testing and any corrective actions are documented.

POCT is monitored and evaluated to ensure that the program is meeting the needs of patients and health care providers.

Point-of-care tests include those performed and interpreted at or near the patient. Examples of point-of-care tests include the following:

- POCT blood glucose tests
- POCT blood gas tests

- Pregnancy test
- Urinalysis
- Fecal occult tests
- Rapid infection tests, including strep and COVID

POCT does not include tests that are performed at or near the patient but are processed or interpreted in another location.

Quality control testing occurs based on manufacturers' guidelines. Examples of when quality control testing occurs include the following:

- Once daily
- Once per week
- Between new batches of test kits

POCT evaluation may be accomplished by one or more of the following methods:

- Developing and monitoring quality improvement measures
- Interviewing patients or conducting surveys
- Reviewing quality control and proficiency test results
- Reviewing utilization reports.

Measurable Elements of AOP.03.02

1. The person responsible for managing the laboratory services, or a designee, provides oversight and supervision of the POCT program.
2. Staff performing POCT have the required qualifications and training and are competent to perform POCT.
3. Ⓓ The POCT program includes a defined process for reporting abnormal test results, including reporting critical results. (*See also* IPSG.02.00, ME 1)
4. Ⓓ The POCT program includes requirements for quality control performance and documentation.
5. Ⓓ The POCT program is monitored, evaluated, and included in quality improvement activities.

Standard AOP.03.03

Laboratory results are reported within time frames defined by hospital policy.

Intent of AOP.03.03

Timely result reporting is vital to the prompt assessment and diagnosis of patients.

The hospital defines the time frame for reporting laboratory test results. Results are reported within a time frame based on patient needs, services offered, and clinical staff needs. Emergent or stat tests and after-hours and weekend testing needs are included.

The hospital monitors whether results are reported within the time frame. Results from stat tests are given special attention in the quality measurement process. If the results are not reported in accordance with the hospital's time frame, the hospital identifies barriers to meeting this goal and implements corrective actions.

In addition, when laboratory services are by contract with an outside organization, the reports are also timely, as set forth by hospital policy or the contract.

Measurable Elements of AOP.03.03

1. Ⓓ The hospital has a written policy that establishes the expected report time for routine and stat test results.
2. The hospital monitors whether stat tests are reported within the expected time frame.
3. The hospital monitors whether routine laboratory results are reported within the expected time frame.
4. When laboratory results are not reported within the expected time frame, the hospital takes corrective action.

Standard AOP.03.04

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

Intent of AOP.03.04

The proper maintenance and calibration of laboratory equipment is essential to ensuring accuracy of test results.

Laboratory staff ensure that all equipment, including medical devices used for point-of-care testing, function properly. The laboratory implements a program to manage equipment. Testing, maintenance, and calibration frequency are completed according to the manufacturer's guidelines or more frequently based on the laboratory's use of the equipment and documented history of service.

The program to manage laboratory equipment includes the following:

- Selecting and acquiring laboratory equipment and medical equipment
- Identifying and taking inventory of laboratory equipment and medical equipment
- Assessing laboratory equipment use through inspection, testing, calibration, and maintenance
- Monitoring and acting on laboratory equipment hazard notices, recalls, reportable incidents, problems, and failures
- Documenting the management program

Measurable Elements of AOP.03.04

1. Ⓓ The laboratory manages laboratory equipment with a written process for how equipment is selected and acquired.
2. Ⓓ There is an inventory of all laboratory equipment. (*See also* FMS.07.00, ME 2)
3. Ⓓ Laboratory equipment is inspected and tested when new and according to manufacturers' guidelines; the inspections are documented.
4. Ⓓ Laboratory equipment is calibrated and maintained according to manufacturers' guidelines, and the calibration and maintenance are documented.
5. The hospital monitors and acts on laboratory equipment hazard notices, recalls, reportable incidents, problems, and failures. (*See also* FMS.07.01, ME 1)

Standard AOP.03.05

Essential reagents and supplies are available, and all reagents are evaluated to ensure accuracy and precision of results.

Intent of AOP.03.05

Reagents are a necessary component of laboratory testing, so the hospital creates a policy to ensure that essential reagents are available and meet their purpose for laboratory tests. The hospital has identified reagents and supplies necessary to provide laboratory services to its patients. There is a process to order or secure essential reagents and supplies.

The laboratory develops and implements guidelines for the periodic evaluation of all reagents, to provide for accuracy and precision of laboratory test results. Reagent performance and adequacy are verified before use. All essential reagents are evaluated according to manufacturers' directives or packaging instructions. Hospital policy requires the complete and accurate labeling of reagents and solutions.

Measurable Elements of AOP.03.05

1. Essential reagents and supplies are identified and available, and there is a process to address when essential reagents are not available. (*See also* FMS.05.00, ME 2)
2. All reagents are stored and dispensed according to manufacturers' instructions.
3. Ⓓ The laboratory establishes and follows the hospital's written policy for the evaluation of all reagents to ensure accuracy and precision of results.
4. All reagents undergo quality control testing as required by the manufacturer.
5. Ⓓ Records for reagents include the following information:
   - Identity of the reagent
   - Date of receipt or preparation
   - Lot number
   - Expiration date
   - Date put into use

   (*See also* FMS.05.00, ME 2)

Standard AOP.03.06

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

Intent of AOP.03.06

Proper management of specimens is required to ensure that test results accurately represent patient condition; specimens must be properly labeled to match the specimen and results to the correct patient.

Procedures are established and implemented for the following:

- Ordering laboratory tests
- Collecting and identifying specimens
- Transporting, storing, and preserving specimens
- Receiving, logging, and tracking specimens
- Disposal of specimens

These procedures are observed for specimens sent to contracted laboratory services for testing.

Measurable Elements of AOP.03.06

1. Ⓓ Procedures are established and implemented for the ordering of tests.
2. Ⓓ Procedures are established and implemented for the collection and identification of specimens.
3. Ⓓ Procedures are established and implemented for the transport, storage, and preservation of specimens.
4. Ⓓ Procedures are established and implemented for the receipt and tracking of specimens.
5. Ⓓ Procedures are established and implemented for the disposal of specimens.
6. The procedures are followed when contracted laboratory services are used.

Standard AOP.03.07

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

Intent of AOP.03.07

Norms and ranges are needed to interpret test results; these norms and ranges are included with the test results so health care providers can interpret test results.

The laboratory establishes reference intervals or "normal" ranges for each test performed. The range is included in the medical record, either as part of the report or by including a current listing of such values approved by the laboratory leader. Ranges are provided when a contracted laboratory service performs the test. The reference ranges are appropriate to the hospital's geography and patient demographics. The reference ranges are reviewed and updated when testing methods change and to reflect current scientific evidence.

Measurable Elements of AOP.03.07

1. Ⓓ The laboratory establishes reference ranges for each test performed.
2. The range is included in the medical record at the time test results are reported.
3. Ranges are provided when tests are performed by contracted laboratory services.
4. Ranges are appropriate to the hospital's geography and patient demographics.
5. The laboratory reviews and updates ranges as needed.

Standard AOP.03.08

The hospital has implemented processes for quality control and proficiency testing of laboratory services.

Intent of AOP.03.08

Well-designed quality control processes and proficiency testing are essential to providing accurate laboratory services.

Quality control procedures are used to validate test methods and results. Quality control also includes daily surveillance to ensure that testing is completed according to procedure. Rapid corrective actions are implemented when deficiencies are identified.

The laboratory participates in an approved proficiency testing program or external quality assessment when available. Proficiency testing determines how well an individual laboratory's results compare with other laboratories that use the same methods. Proficiency testing can identify performance problems not recognized by internal mechanisms.

Quality control processes include the following:

- Validation of the test methods used for accuracy, precision, and reportable range
- Daily surveillance of results by qualified laboratory staff
- Rapid corrective action when a deficiency is identified
- Documentation of results and corrective actions

If an approved proficiency testing program or external quality assessment is not available, the laboratory exchanges samples with a laboratory in another hospital for purposes of peer comparison. Proficiency testing, or an alternative, is carried out for all specialty laboratory programs.

The laboratory maintains documentation of participation in a proficiency testing program.

Measurable Elements of AOP.03.08

1. Ⓓ The hospital establishes and implements a written quality control program for the clinical laboratory.
2. The program includes the validation of test methods for accuracy, precision, and reportable range.
3. The program includes the daily surveillance and documentation of test results.
4. The program includes rapid correction and documentation of deficiencies.
5. The laboratory participates in a proficiency testing program or an alternative for all laboratory tests when external quality assessments are not available.
6. The laboratory's proficiency testing results meet satisfactory performance criteria in accordance with laws and regulations.

Standard AOP.03.09

The hospital ensures the quality of services provided by contracted laboratories.

Intent of AOP.03.09

The hospital has a responsibility to ensure that any service provided by contracted services meets all licensing and legal requirements and meets quality expectations developed by the hospital.

If the hospital uses the services of a contracted laboratory, the hospital has a responsibility to make certain that the contracted laboratory is licensed, accredited, or certified by recognized authorities.

Contracted laboratories must participate in proficiency testing to determine how the contracted laboratory's results compare with other laboratories that use the same testing methods.

The hospital identifies measures to monitor the quality of services provided by all contracted laboratories. Qualified individuals review and act on the results of quality monitoring. This information is used to identify potential process improvements and to make decisions about future contracts with the contracted laboratories.

To be certain the contracted laboratory is licensed and accredited or certified, and participates in an outside proficiency testing program, the hospital must obtain a copy of a license from a recognized licensing authority and of the certificate or letter of accreditation or certification from a recognized laboratory accreditation or certification program.

The hospital defines what measures the contracted laboratory is required to collect and submit to the hospital, as well as how often data are submitted to the hospital. Examples of measures collected to evaluate contracted laboratories include the following:

- Turnaround times for tests, meaning the time it takes for the laboratory to report a result following receipt of the specimen
- Critical results reporting
- Problems with specimens such as missing identifiers or specimen rejections

Measurable Elements of AOP.03.09

1. Ⓓ The hospital maintains a copy of the license and the certificate or letter of accreditation or certification, from a recognized authority, for all contracted laboratories used by the hospital.
2. Ⓓ The hospital maintains documentation that any contracted laboratory used by the hospital participates in a proficiency testing program.
3. The hospital determines the frequency and type of performance expectation data from contracted laboratories. (*See also* GLD.05.00, MEs 4 and 5)
4. The individual responsible for the laboratory or a designee reviews the performance data from contracted laboratories and takes action based on the results. (*See also* GLD.05.00, MEs 4 and 5)
5. Ⓓ An annual report of the data from contracted laboratories is provided to the leaders responsible for the management and renewal of contracts.

Blood Bank and/or Transfusion Services

Standard AOP.04.00

A qualified individual(s) is responsible for blood bank and/or transfusion services and ensures that services adhere to laws and regulations and recognized standards of practice.

Intent of AOP.04.00

Blood bank and/or transfusion services have unique risks to staff and patients.

Blood bank and/or transfusion services are under the direction of a qualified individual(s). This individual assumes professional responsibility for all aspects of blood bank and transfusion services provided in the hospital.

Quality control processes for all blood bank and transfusion services are implemented and documented to ensure the safety and efficacy of blood bank and transfusion services. Blood donor and transfusion services are guided by laws and regulations and recognized standards of practice.

The hospital monitors its use of blood products, outcomes, and availability of blood products. Many hospitals have implemented patient blood management programs to do this. Patient blood management programs include various clinical staff across disciplines and generally include staff from quality and risk management and infection prevention and control.

The hospital implements blood surveillance procedures known as hemovigilance. Hemovigilance covers the entire blood transfusion process, from donation of blood products through follow-up care for the blood product recipient. Monitoring includes any adverse events or near miss events involving the blood bank and/or transfusion services. When an event is discovered, the hospital is responsible for taking corrective action to prevent a repeat occurrence.

The oversight of blood bank and/or transfusion services includes implementation and documentation of the processes for blood administration.

A formal patient blood management program may make oversight of the above processes more efficient. However, the hospital determines how its blood bank and/or transfusion services are monitored and how changes are implemented. The hospital monitors blood bank and/or transfusion services and makes improvements on processes to do the following:

- Ensure optimal use of blood products.
- Ensure optimal patient outcomes.
- Maintain the supply of blood products.

As noted, hemovigilance processes include monitoring any adverse events or near miss events. When an adverse or near miss event is discovered that involves blood bank and/or transfusion services, the event is investigated and reported to all required authorities (for example, hospital risk management committee or the local or regional blood bank).

The hospital then takes corrective action based on monitoring data to prevent any future adverse or near miss events. Examples of these events include the following:

- Transfusion to the wrong patient
- Mislabeled blood product
- Contaminated blood product

Measurable Elements of AOP.04.00

1. A qualified individual(s) is responsible for blood bank and/or transfusion services. (*See also* GLD.06.00, ME 1)
2. Ⓓ The blood bank has implemented and documented processes for the following:
   - Blood donor selection
   - Blood screening for disease
   - Blood collection
   - Blood storage
   - Compatibility testing
   - Blood distribution
3. Ⓓ Quality control measures for all blood bank and transfusion services are implemented and documented.
4. The blood bank and transfusion services comply with applicable laws and regulations and recognized standards of practice.
5. The hospital has a process to monitor and improve blood product utilization throughout the hospital, including the following:
   - Optimal use of blood products
   - Safe transfusion practices
   - Availability of blood products
6. Ⓓ The hospital has a hemovigilance surveillance program to monitor, investigate, and report any adverse events and near miss events involving blood bank and/or transfusion services. (*See also* QPS.03.04, ME 3)

Standard AOP.04.01

Clinical guidelines and procedures are implemented for the handling and administration of blood and blood products.

Intent of AOP.04.01

Proper oversight is required to minimize risks and to ensure optimal use of blood products. Additional guidance for this key requirement is explained below.

In addition to oversight of the blood bank and transfusion services, the hospital identifies who is permitted to administer blood and blood products according to local laws and regulations and uniformly implements clinical guidelines and procedures for the handling and administration of blood and blood products. The hospital provides and documents training for all clinical staff permitted to administer blood and blood products. This training is overseen by an individual with education, knowledge, and expertise related to blood and blood products administration. Uniform training ensures that processes, procedures, and clinical guidelines for transfusions are implemented throughout the hospital.

Training for clinical staff permitted to administer blood and blood products includes the following:

- How to obtain consent
- How to obtain blood and blood products from the blood bank or blood storage areas
- How to verify patient identification
- Administration procedures, including special considerations for special patient populations (for example, neonates, trauma patients)
- Documentation requirements
- How to monitor for and respond to transfusion reactions

The hospital has a process to monitor and investigate any adverse events and near miss events involving the administration of blood and blood products. This process includes the following:

- Clinical staff involved in the event
- The individual(s) who oversees blood and blood product administration training

- The individual(s) who oversees the blood bank and transfusion services
- An individual(s) from the quality and risk management program
- Others as identified

Measurable Elements of AOP.04.01

1. The hospital identifies who is permitted to administer blood and blood products in accordance with laws and regulations.
2. Individuals permitted to administer blood and blood products must have the education, knowledge, and clinical expertise to do so safely.
3. Ⓓ The hospital provides and documents training of practices associated with administering blood and blood products.
4. Clinical guidelines and procedures are uniformly implemented for the handling and administration of blood and blood products.
5. Clinical guidelines and procedures address the processes for the following:
   - Patient consent for administration
   - Procurement of blood from the blood bank or blood storage area
   - Patient identification
   - Blood administration
   - Monitoring of the patient
   - Identification of and response to signs of potential transfusion reactions

Radiology and Diagnostic Imaging Services

Standard AOP.05.00

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

Intent of AOP.05.00

Safe and accurate radiology and diagnostic services are needed to make accurate patient diagnoses and treatment plans.

The hospital has a process for providing radiology and diagnostic imaging services required by its patient population and scope of services. Radiology and diagnostic imaging services meet all applicable local and national standards, laws, regulations, and professional standards.

Radiology and diagnostic imaging services, including those required for emergencies, may be provided within the hospital, by agreement with another organization, or both. Radiology and diagnostic imaging services are available after normal hours for emergencies. In addition, the hospital may identify and contact experts in specialized diagnostic areas, and the hospital maintains a list of such experts. Examples of these specialized areas include the following:

- Radiation physics
- Radiation oncology
- Nuclear medicine
- Interventional radiology
- Neurointerventional radiology
- Cardiac catheterization

Outside sources are convenient for the patient to access, and reports are received in a timely way to support patient care. The hospital selects outside sources based on the recommendation of the individual responsible for radiology and diagnostic imaging services. Outside sources of radiology and diagnostic imaging services

meet applicable laws and regulations and have an acceptable record of accurate, timely services. Patients are informed when an outside source of services is owned by the referring physician.

Measurable Elements of AOP.05.00

1. Radiology and diagnostic imaging services meet applicable professional standards local and national laws and regulations.
2. Radiology and diagnostic imaging services are available to meet the needs related to the hospital's patient population, scope of services, and emergency needs, including after normal hours.
3. Ⓓ The hospital maintains a list of experts in specialized diagnostic areas and ensures that the list is accessible to staff who need it.
4. Outside sources are selected based on recommendations of the individual responsible for radiology and diagnostic imaging services and have an acceptable record of timely performance and compliance with applicable laws and regulations.

Standard AOP.05.01

A qualified individual(s) is responsible for managing the radiology and diagnostic imaging services, and individuals with proper qualifications and experience perform diagnostic imaging studies, interpret the results, and report the results.

Intent of AOP.05.01

Radiology and diagnostic imaging services are managed by an individual who is qualified to ensure that services meet patient needs, laws, and regulations. Qualified radiology and diagnostic imaging staff are needed to perform tests and interpret results to ensure that the data collected through these services are accurate.

Radiology and diagnostic imaging services, provided at any location in the hospital, are under the direction of an individual who is qualified by documented education, training, and experience, consistent with applicable laws and regulations. This individual assumes professional responsibility for the radiology and diagnostic imaging facility, the equipment, and the services provided.

