Accreditation Program: Medicare/Medicaid Long Term Care

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Accreditation Participation Requirements

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APR.01.01.01

The organization submits information to The Joint Commission as required.

Elements of Performance for APR.01.01.01

1. The organization meets all requirements for timely submissions of data and information to The Joint Commission. **A**
Note 1: The Joint Commission will impose the following consequences for failure to comply with this APR:
- If the organization does not comply with the requirement after 31 days, the organization will be placed in Provisional Accreditation.
- If the organization does not comply with the requirement after 61 days, the organization's accreditation decision will be changed from Provisional Accreditation to Conditional Accreditation.
- If the organization does not comply with the requirement after 91 days, the organization's accreditation decision will be changed from Conditional Accreditation to Denial of Accreditation. In accordance with the Accreditation Committee policy, such organizations will not be afforded any appeal.
Note 2: The proposed consequences address only compliance with the requirement itself. They do not address the content of the organization's submissions to The Joint Commission. For example, if information in an organization's electronic application for survey (E-App) leads to inaccuracies in the appropriate length of the survey and a longer survey is required, the organization will incur the additional costs of the longer survey. In addition, if there is evidence that the organization has intentionally falsified the information submitted to The Joint Commission, the requirement at APR.01.02.01, EP 1 and its consequences will apply. (See also APR.01.02.01, EP 1)

KEY: **A** indicates scoring category A; **C** indicates scoring category C; **(2)** indicates situational decision rules apply; **(3)** indicates direct impact requirements apply; **(M)** indicates Measure of Success if needed; **(D)** indicates that documentation is required

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APR.01.02.01

The organization provides accurate information throughout the accreditation process.

Rationale for APR.01.02.01

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

Elements of Performance for APR.01.02.01

1. The organization provides accurate information throughout the accreditation process. (See also APR.01.01.01, EP 1) A
Note 1: Information may be received in any of the following ways:
- Provided verbally
- Obtained through direct observation by, or in an interview or any other type of communication with, a Joint Commission employee
- Derived from documents supplied by the organization to The Joint Commission
Note 2: For the purpose of this requirement, falsification is defined as the fabrication, in whole or in part, of any information provided by an applicant or accredited organization to The Joint Commission. This includes redrafting, reformatting, or deleting document content. However, the organization may submit supporting material that explains the original information submitted to The Joint Commission. These additional materials must be properly identified, dated, and accompanied by the original documents.

APR.01.03.01

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

Elements of Performance for APR.01.03.01

1. (D) The organization notifies The Joint Commission in writing within 30 days of a change in ownership, control, location, capacity, or services offered. A
Note: When the organization changes ownership, control, location, capacity, or services offered, it may be necessary for The Joint Commission to survey the organization again. If the organization does not provide written notification to The Joint Commission within 30 days of these changes, the organization could lose its accreditation.

APR.02.01.01

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

Elements of Performance for APR.02.01.01

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

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APR.05.01.01

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

Rationale for APR.05.01.01

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

Elements of Performance for APR.05.01.01

1. (D) When requested, the organization provides The Joint Commission with all official records and reports of licensing, examining, reviewing, or planning bodies. **A**

3. The organization notifies The Joint Commission when it is designated by the Centers for Medicare & Medicaid Services (CMS) as a Special Focus Facility prior to public announcement of its designation by CMS.
Note: If the organization fails to notify The Joint Commission, a recommendation will be made to the Accreditation Committee to place the organization in Conditional Accreditation. (2) **A**

APR.06.01.01

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

Elements of Performance for APR.06.01.01

1. The organization does not use Joint Commission employees to provide any accreditation-related consulting services.
Note: Consulting services include, but are not limited to, the following:
- Helping the organization to meet Joint Commission standards
- Helping the organization to complete its Periodic Performance Review (PPR)
- Assisting the organization in remedying areas identified in its PPR as needing improvement
- Conducting mock surveys
- Providing the organization with consultation to address Priority Focus Process information
(2) **A**

APR.07.01.01

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

Elements of Performance for APR.07.01.01

1. The organization allows Joint Commission surveyor management staff or a member of the Board of Commissioners to observe the on-site survey.
Note: The observer will not participate in the on-site survey process, including the scoring of standards compliance. The organization will not incur any additional survey fees because an observer(s) is present. **A**

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APR.08.01.01

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

Elements of Performance for APR.08.01.01

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

APR.09.01.01

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

Elements of Performance for APR.09.01.01

1. The organization informs the public it serves about how to contact its management to report concerns about resident safety and quality of care. **A**
2. The organization informs the public it serves about how to contact The Joint Commission to report concerns about resident safety and quality of care. **A**

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APR.09.02.01

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

Rationale for APR.09.02.01

Any individual who provides care, treatment, and services should be free to raise concerns to The Joint Commission when the organization has not adequately prevented or corrected problems that can have or have had a serious adverse impact on residents. To support this culture of safety, the organization must communicate to staff that such reporting is permitted. Further, the organization must make it clear to staff that no formal disciplinary actions (for example, demotions, reassignments, or change in working conditions or hours) or informal punitive actions (for example, harassment, isolation, or abuse) will be threatened or carried out in retaliation for reporting concerns to The Joint Commission.

Elements of Performance for APR.09.02.01

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

APR.09.03.01

The organization is truthful and accurate when describing information in its Quality Report to the public.

Elements of Performance for APR.09.03.01

1. The organization adheres to The Joint Commission's published guidelines for how it describes information in its Quality Report. **A**

APR.10.01.01

The organization notifies The Joint Commission if it has been terminated from the Medicare/Medicaid program.

Elements of Performance for APR.10.01.01

1. The organization notifies The Joint Commission within 24 hours of learning that its Medicare/Medicaid certification has been terminated. **A**

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APR.10.02.01

The organization implements and maintains plans of correction that are required by state and federal inspections.

Elements of Performance for APR.10.02.01

1. (D) The organization implements and maintains plans of correction from its most recent state or federal inspection. **A**

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Environment of Care

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Standard EC.01.01.01

The organization plans activities that minimize risks in the environment of care.
Note: One or more persons can be assigned to manage risks associated with the management plans described in this standard.

Rationale for EC.01.01.01

Risks are inherent in the environment because of the types of care provided and the equipment and materials that are necessary to provide that care. The best way to manage these risks is through a systematic approach that involves the proactive evaluation of the harm that could occur. By identifying one or more individuals to coordinate and manage risk assessment and reduction activities - and to intervene when conditions immediately threaten life and health - organizations can be more confident that they have minimized the potential for harm.

Risks in the environment include safety and security for people, equipment, and other material; the handling of hazardous materials and waste; the potential for fire; the use of medical equipment; and utility systems. High-level written management plans help the organization manage risks. These plans are not the same as operational plans, but they do provide a framework for managing the environment of care. These plans should also address the scope and objectives of risk assessment and management, describe the responsibilities of individuals or groups, and give time frames for specific activities identified in the plan.
Note: It is not necessary to have a separate plan for each of the areas identified in the standard; the plans may all be contained in a single document.

Elements of Performance for EC.01.01.01

1. Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the environment of care, collect deficiency information, and disseminate summaries of actions and results. **A**
   Note 1: This information is disseminated to individuals with responsibility for the issues being addressed.
   Note 2: Deficiencies include injuries, problems, or use errors.
2. Leaders identify an individual(s) to intervene whenever environmental conditions immediately threaten life or health or threaten to damage equipment or buildings. **A**

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Standard EC.02.01.03

The organization prohibits smoking except in specific circumstances.

Elements of Performance for EC.02.01.03

	EP		Text		Category
	1.	(D)	The organization develops a written policy prohibiting smoking in all buildings except for designated areas for residents in specific circumstances. The organization defines specific circumstances that may result in exceptions to the policy.		A
	3.	(D)	If the organization decides that certain residents may smoke, the leaders develop written criteria identifying the specific circumstances under which they may smoke. The criteria also describe where and when they may smoke and whether supervision is required.		A
	4.		If the organization decides that certain residents may smoke, it designates smoking areas that are environmentally separate from care, treatment, and service areas. Note: This does not require that a designated smoking area be a specific distance from care, treatment, and service areas. A physically separate, well-ventilated room that is exhausted to the outside is acceptable.		A
(M)	6.		The organization takes action to maintain compliance with its smoking policy.		C

Standard EC.02.04.01

The organization manages medical equipment risks.

Elements of Performance for EC.02.04.01

	EP		Text		Category
	2.	(D)	The organization maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized by physical risk associated with use (including all life-support equipment) and equipment incident history. The organization evaluates new types of equipment before initial use to determine whether they should be included in the inventory. (See also EC.02.04.03, EPs 1 and 3)		A
(M)	3.	(D)	The organization identifies, in writing, the activities for maintaining, inspecting, and testing for all medical equipment on the inventory. (See also EC.02.04.03, EPs 2 and 3) Note: Organizations may use different strategies for different items as appropriate. For example, strategies such as predictive maintenance, reliability-centered maintenance, interval-based maintenance, corrective maintenance, or metered maintenance may be selected to provide for reliable performance.		C
	4.	(D)	The organization identifies, in writing, frequencies for inspecting, testing, and maintaining medical equipment on the inventory based on criteria such as manufacturers' recommendations, risk levels, or current organization experience. (See also EC.02.04.03, EPs 2 and 3)		A
	6.	(D)	The organization has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment.	(3)	A

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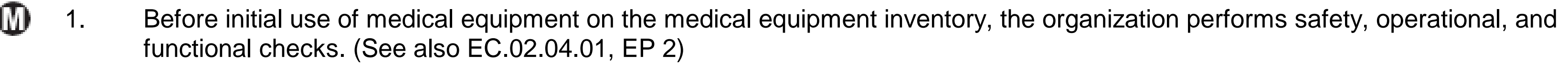
Standard EC.02.04.03

The organization inspects, tests, and maintains medical equipment.

Elements of Performance for EC.02.04.03



	EP		Text		Category
(M)	1.		Before initial use of medical equipment on the medical equipment inventory, the organization performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2)	(3)	C
	2.	(D)	The organization inspects, tests, and maintains all life-support equipment. These activities are documented. (See also EC.02.04.01, EPs 3 and 4)	(3)	A
(M)	3.	(D)	The organization inspects, tests, and maintains non–life-support equipment identified on the medical equipment inventory. These activities are documented. (See also EC.02.04.01, EPs 2-4)		C
	5.	(D)	The organization performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented.	(3)	A

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Standard EC.02.05.01

The organization manages risks associated with its utility systems.

Elements of Performance for EC.02.05.01

1. The organization designs and installs utility systems that meet resident care and operational needs. **A**

2. (D) The organization maintains a written inventory of all operating components of utility systems or maintains a written inventory of selected operating components of utility systems based on risks for infection, occupant needs, and systems critical to resident care (including all life-support systems). The organization evaluates new types of utility components before initial use to determine whether they should be included in the inventory. (See also EC.02.05.05, EPs 1, 3-5) **A**

3. (M) (D) The organization identifies, in writing, inspection and maintenance activities for all operating components of utility systems on the inventory. (See also EC.02.05.05, EPs 3-5; EC.02.05.09, EP 1)
Note: Organizations may use different approaches to maintenance. For example, activities such as predictive maintenance, reliability-centered maintenance, interval-based maintenance, corrective maintenance, or metered maintenance may be selected to provide for dependable performance. **C**

4. (D) The organization identifies, in writing, the frequencies for inspecting, testing, and maintaining all operating components of the utility systems, based on criteria such as manufacturers' recommendations, risk levels, or organization experience. (See also EC.02.05.05, EPs 3-5) **A**

5. The organization minimizes pathogenic biological agents in cooling towers, domestic hot- and cold-water systems, and other aerosolizing water systems. (3) **A**

6. In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration efficiencies.
Note: Areas designed for control of airborne contaminants include spaces such as special procedure rooms, rooms for residents diagnosed or suspected of having airborne communicable diseases (for example, pulmonary or laryngeal tuberculosis), residents in "protective environment" rooms, pharmacies, and sterile supply rooms. For further information, see Guidelines for Design and Construction of Hospitals and Health Care Facilities, 2001 edition, published by the American Institute of Architects. (3) **A**

7. (D) The organization maps the distribution of its utility systems. **A**

8. The organization labels utility system controls so that staff are able to partially or completely shut down systems in emergencies. **A**

9. (D) The organization has written procedures for responding to utility system disruptions. **A**

10. The organization's procedures address shutting off the malfunctioning system and notifying staff in affected areas. **A**

11. The organization's procedures address performing emergency clinical interventions during utility system disruptions. **A**

12. The organization's procedures address how to obtain emergency repair services. **A**

13. The organization responds to utility system disruptions as described in its procedures. (3) **A**

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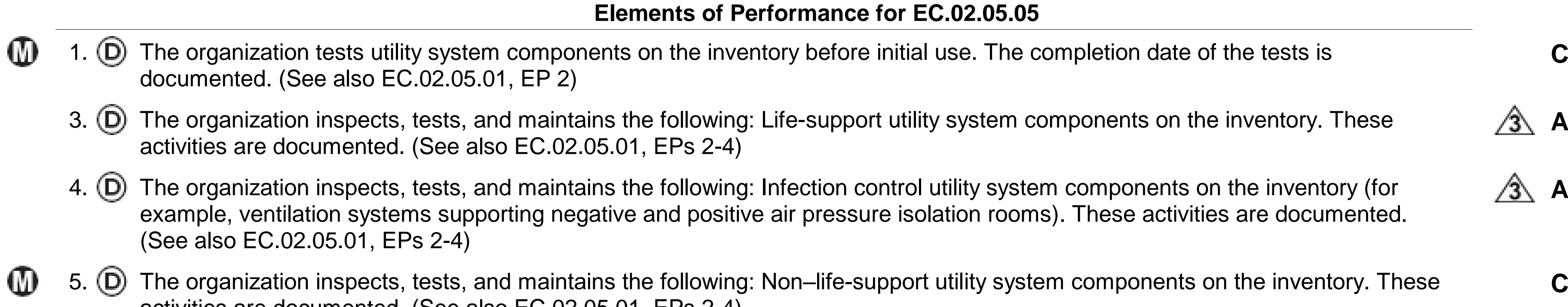
Standard EC.02.05.05

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

Rationale for EC.02.05.05

Equipment and life-support systems critical to resident care are almost always powered by electricity. When electrical power is disrupted unexpectedly, resident health and safety may be seriously threatened. For example, some communities introduce planned “brown-outs” when electric power sources are overloaded. Utility companies may not make special provisions for long term care organizations in these situations, which could compromise resident safety. The availability of emergency electrical power protects residents from utility disruptions.



Elements of Performance for EC.02.05.05

(M) 1. (D) The organization tests utility system components on the inventory before initial use. The completion date of the tests is documented. (See also EC.02.05.01, EP 2) **C**

3. (D) The organization inspects, tests, and maintains the following: Life-support utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2-4) (3) **A**

4. (D) The organization inspects, tests, and maintains the following: Infection control utility system components on the inventory (for example, ventilation systems supporting negative and positive air pressure isolation rooms). These activities are documented. (See also EC.02.05.01, EPs 2-4) (3) **A**

(M) 5. (D) The organization inspects, tests, and maintains the following: Non–life-support utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2-4) **C**

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Standard EC.02.05.09

The organization inspects, tests, and maintains medical gas and vacuum systems.
Note: This standard does not require organizations to have the medical gas and vacuum systems discussed below. However, if an organization has these types of systems, then the following inspection, testing, and maintenance requirements apply.

Rationale for EC.02.05.09

Medical gas and vacuum systems must be reliable. Testing these systems increases the likelihood of detecting reliability problems and reduces the risk of losing this critical resource.

Elements of Performance for EC.02.05.09

1. Ⓓ In time frames defined by the organization, the organization inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets. These activities are documented. (See also EC.02.05.01, EP 3) **A**

2. Ⓓ The organization tests piped medical gas and vacuum systems for purity, correct gas, and proper pressure when these systems are installed, modified, or repaired. The completion date of the tests is documented. **A**

3. The organization makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. **A**

Standard EC.03.01.01

Staff and licensed independent practitioners are familiar with their roles and responsibilities relative to the environment of care.

Rationale for EC.03.01.01

People are the key to successfully managing risks in the physical environment. Plans and procedures are of no value if those who work in the organization do not know how to follow them. Everyone who works in the organization is responsible for safety, and it is important for them to know how to identify and minimize risks, what actions to take when an incident occurs, and how to report it.

Elements of Performance for EC.03.01.01

Ⓜ 1. Staff and licensed independent practitioners can describe or demonstrate methods for eliminating and minimizing physical risks in the environment of care. (See also HR.01.04.01, EP 1) **C**

Ⓜ 2. Staff and licensed independent practitioners can describe or demonstrate actions to take in the event of an environment of care incident. (See also HR.01.04.01, EP 1) **C**

Ⓜ 3. Staff and licensed independent practitioners can describe or demonstrate how to report environment of care risks. (See also HR.01.04.01, EP 1) **C**

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Standard EC.04.01.01

The organization collects information to monitor conditions in the environment.

		Elements of Performance for EC.04.01.01	
	1.	The organization establishes a process(es) for continually monitoring, internally reporting, and investigating the following: - Injuries to residents or others within the organization's facilities - Occupational illnesses and staff injuries - Incidents of damage to its property or the property of others in locations it controls - Security incidents involving residents, staff, or others in locations it controls - Hazardous materials and waste spills and exposures - Fire safety management problems, deficiencies, and failures - Medical equipment management problems, failures, and use errors - Utility systems management problems, failures, or use errors Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities. Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process.	A
M	3.	Based on its process(es), the organization reports and investigates the following: Injuries to residents or others in the organization's facilities. (See also EC.04.01.03, EP 1)	C
M	4.	Based on its process(es), the organization reports and investigates the following: Occupational illnesses and staff injuries. (See also EC.04.01.03, EP 1)	C
M	5.	Based on its process(es), the organization reports and investigates the following: Incidents of damage to its property or the property of others in locations it controls. (See also EC.04.01.03, EP 1)	C
M	6.	Based on its process(es), the organization reports and investigates the following: Security incidents involving residents, staff, or others in locations it controls. (See also EC.04.01.03, EP 1)	C
M	8.	Based on its process(es), the organization reports and investigates the following: Hazardous materials and waste spills and exposures. (See also EC.04.01.03, EP 1)	C
M	9.	Based on its process(es), the organization reports and investigates the following: Fire safety management problems, deficiencies, and failures. (See also EC.04.01.03, EP 1)	C
M	10.	Based on its process(es), the organization reports and investigates the following: Medical equipment management problems, failures, and use errors. (See also EC.04.01.03, EP 1)	C
M	11.	Based on its process(es), the organization reports and investigates the following: Utility systems management problems, failures, or use errors. (See also EC.04.01.03, EP 1)	C

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	12.	The organization conducts environmental tours every six months in resident care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate risks in the environment of care. (See also EC.04.01.03, EP 1)		A
(M)	13.	The organization conducts annual environmental tours in nonresident care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate risks in the environment. (See also EC.04.01.03, EP 1)		C
	14.	The organization uses its tours to identify environmental deficiencies, hazards, and unsafe practices. (See also EC.04.01.03, EP 1)		A
	15.	Every 12 months, the organization evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness. For those organizations seeking Medicare/Medicaid certification-based long term care accreditation that are not required to have environment of care management plans, the organization evaluates the scope, performance, and effectiveness of environment of care management activities. (See also EC.04.01.03, EP 1)	(3)	A

Standard EC.04.01.03

The organization analyzes identified environment of care issues.

Elements of Performance for EC.04.01.03

	1.	Representatives from clinical, administrative, and support services participate in the analysis of environment of care data. (See also EC.04.01.01, EPs 3-6 and 8-15)	A
(M)	2.	The organization uses the results of data analysis to identify opportunities to resolve environmental safety issues. (See also EC.04.01.05, EP 1)	C
	3.	Annually, representatives from clinical, administrative, and support services recommend one or more priorities for improving the environment of care.	A

Standard EC.04.01.05

The organization improves its environment of care.

Elements of Performance for EC.04.01.05

(M)	1.	The organization takes action on the identified opportunities to resolve environmental safety issues. (See also EC.04.01.03, EP 2)	C
(M)	2.	The organization evaluates changes to determine if they resolved environmental safety issues.	C
	3.	The organization reports performance improvement results to those responsible for analyzing environment of care issues.	A

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Emergency Management

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Standard EM.01.01.01

The organization engages in planning activities prior to developing its written Emergency Operations Plan.
Note: An emergency is an unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself. At times, an emergency results in a sudden, increased demand for the organization's services. Emergencies can be either human-made or natural (such as an electrical system failure or a tornado), or a combination of both, and they exist on a continuum of severity. A disaster is a type of emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain resident care, safety, or security functions.

Rationale for EM.01.01.01

An emergency can suddenly and significantly affect demand for the organization's services or its ability to provide those services. Therefore, the organization needs to engage in planning activities that prepare it to form the Emergency Operations Plan. These activities include identifying risks, prioritizing likely emergencies, attempting to mitigate them when possible, and considering its potential emergencies in developing strategies for preparedness.

Elements of Performance for EM.01.01.01

1. The organization's leaders, including the administrator, the medical director, the nursing leader, and other leaders, participate in planning activities prior to developing an Emergency Operations Plan. **A**
Note: Other leaders who participate in planning activities should include, but not be limited to, building services, food services, and housekeeping services.