When this individual provides clinical consultation or medical opinion, they are a physician, preferably a radiologist. When special services are provided, they are under the direction of appropriately qualified individuals. Examples of special services include the following:

- Radiation therapy
- Nuclear medicine
- Interventional radiology
- Neurointerventional radiology
- Cardiac catheterization

The radiology and diagnostic imaging leader's responsibilities include the following:

- Developing, implementing, and maintaining policies and procedures
- Overseeing administrative tasks
- Overseeing quality control
- Developing and implementing a staffing program
- Recommending outside sources of radiology and diagnostic imaging services
- Monitoring and reviewing all radiology and diagnostic imaging services

The hospital identifies which radiology and diagnostic imaging staff members perform diagnostic and imaging studies; are qualified to interpret the results or to verify and report results; and direct or supervise the processes.

Supervisory staff and technical staff have appropriate and adequate training, experience, and skills and are oriented to their responsibilities. Technical staff members are given work assignments consistent with their training and experience. In addition, there is a sufficient number of staff to perform, to interpret, and to report

studies within a time frame defined by hospital policy and to provide necessary staffing during all hours of operation and for emergencies.

Measurable Elements of AOP.05.01

1. Radiology and diagnostic imaging services are under the direction of one or more qualified individuals. (*See also* GLD.06.00, ME 1)
2. Responsibilities of the individual managing radiology and diagnostic imaging services include the following:
   - Developing, implementing, and maintaining policies and procedures
   - Overseeing administrative tasks
   - Overseeing quality control
   - Developing and implementing a staffing program
   - Recommending outside sources of radiology and diagnostic imaging services
   - Monitoring and reviewing all radiology and diagnostic imaging services
3. Staff with proper qualifications and experience perform diagnostic and imaging studies.
4. Staff with proper qualifications and experience interpret study results and verify and report the results within the time frame defined by hospital policy.
5. There is an adequate number of staff to meet patient needs and the hospital's scope of services.
6. Radiology and diagnostic imaging supervisory staff have proper qualifications and experience for the role.

Standard AOP.05.02

A radiation and/or diagnostic imaging safety program for patients, staff, and visitors is implemented and is compliant with applicable professional standards, laws, and regulations.

Intent of AOP.05.02

Radiation exposure can pose potential risk of long-term damage, so the hospital has a responsibility to implement a radiation safety program to protect patients, staff, and visitors from unnecessary or excessive exposure to radiation.

Risks of long-term damage depend on the dose of radiation delivered and the length and frequency of exposure to radiation. The higher the radiation dose, the greater the risk for long-term damage, and repeated doses have a cumulative effect presenting greater risks. The diagnostic procedures most commonly associated with avoidable radiation doses are computed tomography (CT), nuclear medicine, and fluoroscopy. A radiation safety program is important in the safe use of ionizing radiation, including radioactive materials (RAM) and radiation producing machines.

Health care providers weigh the medical necessity of the exposure to radiation for diagnosis or treatment against the risks. Unnecessary exposure to radiation should be avoided. The hospital follows the principles of ALARA (maintain all radiation exposures as low as reasonably achievable).

Diagnostic imaging, such as magnetic resonance imaging (MRI) and ultrasonography (US), does not use ionizing radiation, and therefore the risks from radiation are not present. There are other risk-related diagnostic imaging services that need to be addressed. Hazards from MRI include the following:

- Exposure to a strong magnetic field
- Presence of cryogenic gases used to cool the magnets of the MRI
- Exposure to acoustic noise

The hospital has a radiation and diagnostic imaging safety program that includes all components of the hospital's radiology and diagnostic imaging services, including radiation oncology and the cardiac catheterization laboratory. The safety program addresses the risks and hazards encountered and implements safety practices and prevention measures for radiology and diagnostic imaging staff, patients, and visitors. The program is coordinated with the hospital's facility management and infection prevention and control programs.

As noted, the hospital follows the principles of ALARA (maintain all radiation exposures as low as reasonably achievable), which include the following:

- Minimizing the amount of time staff, patients, and visitors are exposed to radiation
- Increasing the distance between the radiation source and any staff, patients, and visitors
- Using lead or other shields to reduce exposure to radiation

Hospitals must implement measures to address these hazards from diagnostic imaging. For example, MRI safety measures may include the following:

- Clearly marking safety zones in the MRI area to indicate who can have access and what safety precautions are necessary in each zone
- Ensuring proper ventilation and appropriate staff training to address hazards related to cryogenic gases
- Protecting ears to decrease discomfort and harm from acoustic noise during MRI examinations
- Restricting access to the MRI magnetic field area to only authorized staff and to patients accompanied by those staff
- Posting signs in and around the area to identify hazards
- Completing a preimaging checklist to identify any risks or exclusion criteria for patients undergoing MRI (for example, metal implants, shrapnel, pacemaker in place)
- Ensuring that only special non-ferromagnetic equipment enters the MRI environment

The radiation safety management program includes the following:

- Compliance with applicable professional standards, laws, and regulations
- Orientation of all radiology and diagnostic imaging staff to safety procedures and practices
- Training and ongoing education for new procedures, new equipment, and newly acquired or recognized hazardous materials
- Availability of safety protective equipment and devices appropriate to the practices and hazards encountered; in radiology, protective devices and equipment include lead aprons, lead lining in the walls, and radiation badges (for staff), among others.
- Compliance with standards addressing facility management and infection prevention and control programs

Measurable Elements of AOP.05.02

1. Ⓓ A radiation and/or diagnostic imaging safety program for patients, staff, and visitors is implemented and is compliant with applicable professional standards, laws, and regulations.
2. Radiology and diagnostic imaging staff are oriented to safety requirements and receive ongoing education and training for any new procedures, equipment, and hazardous materials. (*See also* SQE.01.07, ME 1)
3. Safety protective equipment and devices appropriate to the practices and hazards encountered from radiation and diagnostic imaging are available to staff, patients, and visitors, and in the area in which radiology and diagnostic imaging services are provided.
4. Radiation safety education includes the principles of ALARA and implementation of protocols that identify the maximum dose of radiation for each type of study.
5. Hazards from magnetic resonance imaging are addressed using industry standards and evidence-based guidelines.
6. The hospital designates an individual to serve as the radiation safety officer who is responsible for the following:
   - Ensuring that radiologic services are provided in accordance with laws, regulation, and organizational policies
   - Monitoring compliance with established radiation safety practices (including oversight of dosimetry monitoring)
7. The radiation and/or diagnostic imaging safety program is part of the organization's facility management and infection prevention and control programs and provides reports to those programs at least annually and when any safety events and infection control events occur.

Standard AOP.05.03

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

Intent of AOP.05.03

Timely reporting of radiology and diagnostic imaging results is vital to the prompt assessment and diagnosis of patients.

The hospital defines the time frame for reporting diagnostic radiology and diagnostic imaging study results. Results are reported within a time frame based on patient needs, services offered, and clinical staff needs. Emergent or stat imaging and after-hours and weekend imaging needs are included.

The hospital monitors whether radiology and diagnostic imaging study results are reported within the time frame. Results from urgent or emergent radiology and diagnostic imaging studies are given special attention in the quality measurement process. If the results are not reported in accordance with the hospital's time frame, the hospital identifies barriers to meeting this goal and implements corrective actions.

Radiology and diagnostic imaging studies performed by outside contractors of services are reported according to hospital policy or contract requirement.

Measurable Elements of AOP.05.03

1. Ⓓ The hospital has a written policy that establishes the expected report time for diagnostic imaging results.
2. The hospital monitors whether urgent or emergent radiology and diagnostic imaging results are reported within the expected time frame.
3. The hospital monitors whether routine radiology and diagnostic imaging results are reported within the expected time frame.
4. When radiology and diagnostic imaging results are not reported within the expected time frame, the hospital takes corrective action.

Standard AOP.05.04

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

Intent of AOP.05.04

The proper maintenance and calibration of radiology and diagnostic imaging equipment is essential to ensure accuracy of test results.

Radiology and diagnostic imaging staff ensure that all equipment used for radiology and diagnostic imaging programs functions properly. The hospital has a program to manage radiology and diagnostic imaging equipment. Testing, maintenance, and calibration frequency are completed according to the manufacturer's guidelines or more frequently based on the use of the equipment and documented history of service.

The program to manage radiology and diagnostic imaging equipment includes the following:

- Selecting and acquiring radiology and diagnostic imaging equipment and medical equipment
- Identifying and taking inventory of radiology and diagnostic imaging equipment
- Assessing radiology and diagnostic imaging equipment use through inspection, testing, calibration, and maintenance
- Monitoring and acting on radiology and diagnostic imaging equipment hazard notices, recalls, reportable incidents, problems, and failures
- Documenting the management program

Measurable Elements of AOP.05.04

1. Ⓓ The hospital develops and implements a written program to manage radiology and diagnostic imaging equipment, including how radiology equipment is selected and acquired.
2. Ⓓ There is a documented inventory of all radiology and diagnostic imaging equipment. (*See also* FMS.07.00, ME 2)
3. Ⓓ Radiology and diagnostic imaging equipment is inspected and tested when new and according to age, use, and each manufacturer's recommendations; the inspections are documented.
4. Ⓓ Radiology and diagnostic imaging equipment is calibrated and maintained according to each manufacturer's recommendations, and the calibration and maintenance is documented.
5. The hospital has a system in place for monitoring and acting on radiology and diagnostic imaging equipment hazard notices, recalls, reportable incidents, problems, and failures. (*See also* FMS.07.01, ME 1)

Standard AOP.05.05

The hospital has implemented quality control procedures for radiology and diagnostic imaging services.

Intent of AOP.05.05

Well-designed quality control processes and proficiency testing are essential to providing accurate radiology and diagnostic imaging services. Quality control also includes daily surveillance to ensure that testing is completed according to procedure. Rapid corrective actions are implemented when deficiencies are identified.

Quality control processes include the following:

- Review of image quality
- Accuracy of interpretation of imaging
- Daily surveillance of results by qualified radiology and diagnostic imaging staff
- Rapid corrective action when a deficiency is identified
- Documentation of results and corrective actions

Measurable Elements of AOP.05.05

1. Ⓓ The hospital establishes and implements a written quality control program for the radiology and diagnostic imaging services.
2. Quality control includes validating test methods for accuracy and precision.
3. Quality control includes rapid correction and documentation when a deficiency is identified.

Standard AOP.05.06

The hospital ensures the quality of services provided by all outside contracted sources of radiology and diagnostic imaging services.

Intent of AOP.05.06

The hospital has a responsibility to ensure that any service provided by a contracted service meets all licensing and legal requirements and meets quality expectations developed by the hospital.

If the hospital uses the services of a contracted radiology or diagnostic imaging service, the hospital has a responsibility to make certain that the radiology or diagnostic imaging service is licensed and accredited or certified by recognized authorities.

The hospital identifies measures to monitor the quality of services provided by all contracted radiology and diagnostic imaging services. Qualified individuals review and act on the results of quality monitoring. This

information is used to identify potential process improvements and to make decisions about future contracts with the contracted radiology and diagnostic imaging services.

The hospital defines what measures the contracted radiology or diagnostic imaging service is required to collect and submit to the hospital, as well as how often data are submitted to the hospital. Examples of measures collected to evaluate contracted radiology or diagnostic imaging service include the following:

- Turnaround times for tests, meaning the time it takes for the radiology or diagnostic imaging to receive an order, obtain the imaging, and report the results
- Critical results reporting
- Problems with images such as missing identifiers or specimen rejections

Measurable Elements of AOP.05.06

1. Ⓓ The hospital maintains a copy of the license from a recognized authority for all contracted radiology and diagnostic imaging services used by the hospital.
2. Ⓓ The hospital maintains a copy of the certificate or letter of accreditation or certification from a recognized authority for all contracted radiology and diagnostic imaging services used by the hospital.
3. The hospital determines the frequency and type of quality data from contracted radiology and diagnostic imaging services. (*See also* GLD.05.00, MEs 4 and 5)
4. The individual responsible for the radiology and diagnostic imaging services or a designee reviews the performance measure data from contracted radiology and diagnostic imaging services and takes action based on the results. (*See also* GLD.05.00, MEs 4 and 5)
5. Ⓓ An annual report of the data from contracted radiology and diagnostic imaging services is provided to those who make decisions about management and renewal of contracts.

Nuclear Medicine Services

Standard AOP.06.00

When applicable, the hospital establishes and implements a nuclear medicine safety program that complies with applicable professional standards, laws, and regulations.

Intent of AOP.06.00

Nuclear medicine is a branch of medical imaging and treatment that uses small amounts of radioactive materials, known as radiopharmaceuticals, to diagnose and treat various diseases. Due to the use of radiation, strict safety standards and guidelines are in place to ensure the well-being of patients, health care professionals, and the general public.

Nuclear medicine practices are regulated by various national and international organizations, such as the International Atomic Energy Agency (IAEA), the Nuclear Regulatory Commission (NRC) in the United States, and the European Medicines Agency (EMA) in Europe. These bodies establish and enforce safety standards, including licensing requirements, training guidelines, and equipment regulations. Medical professionals working with radioactive materials in nuclear medicine, such as nuclear medicine physicians, radiologists, and technologists, must undergo specialized training to ensure that they have the necessary knowledge and skills to handle radioactive materials safely. They should be trained in radiation safety, radiation protection, and proper handling and disposal of radioactive waste.

Nuclear medicine facilities are designed to minimize radiation exposure to staff and the public. Shielding materials, such as lead and concrete, are used to contain radiation within designated areas. Proper ventilation systems, monitoring equipment, and radiation shielding barriers are required to ensure safety. Quality assurance programs are established to ensure the accuracy and safety of nuclear medicine procedures. Regular

equipment calibration, performance testing, and quality control measures are undertaken to maintain the reliability and effectiveness of imaging and treatment equipment.

Patients scheduled for nuclear medicine procedures receive specific instructions regarding preparation, such as fasting requirements or discontinuation of certain medications. Patients are educated about the benefits, risks, and safety precautions associated with the procedure. Informed consent is obtained, and patient concerns or questions are addressed. Radiation exposure is monitored for both patients and health care professionals involved in nuclear medicine procedures. Personal dosimeters are worn to measure the amount of radiation received. Regular monitoring helps ensure that radiation doses are within acceptable limits and that appropriate safety measures are followed.

Proper disposal of radioactive waste is crucial to prevent environmental contamination and ensure public safety. Nuclear medicine facilities follow strict protocols for the collection, storage, and disposal of radioactive materials and waste. These procedures are in accordance with local laws, regulations, and guidelines.

Measurable Elements of AOP.06.00

1. A qualified individual(s) is responsible for overseeing nuclear medicine services, and relevant staff members are properly trained, qualified, and certified to perform their respective roles in nuclear medicine safety and procedures.
2. The hospital implements radiation safety protocols, including the use of appropriate shielding, personal protective equipment (PPE), and monitoring devices for both patients and staff.
3. Radiation doses administered to patients are optimized for diagnostic and therapeutic purposes, and the procedure includes monitoring and minimizing radiation exposure while obtaining the necessary diagnostic information or therapeutic effect.
4. The procurement, storage, handling, and disposal of radiopharmaceuticals complies with laws, regulations, professional standards, and manufacturers' guidelines.
5. Patients and family are informed about the procedures and safety precautions.

Anesthesia and Surgical Care (ASC)

Overview

The use of surgical anesthesia, procedural sedation, and surgical interventions are common and complex processes in a health care organization. They require complete and comprehensive patient assessment, integrated care planning, continued patient monitoring, and criteria-determined transfer for continuing care, rehabilitation, and eventual transfer and discharge. As individual patient response may move along that continuum, general anesthesia and procedural sedation use should be organized in an integrated manner. Thus, this chapter addresses moderate and deep sedation/analgesia to general anesthesia where the patient's protective reflexes needed for a patent airway and ventilatory function maintenance are at risk. This chapter does not address the use of minimal sedation for the purposes of anxiolysis or sedation required in the intensive care unit for ventilator tolerance.

Procedural sedation is defined as the administration of sedatives or dissociative agents with or without analgesics to an individual, in any setting, by any route, to induce an altered state of consciousness that allows the patient to tolerate painful or unpleasant procedures while maintaining cardiorespiratory function. Definitions of four levels of sedation and anesthesia include the following:

Minimal sedation (*anxiolysis):* A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

Moderate sedation/analgesia (*"conscious sedation"):* A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained without supportive measures.

Monitored Anesthesia Care ("MAC") does not describe the continuum of depth of sedation, rather it describes a specific anesthesia service performed by a qualified anesthesia provider, for a diagnostic or therapeutic procedure. Indications for monitored anesthesia care include the need for deeper levels of analgesia and sedation than can be provided by moderate sedation, including potential conversion to a general or regional anesthetic.

Deep sedation/analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained without supportive measures.

General Anesthesia: General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because surgery carries a high level of risk, information about the surgical procedure and care after surgery is carefully planned, based on the patient's assessment, and documented. Special consideration is given to surgery that involves implanting a medical device, including the reporting of devices that malfunction, as well as a process for follow-up with patients in the event of a recall.

Note: The anesthesia and surgery standards are applicable in whatever setting anesthesia and/or procedural sedation are used and where surgical and other invasive procedures that require consent are performed. Such settings include hospital operating theatres, day surgery or day hospital units, endoscopy, interventional radiology, dental and other outpatient clinics, emergency services, intensive care areas, or elsewhere.

Standards

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

Organization and Management

ASC.01.00 The hospital provides sedation and anesthesia services to meet patient needs, and in accordance with laws and regulations.

Sedation Care

ASC.02.00 The administration of procedural sedation is standardized throughout the hospital.

ASC.02.01 Practitioners responsible for procedural sedation and staff responsible for monitoring patients receiving procedural sedation are qualified.

ASC.02.02 Procedural sedation is administered and monitored according to professional practice guidelines and documented in the patient's medical record.

ASC.02.03 The risks, benefits, and alternatives related to procedural sedation are discussed with the patient, their family, or those who make decisions for the patient.

Anesthesia Care

ASC.03.00 A qualified individual conducts a preanesthesia assessment and preinduction assessment.

ASC.03.01 Each patient's anesthesia plan of care is discussed with the patient and/or those who make decisions for the patient and documented in the patient's medical record.

ASC.03.02 Each patient's physiological status during anesthesia and surgery is monitored according to professional practice guidelines and documented in the patient's medical record.

ASC.03.03 Each patient's postanesthesia status is monitored, and the patient is discharged from the recovery area by a qualified individual or by using established criteria.

Surgical Care

ASC.04.00 Each patient's surgical care is planned based on the results of the preoperative assessment and documented in the patient's medical record.

ASC.04.01 The risks, benefits, and alternatives are discussed with the patient and their family or those who make decisions for the patient.

ASC.04.02 Information about the surgical procedure is documented in the patient's medical record to facilitate continuing care.

ASC.04.03 Patient care after surgery is planned and documented.

ASC.04.04 Surgical care that includes the implanting of a medical device is planned with special consideration for how standard processes must be modified.

Standards, Intents, and Measurable Elements

Organization and Management

Standard ASC.01.00

The hospital provides sedation and anesthesia services to meet patient needs, and in accordance with professional practice standards and laws and regulations.

Intent of ASC.01.00

With the complexities involved in sedation and anesthesia care, the hospital must have a system in place for providing such services reflective of its patient population, clinical services offered, and health care practitioners' needs. Sedation and anesthesia are commonly viewed as a continuum from minimal sedation to full anesthesia. Sedation and anesthesia use are complex processes that must be integrated into patient care planning encompassing the stages of sedation and anesthesia. Sedation and anesthesia require a complete and comprehensive patient assessment (presedation/preanesthesia), continued patient monitoring (intraprocedure/intraoperative sedation/anesthesia), and objective recovery criteria (postprocedure/postoperative sedation/anesthesia). These services are provided according to professional practice standards for care, meet all applicable local and national laws and regulations, and must be available at all times for emergencies. It is the recommendation of the Association of periOperative Registered Nurses (AORN, 2022) that the hospital provides the same standard of care (that is, patient monitoring and equipment) for patients who are receiving procedural sedation/analgesia and anesthesia in non-operating room anesthesia locations (for example, interventional cardiology, endoscopy, dental, radiology, office-based surgery) as for patients receiving moderate sedation/analgesia and anesthesia in the operating room.

Sedation and anesthesia services may be provided by the hospital, by agreement with a contracted service (for example, an individual anesthesiologist or anesthesia group practice), or both. Any use of contract anesthesia services is based on the recommendation of the qualified individual(s) responsible for managing the sedation and anesthesia services. Sedation and anesthesia services are under the direction of one or more individuals who are qualified by documented training, expertise, and experience, which are consistent with applicable laws and regulations. This individual(s) assumes professional and some management responsibilities for the anesthesia services provided.

Measurable Elements of ASC.01.00

1. The hospital provides sedation and anesthesia services that meet the needs of the patients the hospital serves.
2. The hospital provides sedation and anesthesia services that comply with laws and regulations.
3. The hospital provides sedation and anesthesia services that comply with professional practice standards for care.
4. A qualified individual(s) assumes professional responsibility for the anesthesia services provided regardless of the location at the hospital. Responsibilities include the following:
   - Developing, implementing, and maintaining policies and procedures
   - Providing administrative oversight
   - Maintaining any necessary quality improvement programs
   - Monitoring and reviewing all sedation and anesthesia services
5. This qualified individual(s) is responsible for managing the sedation and anesthesia services, including ensuring the following:
   - Sedation and anesthesia services are uniform throughout the hospital.
   - Sedation and anesthesia services are available at all times for emergencies.
   - The responsibilities for monitoring and reviewing all sedation and anesthesia services are defined and carried out.
6. Ⓓ The hospital has a process for the selection of contract anesthesia services that includes the following:
   - An updated contract anesthesia service list must be used to select contract anesthesia services approved by hospital leaders and the qualified individual(s) professionally responsible for anesthesia services.
   - The contract anesthesia service must have acceptable records of performance and follow applicable laws and regulations.
   - The hospital must have a record of all the completed training and education for each contract anesthesia staff as required by the hospital.
   - There is a current contract in place when contract anesthesia services are used.

   (*See also* GLD.05.00, ME 3)

Sedation Care

Standard ASC.02.00

The administration of procedural sedation is standardized throughout the hospital.

Intent of ASC.02.00

Procedural sedation is often performed in many areas of the hospital outside of the operating theatre. Clinical practice guidelines and standardization of practices have demonstrated improvement in outcomes; in particular, processes that include protocols and checklists, which have proven to reduce patient harm through standardization and communication. As a result, standardized processes optimize moderate procedural sedation practices regardless of the site where the service is performed; guide appropriate patient selection; decrease the risk of adverse patient outcomes (for example, apnea, airway obstruction, respiratory arrest, cardiac arrest, death); promote sedation education, training, and research; and encourage the use of evidence-based data to promote cross-specialty uniformity for moderate sedation practices.

Procedural sedation is defined as "the technique of administering sedatives or dissociative agents with or without analgesics to an individual, in any setting, by any route, to induce an altered state of consciousness that allows the patient to tolerate painful or unpleasant procedures while preserving cardiorespiratory function." Regardless

of the medication, dose, or route of administration, when a medication is used for the purposes of altering the patient's cognitive state in order to facilitate a specific procedure, it is considered procedural sedation.

Hospitals develop specific guidelines for how and where procedural sedation may be used. The qualifications of staff participating in the procedure, the medical equipment, the supplies, and the monitoring must be the same wherever procedural sedation is provided in the hospital. Certain medications may be used in conjunction for certain populations (for example nitrous oxide used in conjunction with other analgesics for pediatric patients during moderate and deep sedation). For patients under care for procedural sedation, individuals from both the nursing and the medical staff who are trained in advanced life support and emergency medical equipment and supplies appropriate for the age and history of the patient and the type of procedure being performed are immediately available.

Measurable Elements of ASC.02.00

1. Ⓓ The hospital has established a written policy and standardized processes for procedural sedation throughout the hospital.
2. Ⓓ Policy and practice for procedural sedation are understood by all practitioners permitted to administer procedural sedation, and the policies address at least the following:
   - Areas in the hospital where procedural sedation may occur
   - Special qualifications or skills of staff involved in the procedural sedation process
   - Differences between pediatric, adult, and geriatric populations or other special considerations
   - Medications used in conjunction with certain populations
   - Immediate availability and use of specialized medical equipment, as appropriate to the patient
   - Informed consent process for both the procedure and the use of sedation
   - An individual with advanced life-support training is immediately available for patients under care for procedural sedation or anesthesia.

   (*See also* SQE.01.08, ME 2)

Standard ASC.02.01

Practitioners responsible for procedural sedation and staff responsible for monitoring patients receiving procedural sedation are qualified.

Intent of ASC.02.01

Complications related to procedural sedation primarily include cardiac or respiratory depression. Thus, certification in at least basic life support is essential. In addition, knowledge of the pharmacology of the sedation agents used, as well as reversal agents, decreases the risks of adverse outcomes. The qualifications of the physician, dentist, or other staff responsible for the patient receiving procedural sedation are important. Understanding the methods for procedural sedation as they relate to the patient and the type of procedure performed improves the patient's tolerance of an uncomfortable or painful procedure and decreases the risks of complications.

The health care practitioner performing the procedure should not be responsible for performing continuous monitoring of the patient. A separate, qualified individual, such as an anesthesiologist or a trained and competent nurse, should assume responsibility for providing uninterrupted monitoring of the patient's physiological parameters and assistance in supportive or resuscitative measures.

Measurable Elements of ASC.02.01

1. Health care practitioners responsible for providing procedural sedation show evidence of competence in at least the following:
   - Techniques and various modes of sedation
   - Pharmacology of sedation drugs and the use of reversal agents
   - Monitoring requirements
   - Response to complications
   - Airway assessment

   (*See also* SQE.01.03, ME 1)
2. The individual responsible for patient monitoring during procedural sedation is competent in at least the following:
   - Monitoring requirements from the active administration phase during the procedure through the recovery phase after the procedure
   - Response to complications
   - Use of reversal agents
   - Recovery criteria
   - Airway assessment

   (*See also* SQE.01.03, ME 1)
3. Ⓓ Procedural sedation competencies for all staff involved in sedation are documented in the personnel records.

Standard ASC.02.02

Procedural sedation is administered and monitored according to professional practice guidelines and documented in the patient's medical record.

Intent of ASC.02.02

Many factors influence the patient's response to sedation and can affect the degree to which a patient is sedated. The presedation assessment helps identify any factors that may impact the patient's response to procedural sedation and also helps to identify what findings from monitoring during and after the procedure may be significant. The degrees of sedation occur on a continuum from mild to deep sedation, and a patient may progress from one degree to another. Factors include the medications administered, the route and dosages, the age of the patient (pediatric, adult, or geriatric), and the patient's health history. For example, history of impairment of major organs, current medications that may interact with sedating medications, drug allergies, previous adverse response to anesthesia or sedation, and substance abuse may each have an impact on patient response to procedural sedation. If the patient's physical status is high risk, consideration is given to the additional clinical needs of the patient and the appropriateness of procedural sedation. These factors are included in the presedation assessment performed by a qualified individual and documented in the patient's medical record.

Patients undergoing procedural sedation require monitoring of their level of consciousness, ventilator and oxygenation status, and hemodynamic variables at a frequency based on the type and amount of medication administered, the length of the procedure, and the type and condition of the patient. Important considerations during the sedation procedure include the patient's ability to maintain protective reflexes; an independent, continuous patent airway; and the capability to respond to physical stimulation or verbal commands. A qualified individual is responsible for performing uninterrupted monitoring of the patient's physiological parameters and assistance in supportive or resuscitation measures until the patient has been safely recovered.

When the procedure has been completed, patients may continue to be at risk for complications due to delay in the full absorption of the sedating drug, respiratory depression, and/or lack of stimulation from the procedure. Patients continue to require monitoring until they have reached near their baseline level of consciousness and

hemodynamic parameters. Complications associated with moderate sedation and analgesia may be avoided if signs and symptoms of adverse drug effects such as cardiovascular decompensation or cerebral hypoxia are detected and treated in a timely manner. Patient monitoring includes strategies for the following:

- Monitoring patient level of consciousness assessed by the response of patients during procedures performed with moderate sedation/analgesia
- Monitoring patient ventilation and oxygenation, including ventilatory function, by observation of qualitative clinical signs, capnography, and pulse oximetry
- Hemodynamic monitoring, including blood pressure, heart rate, and electrocardiography
- Contemporaneous recording of monitored parameters
- Availability/presence of an individual responsible for patient monitoring

In addition to monitoring the physiological criteria, other important strategies to include are the frequency of monitoring and documentation, and general guidance and/or parameters for recovery goals. Objective established criteria help identify patients who are recovered and/or ready for discharge and are used by qualified individuals who are not qualified anesthesiologists but authorized by the individual(s) responsible for managing the anesthesia services.

Measurable Elements of ASC.02.02

1. A presedation assessment is performed that includes at least the following criteria when evaluating risk and appropriateness of procedural sedation for the patient:
   - Identify airway problems that may influence the type of sedation used.
   - Evaluate at-risk patients for appropriateness of procedural sedation.
   - Select and plan the type and level of sedation needed based on the patient assessment, identified risks, and type of procedure being performed.
   - Safely administer sedation based on the plan.
   - Interpret findings from patient monitoring during procedural sedation and recovery.
2. A qualified individual monitors the patient during the period of sedation and documents the monitoring in the medical record.
3. Established criteria are used and documented for the recovery and discharge from procedural sedation when a patient is discharged by an authorized individual other than a fully qualified anesthesiologist.
4. The presedation assessment is performed by an individual(s) qualified to do so and documented in the patient's medical record.
5. Ⓓ The following criteria are based on professional practice guidelines and defined in hospital policy:
   - Scope and content of the presedation assessment
   - Criteria for the recovery and discharge from procedural sedation, including criteria for monitoring

Standard ASC.02.03

The risks, benefits, and alternatives related to procedural sedation are discussed with the patient, their family, or those who make decisions for the patient.

Intent of ASC.02.03

Adequate information and education must be provided to the patient, their family, and/or decision-makers on the risks, benefits, and alternatives related to procedural sedation so an informed decision can be reached when obtaining consent for the procedure. The procedural sedation planning process includes this information and education. This discussion occurs as part of the process to obtain consent for procedural sedation as required in Standard PCC.03.00. A qualified individual provides this education.

Measurable Elements of ASC.02.03

1. The patient, family, and/or decision-makers are educated on the risks, benefits, and alternatives of procedural sedation. (*See also* PCC.03.00, ME 2)
2. The patient, family, and/or decision-makers are educated about postprocedural sedation recovery and pain management. (*See also* PCC.04.00, ME 1)
3. A qualified individual provides and documents the education.

Anesthesia Care

Standard ASC.03.00

A qualified individual conducts a preanesthesia assessment and preinduction assessment.

Intent of ASC.03.00

Because anesthesia carries such a high level of risk, administration is carefully planned. Therefore, an anesthesiologist or another qualified individual conducts the preanesthesia assessment. The patient's preanesthesia assessment is the basis for the anesthesia plan of care, which includes identifying what findings from the clinical assessment and from monitoring during anesthesia and recovery may be significant, and for the use of postoperative analgesia. The preanesthesia assessment may be carried out some time prior to admission or prior to the surgical procedure or shortly before the surgical procedure, as in emergency and obstetrical patients.

The preinduction assessment is separate from the preanesthesia assessment, as it focuses on the physiological stability and readiness of the patient for anesthesia and occurs immediately prior to the induction of anesthesia. When anesthesia must be provided emergently, the preanesthesia assessment and preinduction assessment may be performed immediately following one another, or simultaneously, but are documented independently.

Measurable Elements of ASC.03.00

1. A preanesthesia assessment is performed that includes at least the following elements when evaluating risk and appropriateness of anesthesia for the patient:
   - Identify airway problems that may influence the type of anesthesia used.
   - Evaluate at-risk patients for appropriateness of anesthesia.
   - Select the anesthesia and plan anesthesia care.
   - Safely administer an anesthetic based on patient assessment, identified risks, and type of procedure.
   - Interpret findings from patient monitoring during anesthesia and recovery.
   - Provide information for the use of analgesia following surgery.
2. A separate preinduction assessment is performed to reevaluate patients immediately before the induction of anesthesia.
3. The preanesthesia assessment and the preinduction assessment are performed by an individual(s) qualified to do so and documented in the patient's medical record.
4. Ⓓ The scope and content of the preanesthesia assessment and the preinduction assessment are based on professional guidelines and defined in hospital policy.

Standard ASC.03.01

Each patient's anesthesia plan of care is discussed with the patient and/or those who make decisions for the patient and documented in the patient's medical record.

Intent of ASC.03.01

The anesthesia planning process includes educating the patient, their family, and/or decision-makers on the risks, benefits, and alternatives related to the planned anesthesia. This discussion occurs as part of the process to obtain consent for anesthesia as required in Standard PCC.03.00. Anesthesia care is carefully planned. The plan includes information from other patient assessments and identifies the anesthesia to be used, the method of administration, other medications and fluids, monitoring procedures, and anticipated postanesthesia care. An anesthesiologist or a qualified individual provides this education.

When postoperative pain management is provided by anesthesia services, the postoperative pain management plan is reviewed and discussed with the patient by the anesthesiologist or other qualified individual and documented in the patient's medical record. The anesthesia agent, dose (when applicable), anesthetic technique, and qualified individual administering the anesthesia are documented in the patient's anesthesia record.

Measurable Elements of ASC.03.01

1. A qualified individual plans and documents the anesthesia care in the patient's medical record.
2. The patient, family, and/or decision-makers are educated on the risks, benefits, and alternatives of anesthesia. (*See also* PCC.04.00, ME 1)
3. When applicable, the patient, family, and/or decision-makers are educated, prior to the procedure being performed, about the options available for postoperative pain management; this education is documented.
4. The anesthesia agent, dose (when applicable), and anesthetic technique are documented in the patient's anesthesia record.
5. The anesthesiologist, or other qualified individual allowed to administer anesthesia, and the anesthesia assistants are identified in the patient's anesthesia record.
6. Ⓓ Anesthesia care is administered and monitored according to professional practice guidelines and as defined in hospital policy.

Standard ASC.03.02

Each patient's physiological status during anesthesia and surgery is monitored according to professional practice guidelines and documented in the patient's medical record.

Intent of ASC.03.02

Physiological monitoring provides reliable information about the patient's status during anesthesia (general, spinal, and regional) and the recovery period. Monitoring information guides medical and nursing care and identifies the need for diagnostic and other services. Results of monitoring trigger key intraoperative decisions as well as postoperative decisions, such as return to surgery, transfer to another level of care, or discharge. Monitoring findings are entered into the patient's medical record. Monitoring methods depend on the patient's preanesthesia status, the anesthesia choice, and the complexity of the surgical or other procedure performed during anesthesia. In all cases, however, the overall monitoring during anesthesia and surgery is consistent with professional practice and defined in hospital policy. The results of monitoring are documented in the patient's medical record.

Measurable Elements of ASC.03.02

1. The frequency and type of monitoring during anesthesia and surgery are based on the patient's preanesthesia status, the anesthesia used, and the surgical procedure performed.
2. Monitoring of the patient's physiological status is consistent with professional practice guidelines.
3. The results of monitoring are documented in the patient's medical record. (*See also* COP.01.00, ME 5)

Standard ASC.03.03

Each patient's postanesthesia status is monitored, and the patient is discharged from the recovery area by a qualified individual or by using established criteria.

Intent of ASC.03.03

The ongoing, systematic collection and analysis of data on the patient's status in recovery support decisions about moving the patient to other settings and less intensive services. Monitoring during the anesthesia period is the basis for monitoring during the postanesthesia recovery period. Monitoring consists of several elements, such as the list of physiological criteria to be monitored, frequency of monitoring and documentation, and general guidance and/or parameters for recovery goals. Monitoring during the postanesthesia recovery period must be performed according to professional practice guidelines and as defined in hospital policy. Recording of monitoring data provides the documentation to support discontinuing recovery monitoring or the discharge decisions. When the patient is transferred directly from the operating theatre to a receiving unit, monitoring and documentation are the same as would be required in the recovery room.