2. Ⓓ The organization conducts a hazard vulnerability analysis (HVA) to identify potential emergencies that could affect demand for the organization's services or its ability to provide those services, the likelihood of the potential emergencies occurring, and the consequences of those events. The findings of this analysis are documented. (See also EM.03.01.01, EP 1) **A**

3. Ⓓ The organization prioritizes the potential emergencies identified in its hazard vulnerability analysis (HVA) and documents these priorities. **A**

4. The organization communicates its needs and vulnerabilities to community emergency response agencies and identifies the community's capability to meet its needs. This communication and identification occur at the time of the organization's annual review of its Emergency Operations Plan and whenever its needs or vulnerabilities change. (See also EM.03.01.01, EP 1) **A**

5. The organization uses its hazard vulnerability analysis as a basis for defining mitigation activities (that is, activities designed to reduce the risk of and potential damage from an emergency). **A**
Note: Mitigation, preparedness, response, and recovery are the four phases of emergency management. They occur over time: Mitigation and preparedness generally occur before an emergency, and response and recovery occur during and after an emergency.

6. The organization uses its hazard vulnerability analysis as a basis for defining the preparedness activities that will organize and mobilize essential resources. **A**

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7. The organization's incident command structure is integrated into its community's command structure. **A**
Note: The incident command structure used by the organization should provide for a scalable response to different types of emergencies.
Footnote: The National Incident Management System (NIMS) is one of many models for an incident command structure available to health care organizations. The NIMS provides guidelines for common functions and terminology to support clear communications and effective collaboration in an emergency situation. The NIMS is required of organizations receiving certain federal funds for emergency preparedness.

8. (D) The organization keeps a documented inventory of the resources and assets it has on site that may be needed during an emergency, including, but not limited to, personal protective equipment, water, fuel, food, and medical- and medication-related resources and assets. **A**

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Standard EM.02.01.01

The organization has an Emergency Operations Plan.
Note: The organization's Emergency Operations Plan (EOP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and resident clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, EM.02.02.09, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This "all hazards" approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the Plan's response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.

Rationale for EM.02.01.01

A successful response effort relies on a comprehensive and flexible Emergency Operations Plan that guides decision making at the onset of an emergency and as an emergency evolves. Although the Emergency Operations Plan can be designed in a variety of ways, it must address response procedures that are both applicable to the organization's likely emergencies and adaptable in supporting key areas (such as communications and resident care) that could be affected by different types of emergencies.

Elements of Performance for EM.02.01.01

1. The organization's leaders participate in the development of the Emergency Operations Plan. **A**

2. (D) The organization develops and maintains a written Emergency Operations Plan that describes the response procedures to follow when emergencies occur. **A**
Note: The response procedures address the prioritized emergencies but can also be adapted to other emergencies that the organization may experience. Response procedures could include the following:
- Maintaining or expanding services
- Conserving resources
- Curtailing services
- Supplementing resources from outside the local community
- Closing the organization to new residents
- Staged evacuation
- Total evacuation

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3. The Emergency Operations Plan identifies the organization’s capabilities and establishes response procedures for when the organization cannot be supported by the local community in the organization's efforts to provide communications, resources and assets, security and safety, staff, utilities, or resident care for at least 96 hours.
Note: In past years, recommendations had advised organizations to prepare for emergencies of 72 hours. However, recent emergency situations have often required a response period of much longer duration. As a result, organizations are now advised to prepare for emergencies lasting 96 hours before the local community can support the organization. This element of performance (EP) does not require organizations to stockpile supplies or continue operating for 96 hours. However, during emergencies of long duration, the organization needs to monitor its capabilities and adjust its response procedures (examples provided in EP 2 of this standard) to support an informed and proactive decision regarding how long the organization can deliver care safely. **A**

Standard EM.02.02.03

As part of its Emergency Preparedness Plan, the organization prepares for how it will manage resources and assets during emergencies.

Rationale for EM.02.02.03

The organization that continues to provide care, treatment, and services to its residents during emergencies needs to determine how resources and assets (that is, supplies, equipment, and facilities) will be managed internally and, when necessary, solicited and acquired from external sources such as vendors, neighboring health care providers, other community organizations, state affiliates, or a regional parent company. The organization should also recognize the risk that some resources may not be available from planned sources, particularly in emergencies of long duration or broad geographic scope, and that contingency plans will be necessary for critical supplies. This situation may occur when multiple organizations are vying for a limited supply from the same vendor.

Elements of Performance for EM.02.02.03

9. The Emergency Preparedness Plan describes the following: The organization's arrangements for transporting some or all residents, and their requisite medications, supplies, and equipment, and staff to an alternative care site(s) when the organization's environment cannot support care, treatment, and services. **A**

10. The Emergency Preparedness Plan describes the following: The organization's arrangements for transferring pertinent information, including essential clinical and medication-related information, with residents moving to an alternative care site(s). **A**

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Standard EM.02.02.13

During disasters, the organization may grant disaster privileges to volunteer licensed independent practitioners.
Note: A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain resident care, safety, or security functions.

Elements of Performance for EM.02.02.13

1. The organization grants disaster privileges to volunteer licensed independent practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the organization is unable to meet immediate resident needs.
Note: Refer to the Glossary for the definition of licensed independent practitioner. **A**

2. (D) The organization identifies, in writing, those individuals responsible for granting disaster privileges to volunteer licensed independent practitioners. **A**

3. The organization determines how it will distinguish volunteer licensed independent practitioners from other licensed independent practitioners. **A**

4. (D) The organization describes, in writing, how it will oversee the performance of volunteer licensed independent practitioners who are granted disaster privileges (for example, by direct observation, mentoring, clinical record review). **A**

5. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the organization obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:
- A current picture identification card from a health care organization that clearly identifies professional designation
- A current license to practice
- Primary source verification of licensure
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organizations or groups
- Identification indicating that the individual has been granted authority by a government entity to provide care, treatment, or services in disaster circumstances
- Confirmation by a licensed independent practitioner currently privileged by the organization or a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster **A**

6. During a disaster, the organization oversees the performance of each volunteer licensed independent practitioner. **A**

7. Based on its oversight of each volunteer licensed independent practitioner, the organization determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue. **C**

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8. Ⓓ Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents him- or herself to the organization, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the organization documents all of the following:
- Reason(s) why it could not be performed within 72 hours of the practitioner's arrival
- Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services
- Evidence of the organization's attempt to perform primary source verification as soon as possible

C

9. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible.
Note: Primary source verification of licensure is not required if the volunteer licensed independent practitioner has not provided care, treatment, or services under the disaster privileges.

C

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Standard EM.02.02.15

During disasters, the organization may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification, or registration.
Note: While this standard allows for a method to streamline the process for verifying identification and licensure, certification, or registration, the elements of performance are intended to safeguard against inadequate care during a disaster.

Elements of Performance for EM.02.02.15

1. The organization assigns disaster responsibilities to volunteer practitioners who are not licensed independent practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the organization is unable to meet immediate resident needs. **A**

2. (D) The organization identifies, in writing, those individuals responsible for assigning disaster responsibilities to volunteer practitioners who are not licensed independent practitioners. **A**

3. The organization determines how it will distinguish volunteer practitioners who are not licensed independent practitioners from its staff.
Note: This distinction could be made by using badges, vests, wristbands, or other articles. **A**

4. (D) The organization describes, in writing, how it will oversee the performance of volunteer practitioners who are not licensed independent practitioners who have been assigned disaster responsibilities. Examples of methods for overseeing their performance include direct observation, mentoring, and clinical record review. **A**

5. Before a volunteer practitioner who is not a licensed independent practitioner is considered eligible to function as a practitioner, the organization obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and one of the following:
- A current picture identification card from a health care organization that clearly identifies professional designation
- A current license, certification, or registration
- Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice)
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
- Identification indicating that the individual has been granted authority by a government entity to provide resident care, treatment, or services in disaster circumstances
- Confirmation by organization staff with personal knowledge of the volunteer practitioner's ability to act as a qualified practitioner during a disaster
(3) **A**

6. During a disaster, the organization oversees the performance of each volunteer practitioner who is not a licensed independent practitioner. **A**

7. Based on its oversight of each volunteer practitioner who is not a licensed independent practitioner, the organization determines within 72 hours after the practitioner's arrival whether assigned disaster responsibilities should continue. **C**

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8. (D) Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice) of volunteer practitioners who are not licensed independent practitioners occurs as soon as the disaster is under control or within 72 hours from the time the volunteer practitioner presents him- or herself to the organization, whichever comes first. If primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice) for a volunteer practitioner who is not a licensed independent practitioner cannot be completed within 72 hours due to extraordinary circumstances, the organization documents all of the following:
   - Reason(s) why it could not be performed within 72 hours of the practitioner's arrival
   - Evidence of the volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment, or services
   - Evidence of the organization's attempt to perform primary source verification as soon as possible

   C

9. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible.
   Note: Primary source verification of licensure, certification, or registration is not required if the volunteer practitioner has not provided care, treatment, or services under his or her assigned disaster responsibilities.

   C

Standard EM.03.01.01

The organization evaluates the effectiveness of its emergency management planning activities.

Rationale for EM.03.01.01

The risks and hazards facing an organization or an area of the organization may change over time. The scope or goals of the organization's planning activities may evolve in response to changes in the organization, its structure, its resident population, community planning partners, or a number of other factors. Such changes can have an impact on the organization's response capabilities, including decisions about its inventory of resources and assets needed during an emergency. The organization conducts an annual review of its planning activities to identify such changes and support decision making regarding how the organization responds to emergencies.

Elements of Performance for EM.03.01.01

1. (D) The organization conducts an annual review of its risks, hazards, and potential emergencies as defined in its hazard vulnerability analysis (HVA). The findings of this review are documented. (See also EM.01.01.01, EPs 2 and 4)

   A

2. (D) The organization conducts an annual review of the objectives and scope of its Emergency Operations Plan. The findings of this review are documented.

   A

3. (D) The organization conducts an annual review of its inventory. The findings of this review are documented.

   A

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Human Resources

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Standard HR.01.04.01

The organization provides orientation to staff.