The time of arrival at and discharge from the recovery area (or the time recovery begins and the time of discontinuation of recovery monitoring) and monitoring findings for the postanesthesia recovery period are documented in the patient's medical record.

Measurable Elements of ASC.03.03

1. Ⓓ Patients are monitored during the postanesthesia recovery period according to professional practice guidelines and as defined in hospital policy.
2. Monitoring findings are documented in the patient's medical record.
3. Patients are discharged from the postanesthesia unit or recovery monitoring is discontinued in accordance with one of the following alternatives:
   - The patient is discharged, or recovery monitoring is discontinued, by a fully qualified anesthesiologist or other individual authorized by the individual(s) responsible for managing the anesthesia services.
   - The patient is discharged, or recovery monitoring is discontinued, by a nurse or similarly qualified individual in accordance with postanesthesia criteria developed by hospital leaders, and the patient's medical record contains evidence that criteria are met.
   - The patient is discharged to a unit that is capable of providing postanesthesia or postsedation care for selected patients, such as a cardiovascular intensive care unit or neurosurgical intensive care unit, among others.
4. The following anesthesia recovery times are recorded in the patient's medical record:
   - Time recovery starts
   - Time recovery phase is complete

Surgical Care

Standard ASC.04.00

Each patient's surgical care is planned based on the results of the preoperative assessment and documented in the patient's medical record.

Intent of ASC.04.00

The *preoperative assessment* is a clinical risk assessment to determine if it is safe for the patient to undergo surgery; therefore, it is an important deciding factor to move forward with planning the surgical procedure.

In addition, the assessment is used to select the appropriate surgical procedure and determine patient needs related to the surgery.

The preoperative assessment evaluates the patient's condition and needs prior to surgery. The assessment includes the following:

- Physical exam and test results
- Medical needs
- Psychological needs
- Social needs (for example, safe housing and support with activities of daily living)
- Economic needs (for example, ability to pay for postoperative medication or medical equipment)
- Discharge needs (for example, transfer to rehabilitation center or home nursing needs)

Results of the preoperative assessment are documented in the patient's medical record prior to surgery. The assessment provides information necessary to do the following:

- Select the appropriate surgical procedure and the optimal time to perform the surgery.
- Perform the procedure safely.
- Interpret the findings of patient monitoring during surgery.

Surgical procedure selection depends on such factors as the following:

- Patient history
- Physical status
- Diagnostic data
- Risks and benefits of the procedure for the patient

Procedure selection considers the information from the initial assessments and reassessments, diagnostic tests, and other available sources. The assessment process is carried out in a shortened time frame when an emergency patient needs surgery.

The planned surgical care is documented in the patient's medical record and includes a preoperative diagnosis. The name of the surgical procedure alone does not constitute a diagnosis.

Measurable Elements of ASC.04.00

1. A preoperative assessment is performed and documented by a qualified provider before surgery.
2. The preoperative assessment includes the following:
   - Physical exam and test results
   - Medical needs
   - Psychological needs
   - Social needs
   - Economic needs
   - Discharge needs
3. Surgical care for each patient is planned based on the preoperative assessment information.
4. A preoperative diagnosis and the planned surgical procedure are documented in the patient's medical record prior to the procedure.

Standard ASC.4.01

The risks, benefits, and alternatives are discussed with the patient and their family or those who make decisions for the patient.

Intent of ASC.04.01

Adequate information and education must be provided to the patient, their family, and/or decision-makers on the risks, benefits, and alternatives related to surgical care to participate in care decisions and to provide the informed consent required in Standard PCC.03.00. Patient education and engagement can be promoted

through improvement in the patient and family's health literacy (the ability to obtain, understand, and act on health information); for example, providing information that a reasonable patient would want and would need to know that relates to the planned surgical procedure and care to make an informed decision. In addition, when blood or blood products may be needed, information on the risks and alternatives is discussed. The patient's surgeon or other qualified individual, as defined by the hospital, provides this information.

Measurable Elements of ASC.04.01

1. The patient, family, and/or decision-makers are educated on the following elements related to the planned surgical procedure:
   - Name of test, procedure, or treatment covered by the informed consent
   - Name of responsible practitioner(s) performing the procedures(s)
   - Risks and benefits of the planned procedure
   - The likelihood of success, potential complications, the recovery process, and possible results of nontreatment
   - Surgical and nonsurgical options and/or alternatives available to treat the patient
   - The need for, risks and benefits of, and alternatives to blood and blood-product use
2. Ⓓ The patient's surgeon, or other qualified individual as defined by hospital policy, provides and documents the education.

Standard ASC.04.02

Information about the surgical procedure is documented in the patient's medical record to facilitate continuing care.

Intent of ASC.04.02

A patient's postsurgical care depends on the events and findings of the surgical procedure. Most important, all actions and results essential to the patient's condition are entered in the patient's medical record. Patient information can be presented in various formats, such as templates (either paper or electronic), an operative report such as a written operative progress note, or nursing or other treatment or care service notes. To support a continuum of postsurgical supportive care, the information about the surgery is recorded in the patient's medical record immediately after surgery, prior to the patient being transferred from the surgical or the postanesthesia recovery area. The time immediately after surgery is defined as "upon completion of surgery, before the patient is transferred to the next level of care."

Information may also be contained in other notations in the medical record. For example, amount of blood loss and transfused blood may be recorded in the anesthesia record, or information about implantable devices may be shown using a manufacturer's preprinted sticker. Defining the time immediately after surgery (for example, "upon completion of surgery, before the patient is transferred to the next level of care") ensures that pertinent information is available to the next caregiver. If the surgeon accompanies the patient from the operating theatre to the next unit or area of care, the operative note, template, or progress note can be written in that unit or area of care.

Note: Documentation of information on nonsurgical procedures and treatments, such as invasive diagnostic procedures, interventional treatments, and other diagnostics and treatments, is identified in COP.01.01.

Measurable Elements of ASC.04.02

1. Surgical reports, templates, or operative progress notes include at least the following elements:
   - Preoperative diagnosis and planned procedure
   - Postoperative diagnosis
   - Name of operative surgeon and assistants
   - Procedures performed and description of each procedure findings

- Perioperative complications
- Tubes and/or drains placed intraoperatively
- Surgical specimens sent for examination
- Amount of blood loss and amount of transfused blood
- Date, time, and signature of responsible physician

2. The hospital identifies information that may routinely be recorded in other specific areas of the medical record.
3. The surgical report, template, or operative progress note is available immediately after surgery before the patient is transferred to the next level of care.

Standard ASC.04.03

Patient care after surgery is planned and documented.

Intent of ASC.04.03

Each patient's postsurgical medical and nursing care needs differ depending on the surgical procedure performed and the health history of the patient. Postsurgical care planning can begin before surgery based on the patient's assessed needs and condition and the type of surgery being performed. Some patients may require care from other services, such as physical therapy or rehabilitation; therefore, it is necessary to plan for that care, including the level of care, care setting, follow-up monitoring or treatment, and the need for medication or other treatment and services. The postsurgical plan of care also includes the patient's immediate postoperative needs.

The postsurgical care is planned, documented in the patient's medical record within 24 hours, and verified by the responsible service to ensure continuity of services during the recovery or rehabilitative period. Postsurgical needs may change as the result of clinical improvement or new information from a routine reassessment, or they may be evident from a sudden change in the patient's condition. The plan of care is revised based on these changes and documented in the medical record as notes to the initial plan or as a revised or new plan of care.

Measurable Elements of ASC.04.03

1. All postsurgical care, treatment, and services meet the patient's immediate postsurgical needs.
2. The continuing postsurgical plan(s) is documented in the patient's medical record within 24 hours by the responsible surgeon or verified by a co-signature from the responsible surgeon on the documented plan entered by the surgeon's delegate.
3. The continuing postsurgical plan of care includes care, treatment, and services based on the patient's assessed needs.
4. When indicated by a change in the patient's needs, the postsurgical plan of care is updated or revised based on the reassessment of the patient by the health care practitioners. (*See also* COP.01.01, ME 3)

Standard ASC.04.04

Surgical care that includes the implanting of a medical device is planned with special consideration for how standard processes must be modified.

Intent of ASC.04.04

Surgical procedures involving the implantation of medical devices require that routine surgical care be modified to account for special factors. Surgical procedures that involve the implantation of a medical device are common for many medical specialties. Medical devices have become critical components of health care, not only in their effects on patient morbidity and mortality but also in their ability to extend the quality of life of the patient. An *implantable medical device* is defined as a device that is placed into a surgically or naturally

formed cavity of the body to continuously assist, restore, or replace a function or structure of the body; deliver medications; or monitor body functions throughout the useful life of the device. These special considerations may be incorporated into guidelines, protocols, operating policies, or other documents to guide the surgical team and facilitate consistent processes and outcomes.

An implantable medical device can be a prosthesis (such as a hip), a stent, a cardioverter defibrillator, a pacemaker, intraocular lenses, or an infusion pump, among other examples. The ability to track implantable medical devices is essential for tracking surgical site infections and identifying patients who may have received nonsterile implants. In addition, the tracking process allows the hospital to assess the reliability of the sterilization process. Therefore, the hospital has a process for tracking implantable medical devices.

In the event of a recall of an implantable medical device, the hospital informs and follows up with those patients who received the device. The hospital develops and implements a process for contacting and following up with the patients, including those who may be outside the country. The hospital determines the time frame for contacting patients (for example, within 24 hours of the official recall notification of a lifesaving device). This time frame may be longer for a non-lifesaving device. The patient receives information on the implantable device such as the unique device identifier, how long-term tracking of the device will be supported, the process for notification in case of a problem with the device, and education on how sharing device information supports patients' long-term health care, safety surveillance, and future research to advance practices and patient safety with the device.

Measurable Elements of ASC.04.04

1. The hospital's surgical services identify the types of implantable medical devices that are included within its scope of services.
2. Ⓓ Written policies and practices include, at least, the following:
   - Selection of devices based on current science and research
   - Verification that implants are present in the operating theatre
   - Verification of the qualifications and training of any outside technical staff required during the implant procedure (for example, the manufacturer's representative who may be required to calibrate the device)
   - Reporting process for implantable device–related adverse events
   - Reporting of implantable device malfunctions to regulatory agencies
   - Unique infection prevention and control considerations
   - Any special discharge instructions for the patient
3. The patient receives information on the implantable device that at the least includes the following:
   - Identifying information on the device, including the unique device identifier
   - How long-term tracking of the device will be supported
   - Process for notification in case of a problem with the device
   - Education on how sharing device information supports patients' long-term health care, safety surveillance, and future research
4. The hospital has a process for tracking implantable medical devices.
5. The hospital implements a process for contacting and following up with patients in a defined time frame after receiving notification of a recall of an implantable medical device.

Care of Patients (COP)

Overview

The most important responsibility of a health care organization and its staff is to provide safe and effective care and services to all patients. This requires effective communication, collaboration, and standardized processes to ensure that the planning, coordination, and implementation of care supports and responds to each patient's unique needs and goals.

Care may be preventive, palliative, curative, or rehabilitative and may include anesthesia, surgery, medication, supportive therapies, or a combination of these and is based on the assessment and reassessment of each patient. High-risk areas of care (including resuscitation, blood administration, organ and tissue transplantation) and care for high-risk or special needs populations require additional attention. Part of care delivery also includes identifying and reducing risk factors that could impact patient care such as risks associated with patients who may be suicidal, or at high risk for complications from a disease process or surgery.

Care for patients is provided by many disciplines and support staff. All individuals involved in patient care must have a clear role determined by licensure; credentials; certification; laws and regulations; an individual's particular skills, knowledge, and experience; and organization policies or job descriptions. Some care may be carried out by the patient, their family, or other trained caregivers. Additional support may also be provided by an appointed individual(s), such as a living donor advocate, who has knowledge about the care process and can independently inform patients on all considerations that could affect decision-making.

The delivery of care and services must be coordinated and integrated by all individuals caring for the patient. Working together with the patient and family, these individuals ensure that the following criteria are met:

- Based on assessment, care is planned to meet each patient's unique needs.
- The planned care is delivered to each patient.
- The patient's response to care is monitored.
- Planned care is modified when necessary, based on the patient's response.

Standards

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

Care Delivery for All Patients

COP.01.00 There is a uniform process for prescribing and completing treatment orders.

COP.01.01 An individualized plan of care is developed and documented for each patient.

COP.01.02 The provision of high-risk services is guided by professional practice guidelines, laws, and regulations.

Clinical Alarm System Management

COP.02.00 The hospital implements policies and procedures for safety of clinical alarm systems.

Recognition of Changes to Patient Condition

COP.03.00 Clinical staff are trained to recognize and respond to changes in a patient's condition.

Resuscitation Services

COP.04.00 Resuscitation services are available throughout the hospital.

Management of Patients at Risk of Suicide or Self-Harm

COP.05.00 The hospital has a process to identify and protect patients at risk for suicide and self-harm.

Food and Nutrition Therapy

COP.06.00 Food, nutrition products, and nutrition therapy are available to patients.

Pain Management

COP.07.00 Pain is managed effectively.

End-of-Life Care

COP.08.00 The hospital has a process to provide end-of-life care that addresses the needs of the patient and family and optimizes the patient's comfort and dignity.

Hospitals Providing Transplant Services

COP.09.00 The hospital informs patients and families about how to donate organs and other tissues.

COP.09.01 The hospital provides oversight for the process of organ and tissue procurement.

COP.09.02 The hospital's leaders provide resources to support the organ, tissue, and/or cell transplant program.

COP.09.03 The hospital identifies a qualified transplant program leader(s) and includes an interdisciplinary team that consists of clinical staff with expertise in the relevant transplant programs.

COP.09.04 There is a designated coordination mechanism for all transplant activities.

COP.09.05 The hospital complies with organ, tissue, and cell transplant responsibilities.

COP.09.06 The transplant program obtains informed consent specific to organ, tissue, and/or cell transplant from the transplant recipient candidate.

COP.09.07 The transplant program has documented protocols, clinical practice guidelines, or procedures for organ recovery and organ receipt to ensure the compatibility, safety, efficacy, and quality of human cells, tissues, and organs for transplantation.

COP.09.08 Clinical practice guidelines and clinical criteria guide the selection and care of organ, tissue, and cell transplant patients.

Transplant Programs Using Living Donor Organs

COP.10.00 Transplant programs that perform living donor transplantation adhere to local and regional laws and regulations and protect the rights of prospective or actual living donors.

COP.10.01 Transplant programs performing living donor transplants obtain informed consent specific to organ donation from the prospective living donor.

COP.10.02 Transplant programs that perform living donor transplants use clinical and psychological selection criteria to determine the suitability of potential living donors.

COP.10.03 Individualized patient care plans guide the care of living donors.

Standards, Intents, and Measurable Elements

Care Delivery for All Patients

Standard COP.01.00

There is a uniform process for prescribing and completing treatment orders.

Intent of COP.01.00

A uniform process for the prescription, completion, and documentation of patient orders contributes to the integration and coordination of patient care activities, more effective use of human and other resources, and the increased likelihood of better patient outcomes.

Each member of the health care team records observations and treatments in the patient's medical record. Many patient care activities require a qualified individual to prescribe an order for that activity. Examples of such activities include the following:

- Orders for laboratory testing
- Administration of medications
- Specific nursing care
- Nutrition therapy
- Rehabilitative therapy

These orders are documented in the patient's medical record and must be easily accessible.

Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces errors and results in improved patient safety. Communication can be electronic, verbal, or written. Patient care circumstances that can be critically affected by poor communication include verbal and telephone patient care orders, verbal and telephone communication of critical test results, and handover communications.

Patient care orders given verbally in person and over the telephone, if permitted under local laws and regulations, are some of the most error-prone communications. Different accents, dialects, and pronunciations can make it difficult for the receiver to understand the order being given. For example, drug names and numbers that sound alike, such as erythromycin and azithromycin or fifteen and fifty, can affect the accuracy of the order. Background noise, interruptions, and unfamiliar drug names and terminology often compound the problem. When received, a verbal order must be transcribed as a written order, which adds complexity and risk to the ordering process.

Clinical and diagnostic procedures and treatments performed are documented in the patient's medical record. The outcomes or results of any treatment or procedure are documented in the patient's medical record. Information about who requested the procedure or treatment and the indication for the procedure or treatment are included in the documentation.

Orders should be in a designated section of the medical record (for example, an orders requisition form in a hard copy medical record or order entry section of an electronic health record). They should not be interspersed throughout various sections of the medical record (for example, the order requisition form and progress notes), as this increases the likelihood of a missed order. Safe practices for communicating orders and test results include the following:

- Limiting verbal communication of prescription or medication orders to urgent situations in which immediate written or electronic communication is not feasible. For example, verbal orders can be disallowed when the prescriber is present, and the patient's chart is available. Verbal orders can be restricted to situations in which it is difficult or impossible for hard-copy or electronic order transmission, such as during a sterile procedure.

- The development of guidelines for requesting and receiving test results on an emergency or stat basis, the identification and definitions of critical tests and critical values, to whom and by whom critical test results are reported, and monitoring compliance
- Writing down, or entering into a computer, the complete order or test result by the receiver of the information; using closed-loop communication with the receiver reading back the order or test result; and the sender confirming that what has been written down and read back is accurate. Permissible alternatives for when the read-back process may not always be possible may be identified, such as in the operating theatre and in emergent situations in the emergency department or intensive care unit.

Measurable Elements of COP.01.00

1. Ⓓ The hospital implements a written uniform process for prescribing patient orders that includes the following:
   - Information required in the order
   - Identifying orders that may be received verbally, via telephone, and via text (*See also* MMU.04.01, ME 6)
   - Who is qualified and permitted to prescribe patient orders (*See also* MMU.04.00, ME 1)
   - How and where orders are documented uniformly in patient medical records
   - Which staff are authorized to receive and record verbal, telephone, and text orders, in accordance with laws and regulations
   - Time frame in which verbal, telephone, and text orders must be signed by the prescriber
2. Diagnostic imaging and clinical laboratory test orders include a clinical indication/rationale when required for interpretation.
3. Complete verbal orders, including telephone orders, are documented and read back by the receiver and confirmed by the individual giving the order.
4. Procedures and treatments are carried out as ordered and are documented in the patient's medical record.
5. The results of procedures and treatments performed are documented in the patient's medical record. (*See also* ASC.03.02, ME 3)
6. Verbally reported test results are documented and read back by the receiver and confirmed by the individual giving the test result.