Elements of Performance for HR.01.04.01

	EP		Text	Category
	1.		The organization determines the key safety content of orientation provided to staff. (See also EC.03.01.01, EPs 1-3) Note: Key safety content may include specific processes and procedures related to the provision of care, treatment, and services; the environment of care; and infection control.	A
Ⓜ	2.	Ⓓ	The organization orients its staff to the key safety content before staff provides care, treatment, and services. Completion of this orientation is documented.	C
Ⓜ	3.	Ⓓ	The organization orients staff on the following: Organization-wide and unit-specific policies and procedures related to job duties and responsibilities. Completion of this orientation is documented.	C
Ⓜ	4.	Ⓓ	The organization orients staff on the following: Their specific job duties and responsibilities, including those related to infection prevention and control and, if applicable to their role, assessing and managing pain. Completion of this orientation is documented.	C
Ⓜ	5.	Ⓓ	The organization orients staff on the following: Sensitivity to cultural diversity based on their job duties and responsibilities. Completion of this orientation is documented.	C
Ⓜ	6.	Ⓓ	The organization orients staff on the following: Resident rights, including ethical aspects of care, treatment, and services and the process used to address ethical issues based on their job duties and responsibilities. Completion of this orientation is documented.	C
Ⓜ	8.		Based on their responsibilities, staff are oriented about psychotropic medications, including the following: - The need for a medication in relation to the resident's documented diagnosis and condition - The potential for drug-drug and drug-food interactions - Effects and adverse reactions to psychotropic medications - The use of a medication for an appropriate duration - Optimal dosages - Frequent monitoring of the medication's effectiveness - Nonmedication interventions and alternatives developed through interdisciplinary team assessment - Reduction and discontinuation of a medication	C

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Standard HR.01.05.03

Staff participate in education and training.

Elements of Performance for HR.01.05.03

	EP		Text		Category
Ⓜ	1.	Ⓓ	Staff participate in education and training to maintain or increase their competency. Staff participation is documented.		C
Ⓜ	4.	Ⓓ	Staff participate in education and training whenever staff responsibilities change. Staff participation is documented.		C
Ⓜ	5.	Ⓓ	Staff participate in education and training that is specific to the needs of the resident population served by the organization. Staff participation is documented.		C
Ⓜ	6.	Ⓓ	Staff participate in education and training that incorporates the skills of team communication, collaboration, and coordination of care. Staff participation is documented.		C
Ⓜ	7.	Ⓓ	Staff participate in education and training that includes information about the need to report unanticipated adverse events and how to report these events. Staff participation is documented.		C

Standard HR.01.06.01

Staff are competent to perform their responsibilities.

Elements of Performance for HR.01.06.01

	EP		Text		Category
	2.		The organization uses assessment methods to determine the individual's competence in the skills being assessed. Note: Methods may include test taking, return demonstration, or the use of simulation.		A
Ⓜ	3.		An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence. Note: When a suitable individual cannot be found to assess staff competence, the organization can utilize an outside individual for this task. Alternatively, the organization may consult the competency guidelines from an appropriate professional organization to make its assessment.		C
Ⓜ	5.	Ⓓ	The organization conducts an initial assessment of staff competence as part of orientation. This assessment is documented.	⚠3	C
Ⓜ	6.	Ⓓ	Staff competence is assessed and documented once every three years, or more frequently as required by organization policy or in accordance with law and regulation.		C
	15.		The organization takes action when a staff member’s competence does not meet expectations. Note: Actions may include, but are not limited to, providing additional training or supervision, or modifying job responsibilities.	⚠3	A

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Standard HR.01.07.01

The organization evaluates staff performance.

Elements of Performance for HR.01.07.01

5. When a licensed independent practitioner brings a nonemployee individual into the organization to provide care, treatment, and services, the organization reviews the individual's competencies and performance at the same frequency as individuals employed by the organization.
Note: This review can be accomplished either through the organization's regular process or an alternative process with input from the licensed independent practitioner who brought staff into the organization. C

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Standard HR.02.01.03

The organization grants initial, renewed, or revised clinical privileges to individuals who are permitted by law and the organization to practice independently.

Elements of Performance for HR.02.01.03

1. The organization has a process, approved by its leaders, to grant initial, renewed, or revised clinical privileges and to deny clinical privileges. **A**
Note: Types of clinical privileges could include internal, geriatric, and pulmonary medicine; infectious diseases; podiatry; and dentistry.

2. Before granting initial clinical privileges, the organization verifies the identity of the individual seeking clinical privileges by viewing a valid picture identification issued by a state or federal agency (for example, a driver's license or passport). **A**

3. (D) Before granting initial, renewed, or revised clinical privileges, the organization uses primary sources when documenting training specific to the clinical privileges requested. **A**
Note 1: The verification of relevant training informs the organization of the licensed independent practitioner’s clinical knowledge and skill set. Verification must be obtained from the primary source of the specific credential. Primary sources include the specialty certifying boards approved by the American Dental Association for a dentist’s board certification, letters from professional schools (for example, medical, dental, nursing) and letters from residency or postdoctoral programs for completion of training. Designated equivalent sources include, but are not limited to, the following:
- The American Medical Association (AMA) Physician Masterfile for verification of a physician’s U.S. and Puerto Rico medical school graduation and residency completion
- The American Board of Medical Specialties (ABMS) for verification of a physician’s board certification
- The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of a physician’s graduation from a foreign medical school
- The American Osteopathic Association (AOA) Physician Database for predoctoral education accredited by the AOA Bureau of Professional Education, postdoctoral education approved by the AOA Council on Postdoctoral Training, and Osteopathic Specialty Board Certification
- The Federation of State Medical Boards (FSMB) for all actions against a physician’s medical license
- The American Academy of Physician Assistants Profile for physician assistant education and National Commission on Certification of Physician Assistants (NCCPA) certification
Note 2: A primary source of verified information may designate to an agency the role of communicating credentials information. The designated agency then becomes acceptable to be used as a primary source.
Note 3: An external organization (for example, a credentials verification organization (CVO)) or a Joint Commission–accredited health care organization functioning as a CVO may be used to collect credentialing information. Both of these organizations must meet the CVO guidelines listed in the Glossary.
Note 4: When it is not possible to obtain information from the primary source, reliable secondary sources may be used. A reliable secondary source could be another health care organization that has documented primary source verification of the applicant’s credentials.

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4. All licensed independent practitioners that provide care possess a current license, certification, or registration, as required by law and regulation. A

5. (D) Before granting initial, renewed, or revised clinical privileges and at the time of licensure expiration, the organization documents required current licensure of a licensed independent practitioner using primary sources, if available. A
Note 1: A primary source of verified information may designate to an agency the role of communicating credentials information. The designated agency then becomes acceptable to be used as a primary source.
Note 2: An external organization (for example, a credentials verification organization (CVO)) or a Joint Commission–accredited health care organization functioning as a CVO may be used to collect credentialing information. Both of these organizations must meet the CVO guidelines listed in the Glossary.
Note 3: Verification of current licensure with the primary source through a secure electronic communication or by telephone is acceptable if this verification is documented.

6. (D) Before granting initial, renewed, or revised clinical privileges to a licensed independent practitioner, the following occurs: The organization's medical director documents current evidence, which includes references from peers, of the individual's competence to perform the clinical privileges requested. A

7. Before granting initial, renewed, or revised clinical privileges to a licensed independent practitioner, the following occurs: The medical director reviews information from any of the organization's performance improvement activities pertaining to professional performance, judgment, and clinical or technical skills. A

8. Before granting initial, renewed, or revised clinical privileges to a licensed independent practitioner, the following occurs: The medical director evaluates the results of any review of the individual's clinical performance. A

9. Before granting initial, renewed, or revised clinical privileges to a licensed independent practitioner, the following occurs: The medical director reviews any clinical performance in the organization that is outside acceptable standards. A

10. (D) Before granting initial, renewed, or revised clinical privileges to a licensed independent practitioner, the medical director evaluates the following: The applicant's written statement that no health problems exist that could affect his or her ability to perform the requested clinical privileges. A
Note: Organizations should consider the applicability of the Americans with Disabilities Act to their assignment of clinical privileges, and, if applicable, review their policies and procedures. In addition, federal entities are required to comply with the Rehabilitation Act of 1974.

11. Before assigning initial, renewed, or revised clinical responsibilities to a licensed independent practitioner, the medical director evaluates the following: Any challenges to licensure or registration. A
Note: The challenges addressed here are those that are in the process of an active investigation by the state licensing board.

12. Before granting initial, renewed, or revised clinical privileges to a licensed independent practitioner, the medical director evaluates the following: Any voluntary and involuntary relinquishment of license or registration. A

13. Before granting initial, renewed, or revised clinical privileges to a licensed independent practitioner, the medical director evaluates the following: Any voluntary and involuntary termination of medical staff membership at another organization. A

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	14.	Before granting initial, renewed, or revised clinical privileges to a licensed independent practitioner, the medical director evaluates the following: Any voluntary or involuntary limitation, reduction, or loss of clinical responsibilities.	A
	15.	Before granting initial, renewed, or revised clinical privileges to a licensed independent practitioner, the medical director evaluates the following: Any professional liability actions that resulted in a final judgment against the applicant.	A
	16.	Before granting initial, renewed, or revised clinical privileges to physicians and dentists, the medical director evaluates information from the National Practitioner Data Bank.	A
	18.	Before granting initial, renewed, or revised clinical privileges to a licensed independent practitioner, the medical director evaluates whether the requested clinical privileges are consistent with the site-specific care, treatment, and services provided by the organization.	A
	19.	Before granting initial, renewed, or revised clinical privileges to a licensed independent practitioner, the organization confirms the licensed independent practitioner’s adherence to organization policies, procedures, rules, and regulations.	A
	20.	The organization uses current, written, information about the licensed independent practitioner’s clinical performance as the basis for granting or denying all clinical privileges.	A
	21.	The organization grants initial, renewed, or revised clinical privileges for no longer than a two-year period.	A
	22.	The organization grants or denies clinical privileges according to its process.	A
	23. (D)	The governing body grants, in writing, clinical privileges. Note: The governing body may delegate to the organization administrator or a committee of two or more voting members of the governing body the authority to grant clinical privileges.	A
(M)	24. (D)	The organization provides the licensed independent practitioner with a written list of granted initial, renewed, or revised clinical privileges and any denied privileges.	C
	25.	The scope and content of resident services provided by a licensed independent practitioner is limited to the granted initial, renewed, or revised privileges.	(2) A
	35.	To make a decision on granting initial, renewed, or revised clinical privileges, the governing body reviews the following: - Recommendations made by the medical director - Documentation on which recommendations are based - Records of any hearings or appeals addressing adverse decisions Note: The organization administrator or a committee of two or more governing body members may substitute for a governing body.	A

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Standard HR.02.01.05

The organization may grant temporary privileges.

Elements of Performance for HR.02.01.05

1. The organization has a process for granting temporary clinical privileges to licensed independent practitioners to meet important resident needs. **A**

2. Ⓓ Before the organization grants temporary clinical privileges to a licensed independent practitioner to meet important resident needs, the organization uses primary source verification, which can be done by telephone, to document current licensure.
Note 1: A primary source of verified information may designate to an agency the role of communicating credentials information. The designated agency then becomes acceptable to be used as a primary source.
Note 2: An external organization (for example, a credentials verification organization (CVO)) or a Joint Commission–accredited health care organization functioning as a CVO may be used to collect credentialing information. Both of these organizations must meet the CVO guidelines listed in the Glossary. **A**

3. Ⓓ Before the organization grants temporary clinical privileges to a licensed independent practitioner to meet important resident needs, the organization uses primary source verification to document current competency. **A**

9. The administrator or the administrator's designee grants temporary clinical privileges to licensed independent practitioners to meet important resident needs upon recommendation of clinical leadership or the medical director. **A**

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Standard HR.02.01.07

Licensed independent practitioners who provide on-call coverage for attending licensed independent practitioners are competent.

Elements of Performance for HR.02.01.07

	1.	When the attending licensed independent practitioner designates an on-call licensed independent practitioner (who is not privileged in the organization) to cover in his or her absence, the medical director and the attending licensed independent practitioner determine that the on-call licensed independent practitioner can perform the required care, treatment, and services.	**A**
	2. (D)	When the attending licensed independent practitioner designates an on-call licensed independent practitioner (who is not privileged in the organization) to cover in his or her absence, the following requirements are met: The organization verifies the current licensure of the on-call licensed independent practitioner from the primary source prior to his or her provision of care, treatment, and services. This verification is documented. Note: It may be more efficient to obtain a list of possible covering licensed independent practitioners ahead of time and verify licensure from the primary source in advance of the licensed independent practitioner actually covering for the attending licensed independent practitioner.	**A**
(M)	3. (D)	When the attending licensed independent practitioner designates an on-call licensed independent practitioner (who is not privileged in the organization) to cover in his or her absence, the following requirements are met: A documented review of orders issued by the on-call licensed independent practitioner is conducted by the attending licensed independent practitioner upon his or her return in the time frame defined by the organization.	**C**
	4.	The organization defines the maximum time frame an on-call licensed independent practitioner (who is not privileged in the organization) can provide coverage in the absence of the attending licensed independent practitioner before he or she is required to go through the organization's privileging process.	**A**

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Standard HR.02.02.01

The organization provides orientation to licensed independent practitioners.

Elements of Performance for HR.02.02.01

1. The organization determines the key safety content of orientation provided to licensed independent practitioners. **A**
Note: Key safety content may include specific processes and procedures related to the provision of care, the environment of care, and infection control.

Ⓜ 2. Ⓓ The organization orients its licensed independent practitioners to the key safety content before they provide care, treatment, and services. Completion of this orientation is documented. **C**
Note: The organization determines the specific responsibilities included in orientation. For example, a covering licensed independent practitioner may have different or fewer responsibilities than an attending licensed independent practitioner.

Ⓜ 3. Ⓓ The organization orients licensed independent practitioners on the following: Relevant policies and procedures. Completion of this orientation is documented. **C**

Ⓜ 4. Ⓓ The organization orients licensed independent practitioners on the following: Their specific responsibilities, including those related to infection prevention and control, and assessing and managing pain. Completion of this orientation is documented. **C**
Note: The organization determines the specific responsibilities included in orientation. For example, a covering licensed independent practitioner may have different or fewer responsibilities than a licensed independent practitioner who is privileged.

Ⓜ 5. Ⓓ The organization orients licensed independent practitioners on the following: Sensitivity to cultural diversity based on their specific responsibilities. Completion of this orientation is documented. **C**

Standard HR.02.03.01

The organization has a fair hearing and appeal process for addressing adverse decisions about clinical privileges.

Elements of Performance for HR.02.03.01

1. The organization has a fair hearing and appeal process. **A**
2. The organization allows hearings and appeals to be scheduled. **A**
3. The organization identifies the procedures for hearings and appeals. **A**
4. The organization defines the composition of the hearing committee. **A**
5. The organization allows adverse decisions to be appealed. **A**
6. The organization consistently applies its fair hearing and appeal process. **A**

KEY: A indicates scoring category A; C indicates scoring category C; ⚠ indicates situational decision rules apply; ⚠ indicates direct impact requirements apply; Ⓜ indicates Measure of Success if needed; Ⓓ indicates that documentation is required

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Infection Prevention and Control

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Standard IC.02.04.03

The organization provides the influenza vaccination to at-risk residents.

Rationale for IC.02.04.03

Influenza and pneumonia combined represent the fifth leading cause of death in the elderly. Along with the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC), The Joint Commission promotes the administration of influenza and pneumococcal vaccines to adult residents in long term care facilities.

Elements of Performance for IC.02.04.03

1. (D) The organization develops protocols on when to administer the influenza vaccine to a resident. **A**

(M) 2. Residents identified as being high-risk for influenza are vaccinated. **C**
Footnote: See the Centers for Disease Control and Prevention guidelines on high-risk populations (Infection Control Measures for Preventing and Controlling Influenza Transmission in Long-Term Care Facilities: http://www.cdc.gov/flu/professionals/infectioncontrol/longtermcare.htm).

Standard IC.02.04.05

The organization provides the pneumococcal vaccination to at-risk residents.

Elements of Performance for IC.02.04.05

1. (D) The organization develops protocols on when to administer the pneumococcal vaccine to a resident. **A**

(M) 2. Residents identified as being high-risk for pneumococcal infection are vaccinated. **C**
Footnote: See the Centers for Disease Control and Prevention guidelines on high-risk populations (Pneumococcal polysaccharide vaccine (PPSV): CDC answers your questions http://immunize.org/catg.d/p2015.pdf).
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Information Management

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Standard IM.01.01.01

The organization plans for managing information.

Elements of Performance for IM.01.01.01

1.	The organization identifies the internal and external information needed to provide safe, quality care.	**A**
2.	The organization identifies how data and information enter, flow within, and leave the organization. Note: The flow of data and information within the organization includes how it moves into and out of storage.	**A**
3.	The organization uses the information identified to develop processes to manage information.	**A**
4.	The organization selects staff to participate in the assessment, selection, integration, and use of information management systems for the delivery of care, treatment, and services.	**A**

Standard IM.02.01.01

The organization protects the privacy of health information.

Elements of Performance for IM.02.01.01

1. (D)	The organization has a written policy addressing the privacy of health information.	**A**
2.	The organization implements its policy on the privacy of health information.	**A**
3.	The organization uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy.	**A**
4.	The organization discloses health information only as authorized by the resident or as otherwise consistent with law and regulation.	**A**
5.	The organization monitors compliance with its policy on the privacy of health information.	**A**

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Standard IM.02.02.01

The organization effectively manages the collection of health information.

Rationale for IM.02.02.01

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

Elements of Performance for IM.02.02.01

1. The organization uses uniform data sets to standardize data collection throughout the organization. **C**

2. (D) The organization has a written policy that includes the following: (3) **A**
- Terminology and definitions approved for use in the organization
- Abbreviations, acronyms, symbols, and dose designations approved for use in the organization
- Abbreviations, acronyms, symbols, and dose designations prohibited from use in the organization, which include the following:
  - U,u
  - IU
  - Q.D., QD, q.d., qd
  - Q.O.D., QOD, q.o.d, qod
  - Trailing zero (X.0 mg)
  - Lack of leading zero (.X mg)
  - MS
  - MSO4
  - MgSO4

Note: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

3. The organization implements its policy regarding the terminology, definitions, abbreviations, acronyms, symbols, and dose designations permitted for use in the organization and the abbreviations, acronyms, symbols, and dose designations prohibited from use in the organization. **C**
Note: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.

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Standard IM.02.02.03

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

Rationale for IM.02.02.03

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

Elements of Performance for IM.02.02.03

	1. (D)	The organization has written policies addressing data capture, display, transmission, and retention.	A
(M)	2.	The organization's storage and retrieval systems make health information accessible when needed for resident care, treatment, and services.	C
(M)	3.	The organization disseminates data and information in useful formats within time frames that are defined by the organization and consistent with law and regulation.	C
	12.	The organization retains data and information for time frames consistent with law and regulation.	A

Standard IM.03.01.01

Knowledge-based information resources are available, current, and authoritative.

Elements of Performance for IM.03.01.01

1.	The organization provides access to knowledge-based information resources 24 hours a day, 7 days a week.	A

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Leadership

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Standard LD.01.03.01

Governance is ultimately accountable for the safety and quality of care, treatment, and services.

Rationale for LD.01.03.01

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

Elements of Performance for LD.01.03.01

1. (D) Governance defines in writing its responsibilities. **A**
2. Governance provides for organization management and planning. **A**
3. (D) Governance approves the organization's written scope of services. **A**
4. Governance selects the administrator. **A**
5. Governance provides for the resources needed to maintain safe, quality care, treatment, and services. (3) **A**
6. Governance works with other leaders to annually evaluate the organization's performance in relation to its mission, vision, and goals. **A**
11. If the organization has an organized medical staff, the governance approves its bylaws, rules, and regulations. **A**

Standard LD.02.01.01

The mission, vision, and goals of the organization support the safety and quality of care, treatment, and services.

Rationale for LD.02.01.01

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

Elements of Performance for LD.02.01.01

3. Leaders communicate the mission, vision, and goals to staff and the population(s) the organization serves. **A**

KEY: **A** indicates scoring category A; **C** indicates scoring category C; (2) indicates situational decision rules apply; (3) indicates direct impact requirements apply; (M) indicates Measure of Success if needed; (D) indicates that documentation is required

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Standard LD.03.01.01

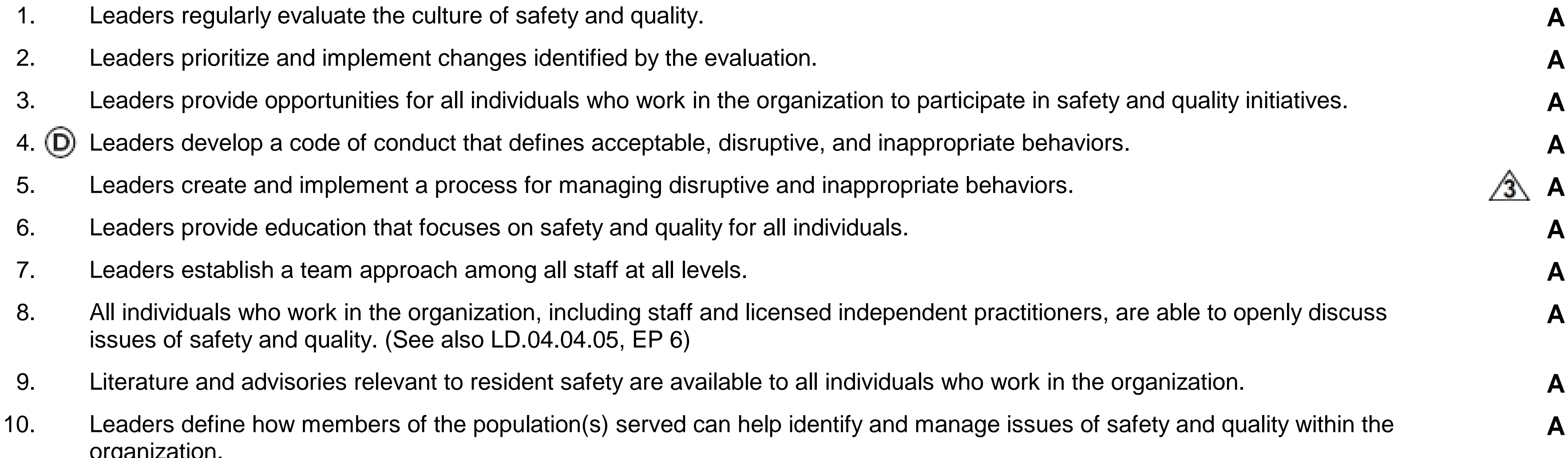
Leaders create and maintain a culture of safety and quality throughout the organization.