Standard COP.01.01

An individualized plan of care is developed and documented for each patient.

Intent of COP.01.01

The plan of care outlines care, treatment, and services to be provided to an individual patient. The overall goal of a plan of care is to achieve optimal clinical outcomes. The planning process is collaborative and uses the data from the initial assessment and reassessments performed by members of the health care team to identify and to prioritize the care, treatments, and services required to meet the patient's needs. The patient and family are involved in the planning process with the health care team.

The care plan is developed within 24 hours of admission as an inpatient and is updated as appropriate to reflect the patient's evolving condition. The plan of care is documented in the patient's medical record.

The plan of care for a patient must be related to their identified needs. Patient needs may change as the result of clinical improvement or new information from a routine reassessment (for example, abnormal laboratory or radiography results), or they may be evident from a change in the patient's condition (for example, loss of consciousness). The plan of care is revised based on these changes and is documented in the medical record as notes to the initial plan or as a new plan of care.

One method of developing care plans is to identify and establish measurable goals. Measurable goals can be chosen by the responsible practitioner with the nurse and other health care team members. Measurable goals are observable, achievable targets related to patient care and expected clinical outcomes.

Goals must be realistic, specific to the patient, and time-based to provide a means for measuring progress and outcomes related to the plan of care. Examples of measurable, realistic goals include the following:

- The patient will resume and maintain an adequate cardiac output as indicated by a heart rate, rhythm, and blood pressure that are within normal limits.
- The patient will demonstrate proper self-administration of insulin injections prior to hospital discharge.
- The patient will be able to walk from his bed to the visitor lounge with a standard walker, bearing weight as tolerated on the affected leg.

Note: A single, integrated plan of care that identifies measurable goals expected by each health care practitioner is preferable. It is good practice for the plan of care to reflect individualized, objective, and measurable goals to facilitate reassessment and revision of the plan of care.

Some departments may conduct multidisciplinary patient care conferences for patients receiving complex care from multiple services. Examples of such patients include the following:

- Patients receiving rehabilitative services
- Patients with multiple diagnoses in intensive care units
- Patients with complex discharge planning needs

Any results or conclusions from collaborative patient care team meetings or similar patient discussions are written in the patient's medical record.

Measurable Elements of COP.01.01

1. The care for each patient is planned by the responsible practitioner, nurse, and other members of the health care team within 24 hours of admission as an inpatient.
2. The plan of care is individualized based on the patient's initial assessment data and identified needs and is documented in the patient's medical record.
3. The plan of care is updated or revised based on any changes in the patient's condition and is documented in the patient's medical record. (*See also* AOP.01.05, ME 1; ASC.04.03, ME 4)
4. The results or conclusions of any patient care team meetings or other collaborative discussions are documented in the patient's medical record.

Standard COP.01.02

The provision of high-risk services is guided by professional practice guidelines, laws, and regulations.

Intent of COP.01.02

Providing high-risk services involves unique risks to patients and staff; the hospital establishes and implements guidelines and procedures to identify and decrease risks associated with these services. Some services are considered high risk because of the complex medical equipment, the nature of the treatment, the potential for harm to the patient, or toxic effects of certain high-risk medications.

High-risk care is supported by the use of such tools as the following:

- Clinical practice guidelines
- Hospital policy and procedures
- Clinical pathways

These tools are important for staff to understand and implement in a uniform manner. Hospital leaders are responsible for the following:

- Identifying services considered high risk in the hospital
- Using a collaborative process to develop written tools for guiding the uniform care
- Training staff in implementing these tools

Written tools for care must be tailored to the high-risk service to be effective in reducing risk. When providing high-risk services, the hospital establishes and implements guidelines and procedures that address the following:

- How care planning will occur, including special considerations related to the high-risk service
- The documentation required for effective communication among the care team
- Special consent considerations, if appropriate
- Patient-monitoring requirements, including the proper use of alarms
- Special qualifications or skills of staff involved in the care process
- The availability and use of specialized medical equipment

Hospital leaders identify additional risk for hospital-acquired conditions as the result of any procedures or plan of care. Examples of hospital-acquired conditions include the following:

- Deep vein thrombosis, pressure ulcers, and ventilator-associated infections in patients on life support
- Neurological and circulatory injury in restrained patients
- Bloodborne pathogen exposure in hemodialysis patients
- Central line infections
- Falls

When these risks are present, they must be prevented by educating staff and developing appropriate policies, guidelines, and procedures. The hospital uses measurement information to evaluate the services provided and integrates that information into the hospital's overall quality improvement program.

Measurable Elements of COP.01.02

1. Ⓓ Hospital leaders identify, in writing, the high-risk services, including at least the following when provided by the hospital:
   - Emergency services
   - Life support, including ventilators and extracorporeal membrane oxygenation
   - Infectious disease services
   - Dialysis
   - Restraints
   - Chemotherapy
   - Critical care services
2. Ⓓ Hospital leaders establish and implement written policies, procedures, and/or principles of care for high-risk services provided by the hospital.
3. Staff are trained to use the written tools for high-risk services.
4. Hospital leaders identify additional risks that may affect high-risk services and implement measures to reduce and/or prevent these risks.
5. Ⓓ Hospital-acquired conditions are tracked and included in the hospital's quality improvement program.

Clinical Alarm System Management

Standard COP.02.00

The hospital implements policies and procedures for safety of clinical alarm systems.

Intent of COP.02.00

Clinical alarm systems are intended to alert caregivers of potential patient problems or equipment malfunction. However, improperly managed clinical alarm systems compromise patient safety. Risk factors associated with alarm management include too many devices with alarms, default settings that are not at an actionable level, and alarm limits that are too narrow or not appropriate for the patient's condition. Patient care areas have multiple alarm signals, and the noise from improperly managed alarms desensitizes staff and causes them to miss, ignore, or disable alarms. These issues vary greatly among hospitals and within different clinical areas in a single hospital. Hospital leaders must develop a systematic, coordinated approach to minimize risks associated with clinical alarm management.

Standardization contributes to safe alarm system management, but alarm management solutions may have to be designed for specific clinical units, groups of patients, or individual patients. In designing customized solutions for proper alarm management, leaders begin by identifying the most important alarm signals to manage. For example, the most common alarms to address in an adult cardiac population would be cardiac monitoring, and in labor and delivery fetal monitoring alarms may be the most common.

Consideration of the following can be helpful in determining alarm signals that may pose a risk to patient safety:

- Input from clinical staff
- Data from medical devices, including false or nonactionable alarms
- Risk to patients if the alarm signal is not attended to or if it malfunctions
- Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
- Potential for patient harm based on internal incident history
- Published best practices and guidelines

Measurable Elements of COP.02.00

1. Ⓓ Hospital leaders implement a written management program for alarm signals that pose a risk to patient safety.
2. The program identifies the most important alarm signals to be managed based on the risk to patient safety.
3. Ⓓ Hospital leaders develop and implement strategies for managing alarms that include the following:
   - Clinically appropriate settings for alarm signals
   - Situations in which alarm signals can be disabled
   - Circumstances under which alarm parameters must be reviewed and/or be changed (for example, with significant changes in patient condition, when patients are transferred to different levels of care)
   - Identification of those who have the authority to set alarm parameters
   - Designation of those who have the authority to change alarm parameters
   - Reducing unnecessary alarm noise and improving alarm fatigue among the clinical staff
4. Clinical staff are educated on the purpose and operation of alarm systems for which they are responsible.
5. Staff responsible for the management of clinical alarms are trained and competent to do so.
6. Alarm systems, policies and procedures, and staff training procedures are reviewed as necessary and in accordance with the hospital's policy review process, at minimum every three years, to identify and implement improvements.

Recognition of Changes to Patient Condition

Standard COP.03.00

Clinical staff are trained to recognize and respond to changes in a patient's condition.

Intent of COP.03.00

Hospitals that implement a systematic approach to early recognition and response to changes in a patient's condition reduce cardiopulmonary arrests and patient mortality. It is essential to recognize the signs indicating a change or deterioration in the patient's condition. Often, a patient will exhibit early warning signs (for example, a worsening of vital signs or a subtle change in neurological status) shortly before experiencing significant clinical decline, resulting in a major event. Clinical staff use physiological criteria to assist in early detection of deteriorating patients. Most patients who experience cardiopulmonary or respiratory arrest experience clinical deterioration prior to arrest. Clinical outcomes improve when staff can identify these patients early and request additional assistance from specially trained individuals.

All clinical staff must receive education and training to recognize and intervene when a patient exhibits physiological signs that are outside of the normal range, indicating a potential for patient deterioration. Early response to changes in a patient's condition is critical to potentially preventing further deterioration.

Failure to rescue (FTR) is failure or delay in recognizing and responding to a hospitalized patient experiencing complications from a disease process or medical intervention and is a recognized cause of mortality in hospitals. Failure to rescue measures have been developed for various specialties, including the following:

- Adult and pediatric surgical services
- Adult cardiac care
- Trauma surgery
- Gastrointestinal surgery

Failure to rescue measures are selected based on the populations treated and services provided; data from these measures are used to identify opportunities for process improvement.

Early warning criteria, also known as early warning scores, are used to quickly determine patient condition or changes in patient condition. These criteria are evidence-based and age-specific. The hospital implements early warning criteria for all age groups it cares for. Examples of early warning criteria include the following:

- Early Warning Score (EWS)
- Modified Early Warning Score (MEWS)
- Pediatric Early Warning Score (PEWS)
- Neonatal Early Warning Score (NEWS)
- Revised Trauma Score (RTS)
- 10 Signs of Vitality score
- Pasero Opioid-Induced Sedation Scale (POSS)

Measurable Elements of COP.03.00

1. The hospital has a systematic process to recognize and respond to changes or deterioration of patient condition.
2. Ⓓ The hospital implements documented age-specific early warning criteria describing early signs of a change or deterioration in a patient's condition.
3. The hospital has a process for staff to seek additional assistance when they have concerns about a patient's condition based on the hospital's early warning criteria.
4. The hospital informs the patient and family how to seek assistance when they have concerns about a patient's condition.

Resuscitation Services

Standard COP.04.00

Resuscitation services are available throughout the hospital.

Intent of COP.04.00

The immediate initiation of chest compressions, respiratory support, and defibrillation when indicated impact patient outcomes, including preventing permanent injury, disability, or death. Therefore, resuscitation services must be available throughout the hospital to decrease response time and improve patient outcomes. Successful resuscitation of patients in cardiopulmonary arrest is dependent on critical interventions, such as early defibrillation and initiation of advanced life support. These services must be available to all patients, 24 hours a day, every day. Staff trained in resuscitation must have access to standardized medical equipment and medications for resuscitation.

Basic life support must be initiated immediately upon recognition of cardiac or respiratory arrest, and a process must be in place for providing advanced life support in fewer than 5 minutes. Although the requirement for COP.04.00, ME 3 is for a response under 5 minutes, the hospital should continually reevaluate its response times and make efforts to shorten the response time as much as possible. This may involve elements such as placement of emergency carts and equipment such as automated external defibrillators (AEDs) and assignment/location of staff who respond to resuscitation emergencies.

Resuscitation services, equipment, and staff training within the hospital must be based on clinical evidence and the population served (for example, if the hospital has a pediatric population, medical equipment for pediatric resuscitation must be available). The hospital performs internal reviews of previous emergency situations to evaluate response times and availability of appropriate equipment and identifies areas for improvement.

Note: *All areas of the hospital* includes all areas where treatment and services are provided, including treatment or diagnostic areas in separate buildings on the hospital campus. The hospital determines what resuscitation services, equipment, and training are provided based on its patient populations. These resources must be immediately available in all areas where specific patient populations receive services. For example, hospitals that treat children must have clinical staff trained in pediatric advanced life support, have standardized pediatric equipment and medications, and be able to appropriately select the size or dose of medication based on the child's weight or size.

Resuscitation equipment and medications are standardized throughout the hospital. Hospital leaders and clinical staff determine how to store and standardize equipment depending on the patient populations served, as in the following examples:

- Emergency departments that treat adults and children may have two separate resuscitation carts—one for adults and one for children—or one cart with designated drawers for adult and pediatric patients.
- Pediatric departments may have resuscitation carts that include weight-based equipment and medications appropriate for neonatal through young adult patients.
- Maternity wards may have resuscitation supplies for laboring patients in one resuscitation box and resuscitation supplies for newborns in a separate resuscitation box.

Advanced life support is provided in fewer than 5 minutes. Patient outcomes depend on high-quality cardiopulmonary resuscitation (CPR) and correct recognition of the causes and treatments for cardiopulmonary arrest. Therefore, at 5 minutes, an adequate amount of staff members trained in advanced life support must have arrived and initiated advanced life support protocols based on the patient's condition and clinical data. Adequate staff trained in advanced life support must remain present and available to support the resuscitation efforts until the event has concluded.

If the hospital has consistently initiated advanced life support in fewer than 5 minutes, quality data should be reviewed to determine how this time could be even shorter. An interdisciplinary committee can be formed to complete resuscitation services reviews. These reviews include resuscitation cases and data to identify and suggest practice and system improvements in resuscitation performance.

Measurable Elements of COP.04.00

1. Resuscitation services are available and provided to all patients 24 hours a day, every day, throughout all areas of the hospital.
2. Medical equipment for resuscitation and medications for basic and advanced life support are standardized and available for use based on the populations served. (*See also* MMU.03.01, ME 4)
3. In all areas of the hospital, basic life support is initiated immediately upon recognition of cardiac or respiratory arrest, and advanced life support is initiated in fewer than 5 minutes.
4. Ⓓ The hospital performs an internal review of all resuscitation events for effectiveness and makes efforts to improve identified areas for improvement, including the following at minimum:
   - How often early warning signs of clinical deterioration were present prior to in-hospital cardiac arrest in patients in unmonitored or noncritical care units
   - Timeliness of staff's response to a cardiac arrest
   - Timeliness of initiation of advanced cardiovascular life support (ACLS) to the shortest time possible
   - The quality of cardiopulmonary resuscitation (CPR)
   - Post–cardiac arrest care processes
   - Outcomes following cardiac arrest

Management of Patients at Risk of Suicide or Self-Harm

Standard COP.05.00

The hospital has a process to identify and protect patients at risk for suicide and self-harm.

Intent of COP.05.00

Suicide is considered a sentinel event. Patients being evaluated or treated for behavioral health conditions often have suicidal ideation. The hospital must implement screenings and assessments to identify patients at risk for suicide and self-harm to minimize the likelihood of a suicide or self-harm attempt.

Screening identifies those at risk or potentially in need of a further, more specialized assessment. An assessment is a systemic process done to evaluate needs that can then be fulfilled, or a plan made around them on how to meet those needs, thus the individual conducting the assessment should have an expertise or specialty in the field being assessed.

Validated screening tools are an effective way to identify individuals who require further assessment to determine risk for suicide. A validated screening tool is one that has been scientifically tested for reliability (the ability of the instrument to provide consistent results), validity (the degree to which the instrument is measuring the condition that it is designed to measure), sensitivity (the ability of the instrument to correctly identify individuals with the condition), and specificity (the ability of the instrument to correctly identify individuals without the condition). In addition, the hospital must select validated screening tools that are appropriate for the population (for example, age-appropriate).

When using validated screening tools, organizations should not change the wording of the questions because small changes can affect the accuracy of the tools.

It is important that organizations ensure that the chosen screening tool(s) is implemented and completed as directed by the creators of the tool(s). For example, the Columbia–Suicide Severity Rating Scale (C-SSRS) is a validated screening tool that contains six questions. Depending on the answer to the first two questions, additional questions apply. One or more questions may get missed if the tool is not implemented or completed as directed. Another example, the Ask Suicide-Screening Questions (ASQ) Suicide Risk Screen Tool, is a four-question validated screening tool, which also contains a fifth question to assess acuity. This question may get missed if the tool is not implemented or completed as directed. Therefore, if not completed as instructed, the validity of the tool to identify individuals who may be at risk for suicide is compromised. Ultimately, it is the responsibility of each organization to ensure that validated tools are implemented and completed accurately.

Hospitals that care for patients at risk for suicide and self-harm need to assess risks in the physical environment to identify areas and features that could be used to attempt suicide. Psychiatric hospitals and hospitals with psychiatric wards and units design, build, and maintain the environment in a manner that minimizes or eliminates risks identified in the environmental risk assessment. Nonpsychiatric units in hospitals assess clinical areas to identify objects that could be used for self-harm so they can be removed, or the risk posed by those items mitigated when needed, from the area around a patient who has been identified as high risk for suicide (for example, in psychiatric hospitals, securing windows that can be opened and removing anchor points, door hinges, and hooks that can be used for hanging; in nonpsychiatric hospitals, removing items such as blood pressure cuffs, phone cords, call light cords, and monitor wires when not needed for clinical care of the patient). In addition, the hospital should have a process to handle patient clothing and belongings to mitigate risks, such as removing and securing shoes with shoelaces and other patient items that could be used for self-harm. The hospital's environmental risk assessment process should be the starting point and should also include a plan for risk mitigation such as one-to-one observation when indicated.

Measurable Elements of COP.05.00

1. Ⓓ The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide or self-harm; the hospital takes necessary action to minimize the risk(s). (*See also* FMS.03.00, ME 1; FMS.04.00, ME 2)
2. Using a validated screening tool, the hospital screens all patients for suicidal ideation who are being evaluated or treated for behavioral conditions as their primary reason for care.
3. The hospital uses an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.
4. Suicide screenings and assessments are documented in the patient's medical record or in accordance with laws and regulations when applicable.
5. Ⓓ The hospital follows written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, the polices should include the following:
   - Training and competence assessment of staff who care for patients at risk for suicide
   - Guidelines for reassessment of patients who are at risk for suicide and self-harm
   - Monitoring patients who are at high risk for suicide and self-harm
6. Ⓓ The hospital follows written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide and self-harm.
7. Ⓓ The hospital monitors implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and self-harm, and takes action as needed to improve compliance.

Food and Nutrition Therapy

Standard COP.06.00

Food, nutrition products, and nutrition therapy are available to patients.

Intent of COP.06.00

Appropriate food and nutrition contribute to improved patient outcomes, including wound healing, and management of complex diseases and disorders. Based on the patient's assessed needs, diagnoses, and plan of care, the patient's practitioner or other qualified caregiver orders food or other nutrients for the patient. The order may include special dietary requirements such as low cholesterol, diabetic diet, or clear liquids.

The patient participates in planning and selecting foods whenever possible. Patients are offered a variety of food choices consistent with their nutritional status when possible. The patient's family may participate in providing food consistent with cultural, religious, and other traditions and practices and compatible with the patient's diagnosis when appropriate. When the patient's family or others provide food to the patient, they are educated about foods that are contraindicated to the patient's care needs and plans, including information about any medications associated with food interactions. Food provided by family or others is stored under proper conditions, following current food storage guidelines, to prevent contamination.

Patients are screened to identify those who may be at nutritional risk during the initial assessment. These patients are referred to a nutritionist for further assessment. A plan for nutrition therapy is developed and carried out for patients at nutritional risk. Nutrition therapy includes the following:

- Enteral feedings
- Total parenteral nutrition
- Fortification of breast milk
- Other nutritional supplements

The patient's progress is monitored and recorded in their medical record. Physicians, nurses, the dietetics service, and, when appropriate, the patient's family collaborate to plan and to provide nutrition therapy.

Measurable Elements of COP.06.00

1. A variety of food choices or nutrition, consistent with the patient's condition, care, and needs, is regularly available.
2. There is an order for food in the patient's medical record based on the patient's nutritional status and needs prior to inpatients being fed.
3. The distribution of food is timely, and special requests are met.
4. When families provide food, they are educated about the patients' diet limitations.
5. Ⓓ Food and nutrition products, including those provided by family, are stored under proper conditions, following current food storage guidelines, to prevent contamination.
6. Patients determined to be at nutrition risk receive nutrition therapy.
7. A collaborative process is used to plan, deliver, and monitor nutrition therapy.
8. The patient's response to nutrition therapy is monitored and documented in the medical record.

Pain Management

Standard COP.07.00

Pain is managed effectively.

Intent of COP.07.00

Unrelieved pain has adverse physical and psychological effects, and patients in pain have the right to appropriate assessment and management of it. Pain may be part of the patient's experience and may be associated with the patient's condition or illness. Pain may also be an expected part of certain treatments, procedures, or examinations. Patients are informed about the likelihood of pain when it is an anticipated effect from treatments, procedures, or examinations and what options for pain management are available.

Based on the scope of services provided, the hospital has processes to manage pain appropriately, including the following:

- Identifying patients with pain during initial assessment and reassessments
- Providing information to patients about pain that may be an expected result of treatments, procedures, or examinations
- Providing management of pain, regardless of the origin of pain, according to guidelines or protocols and in alignment with patient goals for pain management
- Communicating with and educating patients and families about pain and symptom management in the context of their personal, cultural, and religious beliefs
- Educating clinical staff about pain assessment and management

Measurable Elements of COP.07.00

1. Patients are informed about the likelihood of pain and options for pain management when pain is an expected result of planned treatments, procedures, or examinations. (*See also* AOP.01.04, ME 3)
2. Patients in pain receive care according to pain management guidelines and in alignment with the patient's goals for pain management.
3. The hospital has processes to communicate with and to educate patients and families about pain. (*See also* ACC.01.04, ME 3)
4. The hospital provides education to clinical staff about pain assessment and management.

End-of-Life Care

Standard COP.08.00

The hospital has a process to provide end-of-life care that addresses the needs of the patient and family and optimizes the patient's comfort and dignity.

Intent of COP.08.00

End-of-life or dying patients have unique needs; the hospital implements processes to address these needs and to incorporate the patient's and family's preferences into the care processes. End-of-life care may be influenced by cultural and religious traditions. Concern for the patient's comfort and dignity guides all aspects of care during the final stages of life. All staff members are made aware of patients' needs at the end of life. These needs include but are not limited to the following:

- Treatment of primary and secondary symptoms
- Pain and discomfort management
- Response to the patient's and family's psychological, social, emotional, religious, and cultural concerns
- Involvement in care decisions

The patient assessment may identify symptoms that require management, such as nausea, respiratory distress, and pain; factors that alleviate or exacerbate physical symptoms; and the patient's response to symptom management. Identifying the patient's physical needs is just one aspect of determining the patient's end-of-life care. Patients and families may also have a need for spiritual, psychosocial, and support services, as appropriate to the patient's individual needs and cultural preferences.

End-of-life care provided by the hospital includes but is not limited to the following:

- Taking interventions to manage pain and discomfort
- Providing appropriate treatment for any symptoms according to the wishes of the patient and family
- Sensitively addressing such issues as autopsy and organ donation
- Respecting the patient's values, religion, and cultural preferences
- Involving the patient and family in all aspects of care
- Responding to the psychological, emotional, spiritual, and cultural concerns of the patient and family

To accomplish these goals, all staff should be educated and trained to assess and manage the needs of patients and their families at the end of life. The hospital's goal for providing care at the end of life considers the settings in which care or service is provided (such as a hospice or palliative care unit), the type of services provided, and the patient population served. The hospital develops processes to manage end-of-life care, including the use of recognized assessment tools such as the Palliative Performance Scale, or others when appropriate. These processes include the following:

- Assessing and managing symptoms
- Defining the frequency of assessments
- Treating terminally ill patients with dignity and respect
- Planning preventive and therapeutic approaches to manage symptoms
- Educating patients, family, and staff about managing symptoms
- Providing support to the patient's family and/or caregivers
- Providing support to staff members caring for the dying patient

Measurable Elements of COP.08.00

1. The hospital has a process to assess and manage the needs of patients receiving end-of-life care.
2. Staff are educated and trained about assessing and managing needs of patients and their families at the end of life.
3. The hospital provides patient care and support services that accommodate the patient and their family with consideration of their personal, spiritual/religious, and cultural preferences.
4. End-of-life care addresses the symptoms, conditions, and health care needs of the dying patient as indicated by their assessment, including pain and comfort needs.
5. The patient and family are involved in end-of-life care decisions.
6. The hospital provides support to the patient's family, caregivers, and staff members caring for the dying patient.

Hospitals Providing Transplant Services

Note: The following standards are intended to be used in situations when patients request information about organ and tissue donation and/or when organ or tissue donation may occur. When organ or tissue donation and transplantation are performed, the standards for organ and tissue transplant programs apply. It is recognized that there are significant differences between organ and tissue transplants. The requirements apply to both, respectively, depending on the services the hospital offers. For example, if a hospital performs only tissue transplant services, the requirements then apply to the tissue transplant services offered by the hospital. The following are considered *tissue* and *cell products* for the standards below.

Examples of Tissue and Cell Products

- Amnion/amniotic membrane
- Arteries
- Autologous cells
- Autologous tissue
- Bone

- Bone marrow
- Bone paste
- Bone powder
- Bone putty
- Cancellous chips
- Cardiac (heart) valves (aortic, pulmonary)
- Cartilage
- Chondrocytes
- Cornea
- Demineralized bone matrix
- Dendritic cells
- Dermal matrix
- Dermis
- Dura mater
- Embryo
- Fascia/fascia lata
- Hematopoietic stem cells
- Leukocytes
- Ligaments
- Limbal graft
- Limbal stem cells
- Lymphocytes
- Marrow
- Membrane
- Meniscus
- Nerves
- Non-valved conduits
- Oocyte/ovarian cells
- Ovarian tissue
- Pancreatic islet cells
- Parathyroid
- Pericardium
- Peripheral blood stem cells
- Progenitor cells
- Sclera
- Semen, sperm
- Skin
- Somatic cells
- Tendons
- Testicular tissue
- Therapeutic cells (T-cell apheresis)/T-cells
- Tissue (also synthetic tissue)
- Trachea
- Umbilical cord blood stem cells
- Vascular graft
- Veins (saphenous, femoral, iliac)
- Other cellular- and tissue-based transplant or implant products whether classified by the US Food and Drug Administration (FDA) as a tissue or a medical device
- Other tissues that are classified as tissues by national or regional laws and regulations

Transplantation of organs is often a lifesaving procedure, and organ and tissue transplants are sometimes the only options for treatment of a wide range of diseases. Recent advances in transplantation have led to a greater success rate for transplanted organs and tissues. However, transplantation is not free from risk. Transmission of infections from the donor to the recipient is a well-documented safety concern. Diseases with documented transmission from infected donors after transplant include HIV, hepatitis B and C, and Creutzfeldt-Jakob disease (CJD). Recipients may also contract bacterial or fungal infections through contamination during transportation, storage, or handling.

Leaders' commitment to creating a culture conducive to organ and tissue donation can have significant impact on the overall success of the hospital's organ and tissue procurement efforts. These standards address the hospital's responsibilities for organ and tissue donation and procurement. This includes anyone determined medically suitable for donation by the organ procurement organization. If the hospital has the necessary resources to support the recovery of organs and tissues after cardiac death, non–heart-beating donors are included in the organ procurement effort.

Standard COP.09.00

The hospital informs patients and families about how to donate organs and other tissues.

Intent of COP.09.00

Patients and families receive information about the donation process and the way organ procurement is organized for the community, region, or nation (such as a national or regional organ procurement agency or network) to ensure organ donor and recipient safety. Many countries have developed procedures and systems to increase the supply of organs available for transplant. In some countries, laws determine that everyone is a donor unless specified otherwise. This is considered presumed consent. Other countries require explicit consent for organ donation.

The hospital is responsible for defining the process of obtaining and recording consent for cell, tissue, and organ donation in accordance with international ethical standards and the way organ procurement is organized in the hospital's country. The hospital has a responsibility to ensure that adequate controls are in place to prevent patients from feeling pressured to donate.

The hospital supports the choice of patients and families to donate organs and other tissues for research or transplantation. Information is provided to patients and families on the donation process and the way organ procurement is organized for the community, region, or nation.

Measurable Elements of COP.09.00

1. The hospital supports patient and family choices to donate organs and other tissues.
2. The hospital provides information to patients and families on the donation process.
3. The hospital provides information to the patient and family on the manner in which organ procurement is organized.
4. The hospital ensures that adequate controls are in place to prevent patients from feeling pressured to donate.

Standard COP.09.01

The hospital provides oversight for the process of organ and tissue procurement.

Intent of COP.09.01

Oversight for the process of organ and tissue procurement is needed to ensure that it is consistent with laws and regulations, respects the community's religious and cultural values, and is ethical. One of the primary

goals for oversight of the process for organ and tissue procurement is establishing requirements for consent. Hospital staff are trained on the donation process and support patient and family choices about the donation of organs and tissues. Staff are also trained in contemporary concerns and issues related to organ donation and availability of transplants. The hospital cooperates with other hospitals and agencies in the community responsible for all or a portion of the procurement, banking, transportation, or transplantation process.

Measurable Elements of COP.09.01

1. Ⓓ The hospital develops a written organ and tissue donation and procurement process that is consistent with the region's laws and regulations and its religious and cultural values.
2. The hospital identifies consent requirements for organ and tissue donation and procurement and develops a consent process consistent with those requirements.
3. Staff are trained on the issues and concerns related to organ donation and tissue procurement and the availability of transplants.
4. The hospital cooperates with relevant hospitals and agencies in the community to respect and to implement choices to donate.

Standard COP.09.02

The hospital's leaders provide resources to support the organ, tissue, and/or cell transplant program.

Intent of COP.09.02

The transplant program requires staff with specialized education, training, and resources to provide safe, high-quality care. Staff education and training must be specific to the responsibilities and requirements of transplants provided by the hospital. Other essential resources include supplies; patient rooms with ventilation required for the type of transplant procedure (for example, positive pressure ventilation); required pharmaceuticals for the type of transplant procedure; laboratory testing to ensure that tissues, organs, and cells are not contaminated; and other resources as identified by the program service leader. Resources related to information management systems are necessary to help collect data associated with risks, outcomes, and other information that support the transplant program's quality.

Measurable Elements of COP.09.02

1. Staff education and training are specific to the types of organs, tissues, and/or cell transplants provided by the hospital.
2. The hospital's leaders allocate resources for the transplant program.
3. Information management systems are used to support the quality of the transplant program.

Standard COP.09.03

The hospital identifies a qualified transplant program leader(s) and includes an interdisciplinary team that consists of clinical staff with expertise in the relevant transplant programs.

Intent of COP.09.03

Oversight by a qualified individual(s) and the inclusion of an interdisciplinary care team ensures the quality and safety of transplant services and improves the success of the transplant and associated patient outcomes.

A qualified individual(s) must be responsible for supporting and overseeing all transplant program activities. This individual(s) has support and oversight defined in a job description and is qualified to manage transplant services through education, training, experience, licensure, and/or certification. The required qualifications depend on the activities carried out.

Transplant recipients and living donors have specific nursing, psychological, pharmacological, and nutritional needs. As related to the type of transplant, an interdisciplinary team consists of individuals from the following:

- Medicine
- Nursing
- Nutrition
- Pharmacology
- Infection prevention and control
- Social services
- Fertility services
- Psychological services
- Rehabilitative services

This team should have the qualifications, training, and experience to provide care and services to transplant recipients and living donors. Hospitals with transplant programs consider the types of organs and/or tissues harvested and/or transplanted when creating their interdisciplinary transplant teams. These teams are formed with consideration for the specific risks, challenges, needs, laws and regulations, and professional guidelines for each type of transplant.

Measurable Elements of COP.09.03

1. Ⓓ The transplant program has an infrastructure, including systems and written policies and procedures, capable of supporting all aspects of the program.
2. A qualified individual(s) oversees and manages the transplant program.
3. The individual(s) fulfills the program's oversight responsibilities as defined by the transplant program.
4. Ⓓ The transplant program documents the composition of each transplant team(s).
5. Ⓓ The transplant program documents the team members' responsibilities.
6. Based on the services provided by the transplant team, the team includes individuals experienced in medicine, nursing, nutrition, pharmacology, infection prevention and control, social services, psychological services, rehabilitative services, and transplant coordination.
7. The transplant program evaluates team members for qualifications, training, and experience at the time each individual is being considered for the transplant team.

Standard COP.09.04

There is a designated coordination mechanism for all transplant activities.

Intent of COP.09.04

An important component in ensuring safe, high-quality care through all phases of the donor/recipient process is ensuring the coordination and continuity of the live donor's and transplant recipient's care. Transplant services carry unique and critical risks to organ, tissue, and cell recipients and, in the case of living donors, to the donor. The complex care required by the donor and recipient necessitate a coordination mechanism, typically a qualified clinical staff member. This individual ensures continuity of care for the donor and/or the recipient throughout the transplant process. This individual is also responsible for communication with the care team about the donor's and/or recipient's care. This may occur through facilitated meetings and documentation.

The individual responsible for the coordination of all transplant activities may be a physician, registered nurse, or other qualified clinical staff member—this individual may be known as a "transplant coordinator."

Measurable Elements of COP.09.04

1. The individual responsible for the coordination of the live donor's and transplant recipient's care is identified and available through all phases of transplant care.
2. The hospital ensures that continuity of care for transplant patients (candidates and recipients) is facilitated through the pre-transplant, transplant, and discharge phases of transplantation.
3. Continuity of care is facilitated for living donors during the evaluation, donation, and discharge phases of donation.
4. The coordination of all transplant activities is communicated to all staff involved in the transplant program activities.

Standard COP.09.05

The hospital complies with organ, tissue, and cell transplant responsibilities.

Intent of COP.09.05

Organs, tissues, and cells are a limited resource. The hospital ensures that organs, tissues, and cells are managed in a way that protects these resources and ensures their integrity. Organ, tissue, and cell donation, procurement, and transplantation are highly regulated. The hospital complies with all rules and regulations set by the local, regional, or national procurement and transplantation network(s). These networks often require various data regarding transplant services to monitor the quality of these services and to allocate organs, tissues, and cells only to hospitals with successful, compliant programs.

The hospital implements procedures for the handling of all organs, tissues, and cells to ensure their safe handling and to ensure that patients receive the correct organ, tissue, or cells in a condition that increases the likelihood of a successful transplantation. Organs, tissues, and cells have specific requirements for their transportation and storage until transplantation. The hospital fully implements these conditions to maintain the viability of the organ, tissue, and cells. In addition, the hospital has a process to track transplanted organs, tissues, and cells for data collection purposes, including outcomes of the transplant and ability to recall any transplants.

Measurable Elements of COP.09.05

1. The hospital performing solid organ, tissue, and/or cell transplants complies with all rules set by the local, regional, or national procurement and transplantation network.
2. The hospital performing solid organ transplants shares all data related to transplant processes required by the local, regional, or national procurement and transplantation network.
3. Ⓓ The hospital develops and maintains standardized written procedures for the acquisition, receipt, storage, and issuance of organs, tissues, and/or cells.
4. Ⓓ The hospital verifies at the time of receipt of the organ that package integrity is met, and transport temperature range was controlled and acceptable for the organ(s), tissues, and/or cells. This verification is documented.
5. Ⓓ The hospital follows the tissue suppliers' or manufacturers' written directions for transporting, handling, storing, and using tissue.
6. The hospital follows a process to track transplanted tissues.
7. Ⓓ Refrigerators, freezers, nitrogen tanks, and other storage equipment used to store organs, tissues, and cells at a controlled temperature have functional alarms and an emergency backup plan.

Standard COP.09.06

The transplant program obtains informed consent specific to organ, tissue, and/or cell transplant from the transplant recipient candidate.

Intent of COP.09.06

Organ, tissue, and cell transplants carry unique risks; to make an informed decision about whether to proceed with a transplant, the potential recipient must be informed of these risks and challenges. To consent, a patient must be informed of those factors related to the planned care required for an informed decision. Patients are informed about factors that could affect the success of the graft or the candidate's health as a recipient.

In addition, there may be psychological, ethical, financial, and other factors that are unique to the transplant patient, such as the need for immunosuppressive medications and the projected survival rate. The patient needs to be informed of all special considerations as part of the consent process. The transplant program also follows the hospital's policy for informed consent and local and regional laws and regulations.