Rationale for LD.03.01.01

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

Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to resident care. Leaders must address disruptive behavior of individuals working at all levels of the organization, including management, clinical and administrative staff, licensed independent practitioners, and governing body members.

Elements of Performance for LD.03.01.01



1. Leaders regularly evaluate the culture of safety and quality. **A**
2. Leaders prioritize and implement changes identified by the evaluation. **A**
3. Leaders provide opportunities for all individuals who work in the organization to participate in safety and quality initiatives. **A**
4. (D) Leaders develop a code of conduct that defines acceptable, disruptive, and inappropriate behaviors. **A**
5. Leaders create and implement a process for managing disruptive and inappropriate behaviors. (3) **A**
6. Leaders provide education that focuses on safety and quality for all individuals. **A**
7. Leaders establish a team approach among all staff at all levels. **A**
8. All individuals who work in the organization, including staff and licensed independent practitioners, are able to openly discuss issues of safety and quality. (See also LD.04.04.05, EP 6) **A**
9. Literature and advisories relevant to resident safety are available to all individuals who work in the organization. **A**
10. Leaders define how members of the population(s) served can help identify and manage issues of safety and quality within the organization. **A**

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Standard LD.03.02.01

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

Rationale for LD.03.02.01

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

Elements of Performance for LD.03.02.01

1.	Leaders set expectations for using data and information to improve the safety and quality of care, treatment, and services.	**A**
2.	Leaders are able to describe how data and information are used to create a culture of safety and quality.	**A**
3.	The organization uses processes to support systematic data and information use.	**A**
4.	Leaders provide the resources needed for data and information use, including staff, equipment, and information systems.	**A**
5.	The organization uses data and information in decision making that supports the safety and quality of care, treatment, and services. (See also PI.02.01.01, EP 8)	**A**
6.	The organization uses data and information to identify and respond to internal and external changes in the environment.	**A**
7.	Leaders evaluate how effectively data and information are used throughout the organization.	**A**

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Standard LD.03.03.01

Leaders use organization-wide planning to establish structures and processes that focus on safety and quality.

Rationale for LD.03.03.01

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

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

Elements of Performance for LD.03.03.01

1.	Planning activities focus on improving resident safety and health care quality.		A
2.	Leaders can describe how planning supports a culture of safety and quality.		A
3.	Planning is systematic, and it involves designated individuals and information sources.		A
4.	Leaders provide the resources needed to support the safety and quality of care, treatment, and services.	(3)	A
5.	Safety and quality planning is organization-wide.		A
6.	Planning activities adapt to changes in the environment.		A
7.	Leaders evaluate the effectiveness of planning activities.		A

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Standard LD.03.04.01

The organization communicates information related to safety and quality to those who need it, including staff, residents, families, and external interested parties.

Rationale for LD.03.04.01

Effective communication is essential among individuals and groups within the organization, and between the organization and external parties. Poor communication often contributes to adverse events and can compromise safety and quality of care, treatment, and services. Effective communication is timely, accurate, and usable by the audience.

Elements of Performance for LD.03.04.01

1.	Communication processes foster the safety of the resident and the quality of care.	**A**
2.	Leaders are able to describe how communication supports a culture of safety and quality.	**A**
3.	Communication is designed to meet the needs of internal and external users.	**A**
4.	Leaders provide the resources required for communication, based on the needs of residents, staff, and administration.	**A**
5.	Communication supports safety and quality throughout the organization. (See also LD.04.04.05, EPs 6 and 12)	**A**
6.	When changes in the environment occur, the organization communicates those changes effectively.	**A**
7.	Leaders evaluate the effectiveness of communication methods.	**A**

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Standard LD.03.05.01

Leaders implement changes in existing processes to improve the performance of the organization.

Rationale for LD.03.05.01

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

Elements of Performance for LD.03.05.01

1.	Structures for managing change and performance improvements exist that foster the safety of the resident and the quality of care, treatment, and services.	**A**
2.	Leaders are able to describe how the organization's approach to performance improvement and its capacity for change support a culture of safety and quality.	**A**
3.	The organization has a systematic approach to change and performance improvement.	**A**
4.	Leaders provide the resources required for performance improvement and change management, including sufficient staff, access to information, and training.	**A**
5.	The management of change and performance improvement supports both safety and quality throughout the organization.	**A**
6.	The organization's internal structures can adapt to changes in the environment.	**A**
7.	Leaders evaluate the effectiveness of processes for the management of change and performance improvement.	**A**

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Standard LD.03.06.01

Those who work in the organization are focused on improving safety and quality.

Rationale for LD.03.06.01

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

Elements of Performance for LD.03.06.01

1. Leaders design work processes to focus individuals on safety and quality issues. **A**
2. Leaders are able to describe how those who work in the organization support a culture of safety and quality. **A**
3. Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. (3) **A**
4. Those who work in the organization are competent to complete their assigned responsibilities. (3) **A**
5. Those who work in the organization adapt to changes in the environment. **A**
6. Leaders evaluate the effectiveness of those who work in the organization to promote safety and quality. **A**

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Standard LD.04.01.01

The organization complies with law and regulation.

Elements of Performance for LD.04.01.01

1. (D) The organization is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, and services for which the organization is seeking accreditation from The Joint Commission. (2) A
Note 1: Applicable law and regulation include, but are not limited to, individual and facility licensure, certification, Food and Drug Administration regulations, Drug Enforcement Agency regulations, Centers for Medicare & Medicaid Services regulations, Occupational Safety and Health Administration regulations, Department of Transportation regulations, Health Insurance Portability and Accountability Act, and other local, state, and federal laws and regulations.
Note 2: Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state law.
Footnote: For more information on how to obtain a CLIA certificate, see http://www.cms.hhs.gov/CLIA/downloads/HowObtainCLIACertificate.pdf. (See also WT.01.01.01, EP 1; WT.04.01.01, EP 1)
2. The organization provides care, treatment, and services in accordance with licensure requirements, laws, and rules and regulations. A
3. Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies. A

Standard LD.04.01.07

The organization has policies and procedures that guide and support resident care, treatment, and services.

Elements of Performance for LD.04.01.07

1. Leaders review and approve policies and procedures that guide and support resident care, treatment, and services. A
2. (M) The organization manages the implementation of policies and procedures. C

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Standard LD.04.02.03

Ethical principles guide the organization's business practices.

Elements of Performance for LD.04.02.03

1.	The organization has a process that allows staff, residents, and families to address ethical issues or issues prone to conflict.	A
2.	The organization uses its process to address ethical issues or issues prone to conflict.	A
3.	The organization follows ethical practices for marketing and billing.	A
4. (D)	Marketing materials accurately represent the organization and address the care, treatment, and services that the organization provides either directly or by contractual arrangement.	A
5.	Care, treatment, and services are provided based on resident needs, regardless of compensation or financial risk-sharing with those who work in the organization, including staff and licensed independent practitioners.	A
6.	When leaders excuse staff members from a job responsibility, care, treatment, and services are not affected in a negative way.	A
7.	Residents receive information about charges for which they will be responsible.	A
8.	Residents are informed whenever services, charges, or coverage change.	A

Standard LD.04.02.05

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

Rationale for LD.04.02.05

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

Elements of Performance for LD.04.02.05

2.	The safety and quality of care, treatment, and services do not depend on the resident's ability to pay.	A

KEY: **A** indicates scoring category A; **C** indicates scoring category C; (situational icon) indicates situational decision rules apply; (direct impact icon) indicates direct impact requirements apply; (M) indicates Measure of Success if needed; (D) indicates that documentation is required

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Standard LD.04.03.09

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

Elements of Performance for LD.04.03.09

1. Clinical leaders have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement. **A**

2. (D) The organization describes, in writing, the nature and scope of services provided through contractual agreements. **A**

3. (D) Designated leaders approve contractual agreements. **A**

4. Leaders monitor contracted services by establishing expectations for the performance of the contracted services. **A**
Note: When the organization contracts with another accredited organization for resident care, treatment, and services to be provided off site, it can do the following:
- Verify that all licensed independent practitioners who will be providing resident care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.
- Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their privileges.

5. (D) Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. **A**
Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it.

6. Leaders monitor contracted services by evaluating these services in relation to the organization's expectations. **A**

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

8. When contractual agreements are renegotiated or terminated, the organization maintains the continuity of resident care. (3) **A**

10. (D) Reference and contract laboratory services meet the federal regulations for clinical laboratories and maintain evidence of the same. **A**

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Standard LD.04.04.01

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

Elements of Performance for LD.04.04.01

1.	Leaders set priorities for performance improvement activities and resident health outcomes. (See also PI.01.01.01, EPs 1 and 3)	A
2.	Leaders give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities. (See also PI.01.01.01, EPs 9, 12, 14, 15)	A
3.	Leaders reprioritize performance improvement activities in response to changes in the internal or external environment.	A
4.	Performance improvement occurs organization-wide.	A

Standard LD.04.04.03

New or modified services or processes are well designed.

Elements of Performance for LD.04.04.03

1.	The organization's design of new or modified services or processes incorporates the needs of residents, staff, and others.	A
2.	The organization's design of new or modified services or processes incorporates the results of performance improvement activities.	A
3.	The organization's design of new or modified services or processes incorporates information about potential risks to residents. (See also LD.04.04.05, EPs 6, 10-11) Note: A proactive risk assessment is one of several ways to assess potential risks to residents. For suggested components, refer to the Proactive Risk Assessment section at the beginning of this chapter.	A
4.	The organization's design of new or modified services or processes incorporates evidence-based information in the decision-making process. Note: For example, evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards.	A
5.	The organization's design of new or modified services or processes incorporates information about sentinel events.	A
6.	The organization tests and analyzes its design of new or modified services or processes to determine whether the proposed design or modification is an improvement.	A
7.	Leaders involve staff and residents in the design of new or modified services or processes.	A

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Standard LD.04.04.05

The organization has an organization-wide, integrated resident safety program.