Measurable Elements of COP.09.06

1. Ⓓ The transplant program follows the hospital's written policy when obtaining informed consent from solid organ, tissue, and/or cell transplant candidates. (*See also* PCC.03.00, MEs 1 and 2)
2. The transplant program informs the prospective transplant candidate of organ donor risk factors that could affect the success of the graft or the candidate's health as a recipient, including but not limited to the following:
   - Donor's history, as appropriate to the laws and regulations of the country/region
   - Condition of the organ(s) used
   - Age of the organ(s)
   - Potential risk of contracting infectious disease(s) if disease(s) cannot be detected in an infected donor
   - Potential psychosocial risks
3. The transplant program informs the prospective transplant candidate of the transplant center's observed and expected one-year survival rate following solid-organ transplant; or, when the transplant program has been in operation less than 18 months, the one-year survival rate as documented in the literature.
4. The transplant program informs the prospective solid organ, tissue, and/or cell transplant candidate about potential rejection rates, immunosuppressive drugs, and possible associated costs, as applicable to the type of transplant.
5. The transplant program informs the prospective organ, tissue, and/or cell transplant candidate of alternative treatments.

Standard COP.09.07

The transplant program has documented protocols, clinical practice guidelines, or procedures for organ recovery and organ receipt to ensure the compatibility, safety, efficacy, and quality of human cells, tissues, and organs for transplantation.

Intent of COP.09.07

To reduce the risk of organ, tissue, or cell rejection, the transplant surgeon must ensure the compatibility of the donor organ(s), tissue, and/or cells to the recipient. Transmission of infectious diseases and malignancies is a potential risk for recipients of donor cells, tissues, and organs.

Therefore, the level of safety, efficacy, and quality of human cells, tissues, and organs for transplantation must be ensured. Evaluation of organ and tissue donors may identify those donors who have a higher risk for infection with a potentially harmful pathogen. Donor screening of clinical history and donor testing for communicable diseases can significantly reduce the incidence of donor transmission of disease. Donor screening should include evaluation of medical history, behavioral risk factors, and a physical examination. Donor testing should include tests for HIV, hepatitis B, hepatitis C, and other recommended tests.

The most frequently used tests for compatibility include blood typing and crossmatching and tissue typing. The transplant surgeon ensures that testing for compatibility occurs before organ recovery and organ transplantation take place. For any transplantation of human material, traceability should be ensured for the anticipated lifetime of the donor and the recipient. Internationally agreed-on means of coding to identify tissues and cells used in transplantation are essential for full traceability.

Measurable Elements of COP.09.07

1. Ⓓ The transplant team follows written organ recovery protocols, clinical practice guidelines, or procedures, which include reviewing the essential donor data and recipient data to ensure compatibility before organ, tissue, or cell recovery takes place.
2. The transplant surgeon is responsible for confirming, in writing, the medical suitability of donor organs, tissues, and cells for transplantation into the recipient.
3. When an organ or tissue arrives at the transplant center, the transplanting surgeon and at least one other health care practitioner at the transplant center verify and document that the donor's blood type and other essential data are compatible with the recipient prior to transplantation.
4. The transplant surgeon is responsible for confirming that donor evaluation and donor testing for infectious diseases and malignancy have been completed, and are documented in the medical record, before organ, tissue, or cell recovery and transplantation occur.
5. When an organ arrives at the transplant center, the transplanting surgeon and at least one other health care practitioner at the transplant center verify and document that evaluation and testing of the donor organ shows no evidence of disease and the condition of the organ is suitable for transplant.

Standard COP.09.08

Clinical practice guidelines and clinical criteria guide the selection and care of organ, tissue, and cell transplant patients.

Intent of COP.09.08

Individualized care plans are developed and guide the care of transplant patients in conjunction with clinical practice guidelines, as the care of the patient donating or receiving a cell, organ, or tissue transplant is based on the type of transplant and individual needs. The patient's health history has an impact on their recovery. In addition, the patient's psychological status may impact the transplant's success. A psychological evaluation will be conducted by a psychiatrist, psychologist, social worker, or other qualified health care professional with experience in transplantation to determine the decision-making capacity of the patient and screen for any preexisting psychiatric illness.

Measurable Elements of COP.09.08

1. Ⓓ The transplant program has documented cell-, tissue-, and/or organ-specific clinical practice guidelines for the pre-transplant, transplant, and discharge phases of transplantation.
2. Each transplant patient is under the care of a multidisciplinary patient care team coordinated by the patient's primary transplant physician throughout the pre-transplant, transplant, and discharge phases of transplantation.
3. Transplant recipient candidates are evaluated for the suitability of other medical and surgical therapies that may yield short- and long-term survival rates comparable to transplantation.
4. Transplant recipient candidates receive a psychological evaluation by a psychiatrist, psychologist, social worker, or other qualified health care professional with experience in transplantation to determine the decision-making capacity of the patient and screen for any preexisting psychiatric illness.
5. The transplant program updates clinical information in the transplant donor's and/or recipient's medical record on an ongoing basis.
6. The transplant program documents organ compatibility confirmation in the living donor's medical record.

Transplant Programs Using Living Donor Organs

Standard COP.10.00

Transplant programs that perform living donor transplantation adhere to local and regional laws and regulations and protect the rights of prospective or actual living donors.

Intent of COP.10.00

Living donors face difficult decisions and are at potential risk for lifelong complications and should not feel coerced or pressured into organ donation. The growing demand for and limited supply of organs from deceased donors have resulted in increased efforts to promote live organ donation. Living donor standards for the selection of suitable candidates for donation, informed consent, and care following the donation do not universally exist.

To help with decisions and to ensure that the living donor's rights are protected, an individual with knowledge of living organ donation, transplantation, medical ethics, and informed consent is identified and appointed to protect the patient's rights. This person is independent of the transplant team and if employed by the hospital does not report to any member of the transplant team. The goal of this person is to ensure that the living donor understands all aspects of the donation process and is autonomous in their decision-making abilities.

Measurable Elements of COP.10.00

1. Transplant programs that perform living donor transplantation adhere to local and regional laws and regulations.
2. The living organ donor has the right to make a decision about donation in a setting free of coercion and pressure.
3. An individual with knowledge of living organ donation, transplantation, medical ethics, and informed consent is identified and appointed as an advocate for the living donor.
4. The individual appointed as the living donor advocate is not involved in routine transplantation activities.
5. The individual appointed as the living donor advocate informs, supports, and respects the living donor in a culturally appropriate manner during decision-making.

Standard COP.10.01

Transplant programs performing living donor transplants obtain informed consent specific to organ donation from the prospective living donor.

Intent of COP.10.01

The prospective donor needs to thoroughly understand all aspects of the donation process, particularly to understand the risks and benefits associated with being a living donor. Many living donors give their organ to a family member or acquaintance; however, some living donors do not influence the placement of their donated organ. A very important aspect of obtaining informed consent is to ensure that the prospective donor is willing to donate and has not been coerced or promised compensation and understands that they may decline to donate at any time. The consent process includes information provided to any patient undergoing anesthesia, sedation, or surgery, and information specific to transplant.

Measurable Elements of COP.10.01

1. Ⓓ Informed consent for living donation is obtained by trained staff and is in a language the prospective living donor can understand. (*See also* PCC.03.00, MEs 1 and 2)
2. The transplant program informs the prospective living donor of potential complications, risks (including psychological risks), and future health problems associated with living organ donation.
3. The transplant program informs the prospective living donor of alternative treatments for the transplant candidate.
4. The transplant program informs the prospective living donor of the donor's right to opt out of donation at any time during the donation process.

Standard COP.10.02

Transplant programs that perform living donor transplants use clinical and psychological selection criteria to determine the suitability of potential living donors.

Intent of COP.10.02

Organ donors must be evaluated for suitability, both physical and psychological, as an organ donor. The medical evaluation determines the donor's physical ability to donate and identifies any immediate health risks and possible future health risks. The psychological evaluation will be conducted by a psychiatrist, psychologist, or social worker with experience in transplantation to determine decision-making capacity, screen for any preexisting psychiatric illness, and evaluate any potential coercion. The donor must also be evaluated for their ability to comprehend the donation process and the potential outcomes, including possible adverse outcomes.

Measurable Elements of COP.10.02

1. Ⓓ The transplant program documents defined organ-specific living donor selection criteria.
2. The transplant program's living donor selection criteria are consistent with laws and regulations and the principles of medical ethics. (*See also* GLD.07.00, ME 1)
3. The results of a medical evaluation related to the living donor's own physical health are included in the determination of suitability for donation.
4. The results of medical tests identifying infectious diseases or malignancies are included in the determination of suitability for donation.
5. The results of a psychological evaluation conducted by a psychiatrist, psychologist, or social worker with experience in transplantation are documented in the living donor's medical record and included in the determination of suitability for donation.
6. The transplant program documents organ compatibility confirmation in the living donor's medical record.

Standard COP.10.03

Individualized patient care plans guide the care of living donors.

Intent of COP.10.03

The living donor has unique treatment and health care needs that require specific consideration. Individualized care plans are developed and implemented for all living donors. Live donor transplants are guided by living donor guidelines. However, donors have individual needs that must be addressed through careful care planning. The care of the donor is coordinated by a physician and carried out by a multidisciplinary team to ensure that the donor's needs are met prior to, during, and following donation.

Measurable Elements of COP.10.03

1. Ⓓ Transplant programs performing living donor transplants are guided by documented living donor guidelines for care in the evaluation, donation, and discharge phases of donation.
2. Transplant programs performing living donor transplants provide interdisciplinary care by a team coordinated by a physician to each donor throughout the donor evaluation, donation, and discharge phases of donation.
3. The living donor candidate receives ongoing psychological support following donation.

International Patient Safety Goals (IPSG)

Overview

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

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

The goals are structured in the same manner as the other standards, including a standard (goal statement), an intent statement, and measurable elements (MEs). The goals are scored similar to other standards as "met" or "not met." The accreditation decision rules include compliance with the goals as a separate decision rule.

Goals and Standards

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

Goal 1: Identify Patients Correctly

IPSG.01.00 The hospital implements a process to improve accuracy of patient identifications.

Goal 2: Improve Effective Communication

IPSG.02.00 The hospital implements a process for reporting critical results of diagnostic tests.

IPSG.02.01 The hospital implements a standardized process for handover communication.

Goal 3: Improve the Safety of Medications

IPSG.03.00 The hospital implements a process to improve the safety of high-alert medications.

IPSG.03.01 The hospital implements a process to improve the safety of look-alike/sound-alike medications.

IPSG.03.02 The hospital implements a process to manage the safe use of concentrated electrolytes.

Goal 4: Ensure Safe Surgery

IPSG.04.00 The hospital implements a process for the preoperative verification and surgical/invasive procedure site marking.

IPSG.04.01 The hospital implements a process for the time-out that is performed immediately prior to the start of the surgical/invasive procedure and the sign-out that is conducted after the procedure.

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

IPSG.05.00 The hospital implements evidence-based hand-hygiene guidelines to reduce the risk of health care–associated infections.

Goals, Standards, Intents, and Measurable Elements

Goal 1: Identify Patients Correctly

Standard IPSG.01.00

The hospital implements a process to improve accuracy of patient identifications.

Intent of IPSG.01.00

Incorrect patient identification can result in wrong-person and wrong-procedure errors, treatment errors, medication errors, diagnostic errors, and more that may result in patient harm. Correctly identifying a patient and matching them with intended treatment and services must be performed in all care settings. The identification process used throughout the hospital requires two patient identifiers, such as the patient's name, identification number, birth date, a bar-coded wristband, or other ways. The patient's room number or location in the hospital, or other numbers such as incubator numbers for neonates, cannot be used for identification. The two different patient identifiers used may be different in different circumstances; however, the two identifiers used must be consistent within an area. It is a best practice that the patient be involved in the identification process to whatever extent possible. There are special circumstances in which the hospital may need to develop a specific process for patient identification. The process considers the unique needs of the patients, and staff use the process for patient identification in these special circumstances to prevent error. Two different patient identifiers are required in any circumstance involving patient interventions. Patients are identified before providing treatments, before performing procedures, and before any diagnostic procedures are performed. The hospital should include the following in its patient identification practices:

- Involve the patient in the identification process whenever possible.
- Include special circumstances in the identification process. Examples include the following:
  - Comatose or confused/disoriented patients with no identification
  - Newborn patients when the parents have not immediately chosen a name, such as using the mother's given name in addition to "baby boy" or "baby girl" and the parents' surname (for example, "Baby Girl Mariam Khan" instead of "Baby Girl Khan," or "Baby Boy Maria Silva" instead of "Baby Boy Silva" in the event more than one baby of the same gender has the same last name, and adding a third name such as the father's given name or the mother's middle name if there is the likelihood of two or more patients on the ward with the same given and surname, or multiple births
- Organizations that allow different identifiers to be used in different care areas or scenarios must ensure that the process is consistent in these circumstances, as in the following examples:
  - A patient's name and date of birth are used in verbal interactions with the patient on the ward; these same two identifiers must be used in all verbal interactions with the patient.
  - A patient's name and identification number or medical record number are used during the time-out for surgical/invasive procedures, to label specimens, or to report diagnostic tests, and the like; these same two identifiers must be used in all similar circumstances.
- Patients are identified before providing treatments, before performing procedures, before any diagnostic procedures, and before any other treatments, cares, or interventions intended for a specific patient; this includes labeling any treatments and medications intended for a specific patient. Examples include the following:
  - Blood samples and pathology samples

- o Dietary trays
- o Expressed mother's milk

Measurable Elements of IPSG.01.00

1. Ⓓ The hospital uses at least two patient identifiers, that do not include the use of the patient's room number or location in the hospital, to identify the patient and to label elements associated with the patient's care and treatment plan. (*See also* MMU.04.01, ME 4; MMU.05.03, ME 4; MOI.03.00, ME 1)
2. The hospital identifies patients with at least two identifiers before performing diagnostic procedures, providing treatments, and performing other procedures. (*See also* MMU.04.01, ME 4)
3. Ⓓ The hospital ensures the correct identification of patients in special circumstances, such as the comatose patient or newborn who is not immediately named.

Goal 2: Improve Effective Communication

Standard IPSG.02.00

The hospital implements a process for reporting critical results of diagnostic tests.

Intent of IPSG.02.00

Patient harm can result when critical results of diagnostic tests are not reported and acted on promptly. A *critical result* is defined as a variance from normal range that represents a pathophysiologic state that is high risk or life-threatening, is considered urgent or emergent, and in which immediate medical action is likely necessary to preserve life or prevent a catastrophic event. This is different from an *abnormal result*, defined as one outside the expected test range but not an urgent or emergent life threat. It is also important to distinguish between *critical* ***tests*** (the diagnostic tests themselves, some of which hospitals may define as being critical by nature) and *critical* ***test results*** (meaning the outcome of any diagnostic test that indicates a very serious or life-threatening condition). This standard and its measurable elements are concerned with *critical* ***test results*** (*outcomes*) from any diagnostic test, and these critical result parameters and the response to them must be established by the hospital. For example, the hospital may define a critical result for potassium levels as being below 2.5 mmol/L or above 6.0 mmol/L, indicating potentially life-threatening hypokalemia or hyperkalemia.

Hospital health care practitioners may consider a result to be very serious in some clinical situations in which the result is not in the defined critical range, such as a mildly low potassium level in the setting of digitalis toxicity. However, those clinical decisions are separate from the purposes of compliance with this standard, which requires the hospital to formally define the parameters of absolute critical ranges for tests, as in the example of critical potassium levels above, and establish a procedure for reporting and response.

Diagnostic tests include all tests, such as laboratory, imaging, and cardiac diagnostics. Critical results may also be produced from any diagnostic tests performed at the bedside, such as point-of-care blood testing, portable imaging, and 12-lead electrocardiograms. Diagnostic tests that produce defined test results that may indicate a threat to life are different from continuous electronic monitoring, such as cardiac telemetry, continuous EEG (electroencephalogram) monitoring, or fetal monitoring. Continuous electronic monitoring is a clinical assessment tool used to detect changes in the patient's condition over time that may identify a threat to life but is not designed to produce a defined critical result.

A formal reporting system is used throughout the hospital that clearly identifies how critical results of diagnostic tests are communicated to health care practitioners and how the information is documented and acted on. This should include closed-loop communication by a read-back between the reporter and the receiver. The objective is to provide the critical results within an established time frame so that the responsible licensed health care provider can evaluate its significance and act on the results within a defined time frame.

The organization must identify tests that may have critical results and educate clinical staff on what these tests are and how to recognize a critical result.

The organization implements a protocol that describes how critical results are recognized, documented, and communicated to the provider responsible for the patient's care, and the time frames for reporting and responding to critical results, including documenting of actions taken when applicable. This should include how to proceed when the individual performing the test is also the individual responsible for interpreting and responding to the test; for example, when a cardiologist performs and interprets the 12-lead electrocardiogram on the patient they are treating, or when the practitioner who performs the test is the same practitioner who is treating the patient. In these cases, the reporting of a critical result would not be necessary.

In addition to clearly identifying how results are communicated and the required time frame for doing so, the organization must implement a protocol that describes how the treating practitioner is expected to respond and in what time frame. The hospital must then monitor compliance with the above protocols and time frames for critical results and act when negative trends are observed, or adverse events occur. For example, keeping a log in the lab to document times that critical results are reported and that includes patient identifiers and names of staff who received the report is one way to simplify monitoring for compliance.

Measurable Elements of IPSG.02.00

1. Ⓓ The hospital defines, in writing, critical test results that may represent urgent or emergent life-threatening values for diagnostic tests. (*See also* AOP.03.02, ME 3)
2. Ⓓ The hospital develops a formal reporting process that identifies how critical results of diagnostic tests are reported/communicated to health care practitioners and the expected time frame for reporting the critical results.
3. The hospital identifies what critical result information is documented in the medical record.
4. Ⓓ The hospital monitors compliance with the defined time frames for reporting and acting on critical results, and documents actions taken when time frames are not met.

Standard IPSG.02.01

The hospital implements a standardized process for handover communication.