Elements of Performance for LD.04.04.05

1. The organization implements an organization-wide resident safety program. **A**
2. One or more qualified individuals or an interdisciplinary group manages the safety program. **A**
3. The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events. **A**
4. All departments, programs, and services within the organization participate in the safety program. **A**
5. As part of the safety program, the organization creates procedures for responding to system or process failures. **A**
   Note: Responses might include continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.
6. The organization provides and encourages the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. (See also LD.03.01.01, EP 8; LD.03.04.01, EP 5; LD.04.04.03, EP 3) **A**
7. The organization defines “sentinel event” and communicates this definition throughout the organization. **A**
   Note: At a minimum, the organization's definition includes those events subject to review in the "Sentinel Events" (SE) chapter of this manual. The definition may include any process variation that does not affect the outcome or result in an adverse event, but for which a recurrence carries significant chance of a serious adverse outcome or result in an adverse event, often referred to as a near miss.
8. The organization conducts thorough and credible root cause analyses in response to sentinel events as described in the "Sentinel Events" (SE) chapter of this manual. (3) **A**
9. The organization makes support systems available for staff who have been involved in an adverse or sentinel event. **A**
   Note: Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals.
10. At least every 18 months, the organization selects one high-risk process and conducts a proactive risk assessment. (See also LD.04.04.03, EP 3) **A**
    Note: For suggested components, refer to the Proactive Risk Assessment section at the beginning of this chapter.
11. To improve safety, the organization analyzes and uses information about system or process failures and the results of proactive risk assessments. (See also LD.04.04.03, EP 3) **A**
12. The organization disseminates lessons learned from root cause analyses, system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation. (See also LD.03.04.01, EP 5) **A**

KEY: A indicates scoring category A; C indicates scoring category C; (2) indicates situational decision rules apply; (3) indicates direct impact requirements apply; (M) indicates Measure of Success if needed; (D) indicates that documentation is required

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13. Ⓓ At least once a year, the organization provides governance with written reports on the following: **A**
- All system or process failures
- The number and type of sentinel events
- Whether the residents and the families were informed of the event
- All actions taken to improve safety, both proactively and in response to actual occurrences

14. The organization encourages external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs. **A**
Note: Examples of voluntary programs include The Joint Commission Sentinel Event Database and the U.S. Food and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated.

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Medication Management

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Standard MM.01.02.01

The organization addresses the safe use of look-alike/sound-alike medications.

Elements of Performance for MM.01.02.01

1. (D) The organization develops a list of look-alike/sound-alike medications it stores, dispenses, or administers. Note: One source of look-alike/sound-alike medications is The Institute for Safe Medication Practices (http://www.ismp.org/Tools/confuseddrugnames.pdf). **A**
2. The organization takes action to prevent errors involving the interchange of the medications on its list of look-alike/sound-alike medications. **A**
3. The organization annually reviews and, as necessary, revises its list of look-alike/sound-alike medications. (3) **A**

Standard MM.08.01.01

The organization evaluates the effectiveness of its medication management system.

Elements of Performance for MM.08.01.01

1. The organization collects data on the performance of its medication management system. (See also PI.01.01.01, EPs 14 and 15) **A**
2. The organization analyzes data on its medication management system. **A**
3. The organization compares data over time to identify risk points, levels of performance, patterns, trends, and variations of its medication management system. **A**

5. Based on analysis of its data, as well as review of the literature for new technologies and best practices, the organization, in collaboration with its primary pharmacy, identifies opportunities for improvement in its medication management system. **A**

7. The organization evaluates its actions to confirm that they resulted in improvements for its medication management system. **A**
8. The organization takes action when planned improvements for its medication management processes are either not achieved or not sustained. **A**

KEY: A indicates scoring category A; C indicates scoring category C; (2) indicates situational decision rules apply; (3) indicates direct impact requirements apply; (M) indicates Measure of Success if needed; (D) indicates that documentation is required

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National Patient Safety Goals

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NPSG.01.01.01

Use at least two resident identifiers when providing care, treatment, and services.
Note: At the first encounter, the requirement for two identifiers is appropriate; thereafter, and in any situation of continuing one-on-one care in which the clinician knows the resident, one identifier can be facial recognition.

Rationale for NPSG.01.01.01

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

Elements of Performance for NPSG.01.01.01

1. Use at least two resident identifiers when administering medications; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The resident's room number or physical location is not used as an identifier. **C**

2. Label containers used for blood and other specimens in the presence of the resident. **A**

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NPSG.03.05.01

Reduce the likelihood of resident harm associated with the use of anticoagulant therapy.
Note: This requirement applies only to organizations that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the resident's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the resident's laboratory values for coagulation will remain within, or close to, normal values.

Rationale for NPSG.03.05.01

Anticoagulation therapy can be used as therapeutic treatment for a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant. However, it is important to note that anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent resident compliance. This National Patient Safety Goal has great potential to positively impact the safety of residents on this class of medications and result in better outcomes.

To achieve better resident outcomes, resident education is a vital component of an anticoagulation therapy program. Effective anticoagulation resident education includes face-to-face interaction with a trained professional who works closely with residents to be sure that they understand the risks involved with anticoagulation therapy, the precautions they need to take, and the need for regular International Normalized Ratio (INR) monitoring. The use of standardized practices for anticoagulation therapy that include resident involvement can reduce the risk of adverse drug events associated with heparin (unfractionated), low molecular weight heparin, and warfarin.

Elements of Performance for NPSG.03.05.01

	#	Element		Category
	1.	Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available. Note: For pediatric residents, prefilled syringe products should be used only if specifically designed for children.	(3)	A
(M)	2.	Use approved protocols for the initiation and maintenance of anticoagulant therapy.	(3)	C
	3.	Before starting a resident on warfarin, assess the resident's baseline coagulation status; for all residents receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the clinical record.	(3)	A
	4.	Use authoritative resources to manage potential food and drug interactions for residents receiving warfarin.	(3)	A
	5.	When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing.	(3)	A
	6. (D)	A written policy addresses baseline and ongoing laboratory tests that are required for heparin and low molecular weight heparin therapies.	(3)	A

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7. Provide education regarding anticoagulant therapy to staff, residents, and families. Resident/family education includes the following:
- The importance of follow-up monitoring
- Compliance
- Drug-food interactions
- The potential for adverse drug reactions and interactions

C

8. Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization. **A**

NPSG.07.01.01

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

Rationale for NPSG.07.01.01

Compliance with the WHO or CDC hand hygiene guidelines will reduce the transmission by staff to residents of infectious agents, thereby decreasing the incidence of health care–associated infections.

Elements of Performance for NPSG.07.01.01

1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines. **A**
2. Set goals for improving compliance with hand hygiene guidelines. **A**
3. Improve compliance with hand hygiene guidelines based on established goals. **A**

NPSG.07.04.01

Implement evidence-based practices to prevent central line–associated bloodstream infections.
Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

Elements of Performance for NPSG.07.04.01

1. Educate staff and licensed independent practitioners who are involved in managing central lines about central line–associated bloodstream infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in these procedures is added to an individual's job responsibilities. **C**

12. Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports. **C**

13. Evaluate all central venous catheters routinely and remove nonessential catheters. **C**

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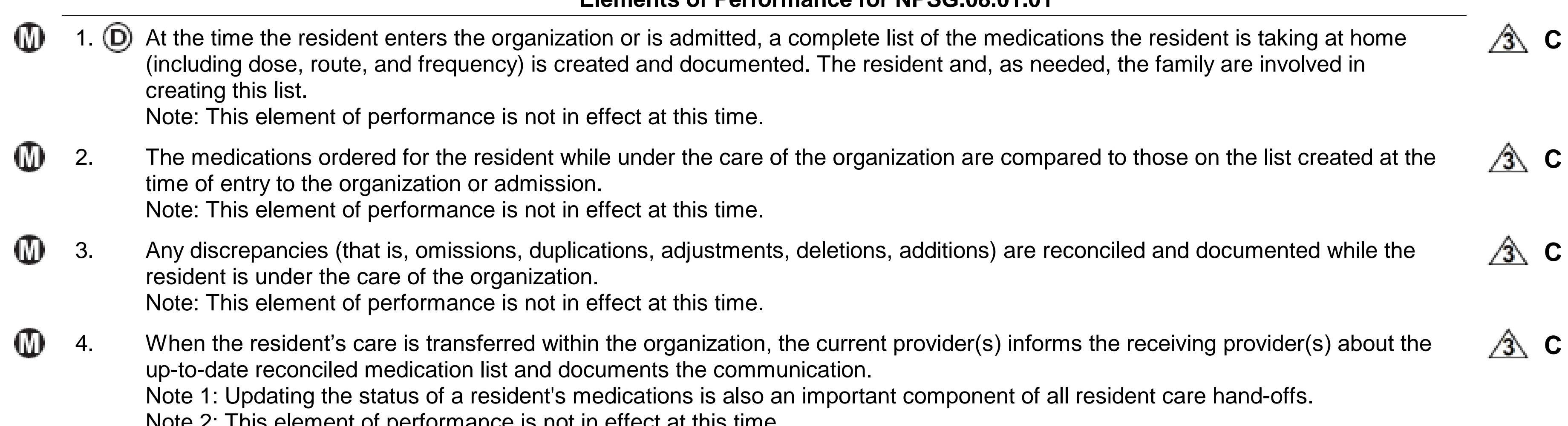
NPSG.08.01.01

A process exists for comparing the resident’s current medications with those ordered for the resident while under the care of the organization.
Note: This standard is not in effect at this time.

Rationale for NPSG.08.01.01

Residents are at high risk for harm from adverse drug events when communication about medications is not clear. The chance for communication errors increases whenever individuals involved in a resident’s care change. Communicating about the medication list, making sure it is accurate, and reconciling any discrepancies whenever new medications are ordered or current medications are adjusted are essential to reducing the risk of transition-related adverse drug events.



Elements of Performance for NPSG.08.01.01

(M) 1. (D) At the time the resident enters the organization or is admitted, a complete list of the medications the resident is taking at home (including dose, route, and frequency) is created and documented. The resident and, as needed, the family are involved in creating this list.
Note: This element of performance is not in effect at this time. (3) C

(M) 2. The medications ordered for the resident while under the care of the organization are compared to those on the list created at the time of entry to the organization or admission.
Note: This element of performance is not in effect at this time. (3) C

(M) 3. Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the resident is under the care of the organization.
Note: This element of performance is not in effect at this time. (3) C

(M) 4. When the resident’s care is transferred within the organization, the current provider(s) informs the receiving provider(s) about the up-to-date reconciled medication list and documents the communication.
Note 1: Updating the status of a resident's medications is also an important component of all resident care hand-offs.
Note 2: This element of performance is not in effect at this time. (3) C

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NPSG.08.02.01

When a resident is referred to or transferred from one organization to another, the complete and reconciled list of medications is communicated to the next provider of service, and the communication is documented. Alternatively, when a resident leaves the organization's care to go directly to his or her home, the complete and reconciled list of medications is provided to the resident's known primary care provider, the original referring provider, or a known next provider of service.
Note 1: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the resident and, as needed, the family the list of reconciled medications is sufficient.
Note 2: This standard is not in effect at this time.