Intent of IPSG.02.01

Breakdowns in communication can occur during any handover of patient care and can result in patient safety events. *Handover* communications can also be referred to as *handoff* communications. Handovers of patient care within a hospital occur in the following ways:

- Between health care practitioners (for example, physician to physician, physician to nurse, nurse to nurse)
- Between different levels of care in the same hospital (for example, when the patient is moved from an intensive care unit to a medical unit or from an emergency department to the operating theatre)
- From inpatient units to diagnostic or other treatment departments, such as radiology or physical therapy
- Between staff and patients/families, such as at discharge

Interruptions and other distractions from unit activities can inhibit clear communication of important patient information. Standardized, critical content and processes for communication between the patient, family, caregiver, and health care team can significantly improve the outcomes related to handovers of patient care.

Standardized forms, tools, or methods support a consistent and complete handover process. The content of the handover communication and the form, tool, or method used are standardized for the type of handover. The handover process may be different for different types of handovers within the hospital. For example, handovers of patient care for the emergency department to a medical ward may require a different process or different

content than handovers from the operating theatre to the intensive care unit; however, the handovers are standardized for the type of handover occurring.

Safe practices for effective communication include the following:

- Use of standardized, critical content and processes for communication between the patient, family, health care practitioner, and others involved in the patient's care during handovers of patient care
- Use of standardized methods, forms, or tools to facilitate consistent and complete handovers of patient care
- The handover process must allow for the participants to have an opportunity to clarify information during the handover process, by providing the opportunity to ask questions, or for discussion between the giver and the receiver of information. However, it is acceptable for the discussion to take place outside of in-person interactions, such as by phone, text, or other communication format.

Handover forms or tools, if used by the hospital, are not required to be part of the medical record. In addition, the detailed information communicated during the handover is not required to be documented in the medical record; however, the hospital may want to have documentation that the handover occurred. For example, the health care practitioner would record that they completed the handover and to whom they transferred responsibility for care, and then sign, date, and time the entry.

Measurable Elements of IPSG.02.01

1. The hospital implements a standardized procedure to communicate critical information between health care practitioners during handovers of patient care.
2. The hospital uses standardized forms, tools, or methods that support a consistent and complete handover process that includes the opportunity for all staff involved to clarify information and ask questions.
3. Ⓓ The hospital collects, analyzes, tracks, and trends data for patient safety events related to handovers.

Goal 3: Improve the Safety of Medications

Standard IPSG.03.00

The hospital implements a process to improve the safety of high-alert medications.

Intent of IPSG.03.00

High-alert medication errors can lead to patient injury or death and potentially additional costs associated with caring for these patients. The Institute for Safe Medication Practices (ISMP) defines *high-alert medications* as "drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients." The most frequently cited examples of high-alert medications include the following:

- Insulin
- Opioids
- Chemotherapeutic agents
- Antithrombotic agents
- Anticoagulants
- Thrombolytics
- Medications with a narrow therapeutic range (for example, digitalis)
- Neuromuscular blocking agents
- Epidural or intrathecal medications

Examples of lists of high-alert medications are available from organizations such as ISMP and the World Health Organization (WHO). For safe management, the hospital needs to develop its own list(s) of high-alert medications based on the following:

- Its unique utilization patterns of medications
- Its own internal data about near misses (or close calls)
- Medication errors and sentinel events
- Safety issues published in professional literature

The list includes medications identified as high risk for adverse outcomes. Information from the literature and/or Ministry of Health may also help identify which medications should be included. This list is updated at least annually. The list may need to be updated more frequently if there are additions or changes to hospital services, patient populations, or new medications added to the hospital formulary that are deemed high risk.

Some high-alert medications/categories (such as neuromuscular blockade medication) have their own specific set of risks in addition to those that exist based on the high-alert category alone. Strategies to prevent harm should be based on the specific risk profile of that medication/category, in that case. Some high-alert medications may not require additional strategies in addition to the standardized strategies adopted by the hospital. The hospital must determine when a tailored strategy and standardized measures are needed. For example, neuromuscular blockade medications can be inadvertently retrieved from refrigerated storage when stored along with other refrigerated medications. An example of a strategy to mitigate this risk is to store neuromuscular blockade agents segregated from other medications, such as in lidded containers, with prominent warning labels on the container and the medications inside. Other examples are chemotherapy agents, due to the complexity of medication orders and protocols and due to the properties of some of these medications, such as those that can cause tissue necrosis when extravasation occurs. Examples of strategies for those medications include chemotherapy ordering protocols, use of central lines for administration, patient monitoring protocols during administration, and readily available extravasation kits.

A specific example of a high-alert medication best practice identified by ISMP relates to the dispensing of vincristine (and other vinca alkaloids) in a minibag of a compatible solution and not in a syringe. Significant adverse events resulting in severe neurological damage and often death have occurred from the inadvertent administration of vinca alkaloids via the intrathecal route. In organizations in which vinca alkaloids are dispensed in a minibag, there have been no reported cases of accidental administration of a vinca alkaloid by the intrathecal route. This best practice is supported by the following organizations:

- ISMP
- The Joint Commission and Joint Commission International
- World Health Organization (WHO)
- American Society of Clinical Oncology (ASCO)
- Oncology Nursing Society (ONS)
- National Comprehensive Cancer Network

However, the overall process for managing high-alert medications must still be standardized throughout the hospital, such as standard high-alert medication labeling and requiring a double-check process. The examples of additional tailored risk mitigation strategies should be *in addition* to the hospital's standardized process. Additional guidance for this is explained below. The hospital must educate clinical and technical staff handling high-risk medication on the standardized process, the risks related to each medication, and the risk mitigation strategies for each medication.

The hospital must develop a list of high-alert medications stocked and used in the hospital. The list of high-alert medications must meet the following criteria:

- Up to date
- Reviewed at least annually and when new medications are added to the formulary
- Known by clinical staff

- Accompanied by robust, well-developed risk reduction strategies that decrease the risk of errors and minimize harm

Strategies should be applicable to all hospital departments and services and sustainable over time. According to ISMP, examples of these include the following:

- Standardizing processes associated with ordering, storage, preparation, and administration of these medications
- Improving access to information about these drugs
- Limiting access to high-alert medications
- Using additional labels and automated alerts
- Building redundancies into the medication management process such as automated or independent double checks, fail-safe methods such as pumps with locking mechanisms, and reducing available options, such as limiting available concentrations of the same medication

The hospital's risk mitigation interventions must be evident in the overall medication management program and in the clinical areas where these medications are used. For example, IV heparin used in neonatal intensive care units may require different safety strategies than IV heparin in the emergency department, and this should be evident in those areas. However, general strategies such as special labels for high-alert medications and a double-check process must be standardized throughout the hospital to avoid confusion.

Measurable Elements of IPSG.03.00

1. Ⓓ The hospital identifies, in writing, its list of high-alert medications. (*See also* MMU.02.00, ME 1)
2. The hospital implements a risk mitigation strategy for reducing the risk of harm from high-alert medications that is uniform throughout the hospital and, in addition, includes tailored strategies for specific medications when necessary.
3. The hospital reviews and, as necessary, revises its list of high-alert medications annually at minimum.

Standard IPSG.03.01

The hospital implements a process to improve the safety of look-alike/sound-alike medications.

Intent of IPSG.03.01

Medications that have similar product packaging or that have names that sound similar can easily be confused by health care practitioners and may lead to potentially harmful medication errors. Look-alike/sound-alike (LASA) names are medicine names that look or sound the same as other medicine names when written or spoken. Look-alike medicine packaging refers to medicine containers or primary packaging that looks like that of another medicine. There are many medication names that sound or look like other medication names. For example, *dopamine* and *dobutamine* sound alike, and the printed names may also look alike in some languages such as English. Confusing names are a common cause of medication errors throughout the world. The following factors contribute to this confusion:

- Incomplete knowledge of drug names
- Newly available products
- Similar packaging or labeling
- Similar clinical use
- Illegible prescriptions or misunderstanding during issuing of verbal orders

Hospitals must institute risk management strategies to avoid confusion with LASA medications and enhance patient safety. The hospital must determine which medications require safeguards to prevent LASA–related confusion that can cause errors. Strategies may include but are not limited to the following:

- Including the medication's purpose on the prescriptions
- Configuring safeguards in computerized medication ordering systems to require a minimum number of letters, such as at least five letters, when health care practitioners are searching for a medication

- Changing the appearance of look-alike medication names (for example, using "**TALL**man lettering" on labels such as **DOBUT**amine and **DOP**amine or oxy**BUTY**nin and oxy**CONTIN**)

When use of the above suggested methods is not possible, the hospital must implement an alternative strategy to prevent LASA errors. The hospital should also stay updated on emerging strategies to prevent LASA errors when applicable and when available resources allow. Examples include the following:

- Configuration of computer selection screens and drop-down menus in prescription systems to prevent LASA names from appearing adjacent to each other
- Automated dispensing by means of electronic devices and serialization technology
- Use of a closed-loop system with barcode technology to enhance the readability of look-alike labels
- Consideration of potential LASA errors when reordering stock or making purchasing decisions

The hospital should keep its list of LASA medications updated regularly, as new medications are approved or trade names of drugs change. The risks for LASA–related errors are not limited to prescribing and dispensing. Other strategies to prevent LASA errors include avoiding storage of these medications close to each other, where a health care practitioner could inadvertently retrieve the wrong one for dispensing or administration. The hospital's process should also include a mechanism to evaluate whether a LASA risk exists when the hospital must substitute medications to address shortages (for example, when substituting another brand of medication that has packaging similar to a different medication in the existing formulary, or which has a different trade name from the original that is similar to another medication). The hospital should implement a *comprehensive approach* to LASA medication management, from the point of medication stock ordering where decisions are made regarding brands (trade names of medications, label appearances), throughout the continuum all the way to the frontline staff who handle and administer them. The hospital must educate clinical and technical staff handling LASA medications on the standardized process, the risks related to each medication, and the risk mitigation strategies for each medication.

Measurable Elements of IPSG.03.01

1. Ⓓ The hospital identifies, in writing, its list of look-alike/sound-alike medications. (*See also* MMU.02.00, ME 1; MMU.07.01, ME 2)
2. The hospital implements a process for managing look-alike/sound-alike medications that is comprehensive and uniform throughout the hospital. (*See also* MMU.07.01, ME 2)
3. The hospital reviews and revises, when necessary, its list of look-alike/sound-alike medications annually at minimum.

Standard IPSG.03.02

The hospital implements a process to manage the safe use of concentrated electrolytes.

Intent of IPSG.03.02

The incorrect or unintentional administration of concentrated electrolytes can be deadly errors, and the most effective means to reduce or to eliminate these occurrences is to implement a process for managing concentrated electrolytes. Concentrated electrolytes are *vials* of concentrated forms of electrolytes that *require dilution* or other preparation before IV administration. It is important to distinguish that the standard excludes concentrated forms of electrolytes such as 3%–5% saline for infusion, because it is already diluted and prepared for infusion rather than being stocked in vials that require dilution before administration. Concentrated electrolytes include but are not limited to the following:

- Potassium chloride
- Potassium phosphate
- Sodium chloride
- Magnesium sulfate

Concentrated electrolytes should not be available as unit stock on any patient care units (including in operating room/anesthesia regular stock) as much as is possible given the pharmacy capabilities. Wherever concentrated electrolytes are stored, it is critical that the hospital perform a risk assessment such as a failure mode and effects analysis (FMEA) or other recognized risk assessment methodology to identify and mitigate potential risks associated with it. In addition, concentrated electrolytes must always be segregated from other medications, and access to these restricted to only qualified and trained staff. For example, if the hospital determines it is necessary to stock concentrated electrolytes in emergency carts, they must still be segregated from the other medications in the cart with appropriate warning labels, staff must be trained on the risks and safety considerations, a risk assessment must have been conducted that includes mitigation of those risks, and this must be outlined in hospital policy.

Electrolytes should not be dispensed in their concentrated form to patient care units for individual patients. The exceptions to this recommendation are for vials contained in a cardiac surgery kit or a cardiac surgery locked storage area and available only to the operating team, magnesium sulfate contained in emergency carts or in areas where patients with preeclampsia may be treated (labor and delivery, emergency department, or intensive care unit), concentrated sodium in areas treating patients who may suffer from increased intracranial pressure (intensive care unit, emergency department, and operating room), and other special areas and circumstances defined by hospital policy and procedures.

The hospital can use labeling practices to decrease the risk of inadvertent administration of concentrated electrolytes, when it is possible for a single vial to be removed or transported from an open bin, box, or container. The individual vial must be labeled in addition to the storage container. Only qualified and trained individuals should have access to these vials.

Administration of electrolyte replacement therapy for hypokalemia, hyponatremia, and hypophosphatemia is safest when standardized guidelines and/or protocols with prediluted electrolytes (such as 20 mEq of potassium chloride in 100 cc of normal saline) are used, and the dispensing or handling of concentrated electrolyte vials on the patient care units is prohibited.

Measurable Elements of IPSG.03.02

1. Only qualified and trained individuals have access to concentrated electrolytes, and they are labeled with appropriate warnings and segregated from other medications throughout the storage and dispensing process. (*See also* MMU.04.00, ME 1; MMU.04.01, MEs 4 and 5; MMU.05.00, ME 1; MMU.05.03, ME 4)
2. The hospital only stores vials of concentrated electrolytes outside of the pharmacy for emergency situations or specific purposes, and these are clearly identified in hospital policy. (*See also* MMU.03.00, MEs 1 and 2)
3. Ⓓ The hospital performs initial and ongoing proactive risk assessments at least annually for all areas where concentrated electrolytes are stored.

Goal 4: Ensure Safe Surgery

Standard IPSG.04.00

The hospital implements a process for the preoperative verification and surgical/invasive procedure site marking.

Intent of IPSG.04.00

Wrong-patient, wrong-site, and wrong-procedure surgery present a risk for significant patient safety events that result in patient injury. Wrong-patient, wrong-site, and wrong-procedure surgery events can result from

ineffective or inadequate communication between members of the team performing the surgical or invasive procedure. The following are common risk factors for these surgery events:

- Lack of a standardized process for marking the procedure site
- Use of ambiguous site marks, such as "X" (which could be interpreted as "do not operate here" instead of marking the operative site)
- Use of materials or media that can easily be removed, such as tape, or ink that washes off during the skin preparation process
- Lack of patient involvement in the site marking
- Inadequate patient assessment
- Inadequate medical record review
- A culture that does not support open communication among team members
- Problems related to illegible handwriting
- Use of abbreviations

Surgical and invasive procedures include all procedures involving an incision or puncture, including but not limited to the following:

- Open surgical procedures
- Percutaneous aspiration
- Selected injections
- Biopsy
- Percutaneous cardiac and vascular diagnostic or interventional procedures
- Laparoscopies
- Endoscopies
- Central line insertions outside the operating theatre

Organizations need to identify all areas within the hospital where surgical and invasive procedures take place. Examples include the following:

- Cardiac catheterization lab
- Interventional radiology department
- Gastrointestinal lab
- Intensive care or critical care units

The approach the hospital takes to ensuring safe surgery applies to all areas of the hospital in which surgical and invasive procedures occur.

The (US) Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™ is based in part on the principle of using multiple strategies to achieve the goal of always identifying the correct patient, correct procedure, and correct site. The essential elements of the Universal Protocol are the preoperative verification process, marking the surgical site, and the time-out that is held immediately before the start of the procedure.

Preoperative Verification Process

Preoperative verification is an ongoing process of information gathering and confirmation. The purpose of the preoperative verification process is to do the following:

- Verify the correct patient, procedure, and site.
- Ensure that all relevant documents, images, and studies are available, properly labeled, and displayed.
- Verify that any required blood products, special medical equipment, and/or implants are present.

There are various elements of the preoperative verification process that can be completed before the patient arrives at the preoperative area—such as ensuring that documents, imaging, test results, and paperwork are properly labeled and match the patient's identifiers. Waiting until the time-out to complete the preoperative verification process may unnecessarily delay surgery if paperwork or imaging are not labeled or available when surgery is about to begin. It is more likely that portions of the preoperative verification may occur more than once and in more than one place. For example, the surgical informed consent may be obtained in the surgeon's office, and then verification that it has been completed may take place in the preoperative holding area.

Marking the Site

Marking the surgical/invasive site involves the patient and is done with an instantly recognizable and unambiguous mark. Ideally, an "X" is not used as the mark, as it may be interpreted as "not here" or "wrong side" and could potentially lead to errors in patient care, nor should other ambiguous marks such as a line or a dot be used. The mark must be consistent throughout the hospital. The site is marked in all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine). When an anesthesia provider performs a procedure, such as a regional block, that involves any of the above, that provider must also mark the site in addition to the surgeon marking the surgical site. The practitioner performing the invasive procedure must be the one who marks the site.

Marking of the surgical site can be performed in the preoperative holding area, the day surgery unit (DSU), and in patient units, prior to entering the operating/procedure room by a physician who will be participating during the entire procedure. In cases of surgical procedures, the surgeon who performs the surgery should mark the site. There are different titles used for the responsible surgeon, such as attending or consulting surgeon. For nonsurgical invasive procedures, it may be a general physician who will do the procedure. The hospital should identify who is authorized to perform surgical site marking in policy and procedure, or medical staff governing documents.

There are circumstances when a trainee or other authorized designee may perform the site marking—this is when the trainee performs the entire procedure, requiring minimal or no supervision from the responsible surgeon or physician. In these circumstances, the trainee marks the surgical site. When a trainee assists the surgeon or physician responsible, only the surgeon or physician may perform the site marking.

The site marking may take place any time before the surgical/invasive procedure begins, as long as the patient is actively involved in the site marking whenever possible and the mark is visible after the patient is prepped and draped. Examples of when patient participation may not be possible include the following:

- Patients who are not competent to make health care decisions
- Children
- Patients requiring emergent surgery

The hospital has an alternative procedure for identifying the correct site in cases in which site marking may cause harm, such as premature infants, or when a patient refuses site marking, and this should be outlined in policies and procedures. The site mark must be located where it will be visible after draping of the surgical site, so that it can be verified during the final time-out.