Rationale for NPSG.08.02.01

The accurate communication of a resident's reconciled medication list to the next provider of service reduces the risk of transition-related adverse drug events. The communication enables the next provider of service to receive thorough knowledge of the resident's medications and to safely order/prescribe other medications that may be needed. This communication is especially important at transitions in care when a resident is referred or transferred from one organization to another.

Elements of Performance for NPSG.08.02.01

1. The resident's most current reconciled medication list is communicated to the next provider of service, either within or outside the organization. The communication between providers is documented.
Note: This element of performance is not in effect at this time. **C**

2. At the time of transfer, the transferring organization informs the next provider of service how to obtain clarification on the list of reconciled medications.
Note: This element of performance is not in effect at this time. **C**

NPSG.08.03.01

When a resident leaves the organization's care, a complete and reconciled list of the resident's medications is provided directly to the resident and, as needed, the family, and the list is explained to the resident and/or family.
Note: This standard is not in effect at this time.

Rationale for NPSG.08.03.01

The accurate communication of the resident's medication list to the resident and, as needed, the family, reduces the risk of transition-related adverse drug events. A thorough knowledge of the resident's medications is essential for the resident's primary care provider or next provider of service to manage the subsequent stages of care for the resident.

Elements of Performance for NPSG.08.03.01

1. (D) When the resident leaves the organization's care, the current list of reconciled medications is provided and explained to the resident and, as needed, the family. This interaction is documented.
Note 1: Residents and families are reminded to discard old lists and to update any records with all medication providers or retail pharmacies.
Note 2: This element of performance is not in effect at this time. **C**

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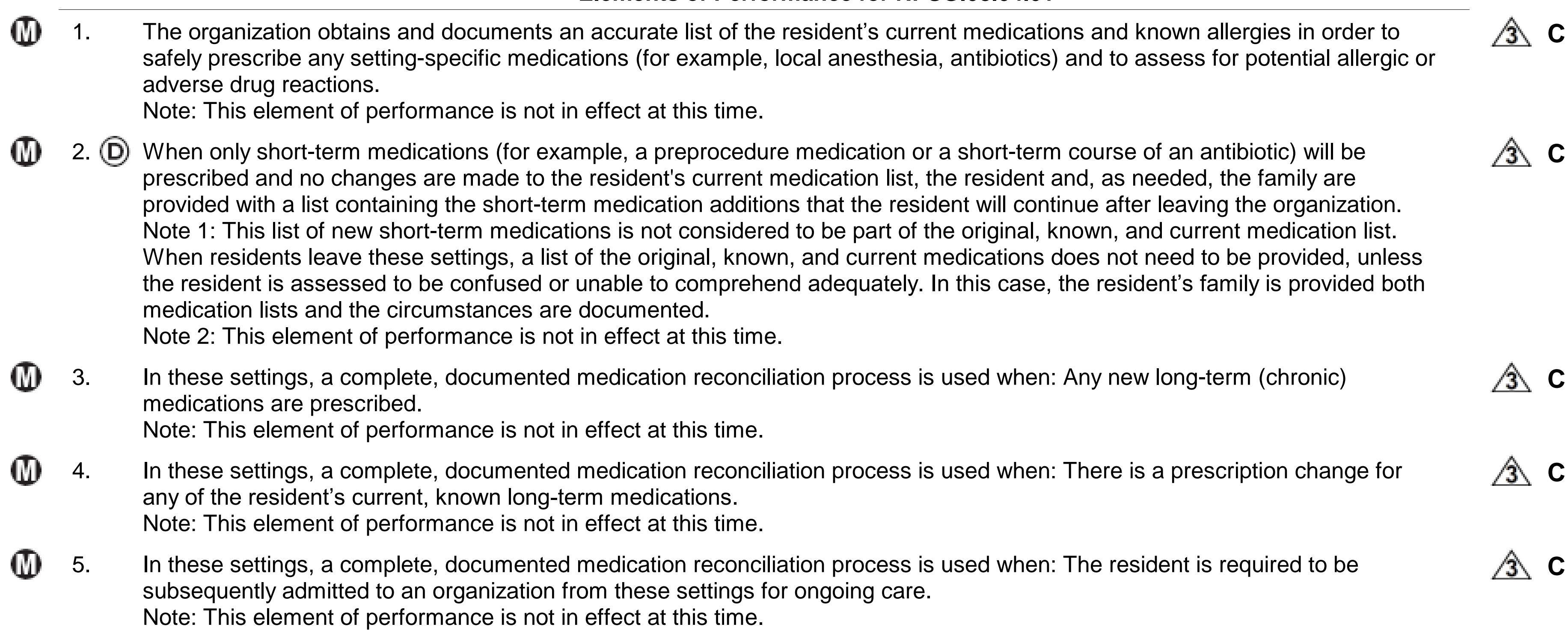
NPSG.08.04.01

In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed.
Note 1: This requirement does not apply to organizations that do not administer medications. It may be important for health care organizations to know which types of medications their residents are taking because these medications could affect the care, treatment, and services provided.
Note 2: This standard is not in effect at this time.

Rationale for NPSG.08.04.01

A number of resident care settings exist in which medications are not used, are used minimally, or are prescribed for only a short duration. This includes areas such as the emergency department, urgent and emergent care, convenient care, office-based surgery, outpatient radiology, ambulatory care, and behavioral health care. In these settings, obtaining a list of the resident's original, known, and current medications that he or she is taking at home is still important; however, obtaining information on the dose, route, and frequency of use is not required.



Elements of Performance for NPSG.08.04.01

(M) 1. The organization obtains and documents an accurate list of the resident's current medications and known allergies in order to safely prescribe any setting-specific medications (for example, local anesthesia, antibiotics) and to assess for potential allergic or adverse drug reactions.
Note: This element of performance is not in effect at this time. (3) C

(M) 2. (D) When only short-term medications (for example, a preprocedure medication or a short-term course of an antibiotic) will be prescribed and no changes are made to the resident's current medication list, the resident and, as needed, the family are provided with a list containing the short-term medication additions that the resident will continue after leaving the organization.
Note 1: This list of new short-term medications is not considered to be part of the original, known, and current medication list. When residents leave these settings, a list of the original, known, and current medications does not need to be provided, unless the resident is assessed to be confused or unable to comprehend adequately. In this case, the resident's family is provided both medication lists and the circumstances are documented.
Note 2: This element of performance is not in effect at this time. (3) C

(M) 3. In these settings, a complete, documented medication reconciliation process is used when: Any new long-term (chronic) medications are prescribed.
Note: This element of performance is not in effect at this time. (3) C

(M) 4. In these settings, a complete, documented medication reconciliation process is used when: There is a prescription change for any of the resident's current, known long-term medications.
Note: This element of performance is not in effect at this time. (3) C

(M) 5. In these settings, a complete, documented medication reconciliation process is used when: The resident is required to be subsequently admitted to an organization from these settings for ongoing care.
Note: This element of performance is not in effect at this time. (3) C

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6. When a complete, documented, medication reconciliation is required in any of these settings, the complete list of reconciled medications is provided to the resident, and their family as needed, and to the resident's known primary care provider or original referring provider or a known next provider of service.
Note: This element of performance is not in effect at this time. **C**

NPSG.09.02.01

Reduce the risk of falls.

Rationale for NPSG.09.02.01

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

Elements of Performance for NPSG.09.02.01

1. Assess the resident's risk for falls. **C**

2. Implement interventions to reduce falls based on the resident's assessed risk. **A**

3. Educate staff on the fall reduction program in time frames determined by the organization. **C**

4. Educate the resident and, as needed, the family on any individualized fall reduction strategies. **C**

5. Evaluate the effectiveness of all fall reduction activities, including assessment, interventions, and education.
Note: Examples of outcome indicators to use in the evaluation include decreased number of falls and decreased number and severity of fall-related injuries. **A**

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NPSG.14.01.01

Assess and periodically reassess each resident's risk for developing a pressure ulcer and take action to address any identified risks.

Rationale for NPSG.14.01.01

Pressure ulcers (decubiti) continue to be problematic in all heath care settings. Most pressure ulcers can be prevented, and deterioration at Stage I can be halted. The use of clinical practice guidelines can effectively identify residents and define early intervention for prevention of pressure ulcers.

Elements of Performance for NPSG.14.01.01

	#	Element		Category
	1. (D)	Create a written plan for the identification of risk for and prevention of pressure ulcers.		**A**
(M)	2.	Perform an initial assessment at admission to identify residents at risk for pressure ulcers.	(3)	**C**
(M)	3.	Conduct a systematic risk assessment for pressure ulcers using a validated risk assessment tool such as the Braden Scale or Norton Scale.	(3)	**C**
(M)	4.	Reassess pressure ulcer risk at intervals defined by the organization.	(3)	**C**
(M)	5.	Take action to address any identified risks to the resident for pressure ulcers, including the following: - Preventing injury to residents by maintaining and improving tissue tolerance to pressure in order to prevent injury - Protecting against the adverse effects of external mechanical forces	(3)	**C**
	6.	Educate staff on how to identify risk for and prevent pressure ulcers.		**A**

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Provision of Care, Treatment, and Services

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Standard PC.01.02.07

The organization assesses and manages the resident's pain.

Rationale for PC.01.02.07

The identification and treatment of pain is an important component of the plan of care. Residents can expect that their health care providers will ask them about whether they have pain. When pain is identified the resident is assessed based on his or her clinical condition or symptoms and in accordance with the care, treatment, and services provided by the organization.

Elements of Performance for PC.01.02.07

	#	Element		
M	1.	The organization conducts a comprehensive pain assessment of the resident that is consistent with the resident's condition.	3	C
M	2.	The organization uses methods to assess pain that are consistent with the resident’s age, condition, and cognitive ability.		C
M	3.	The organization reassesses the resident’s pain, based on its reassessment criteria.	3	C
M	4.	The organization either treats the resident’s pain or refers the resident for treatment.	3	C

Standard PC.02.01.03

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

Elements of Performance for PC.02.01.03

	#	Element		
M	20.	Before taking action on a verbal order or verbal report of a test result, staff uses a record and "read back" process to verify the information.		C

Standard PC.02.02.01

The organization coordinates the resident's care, treatment, and sevices based on the resident's needs.

Elements of Performance for PC.02.02.01

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

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Standard PC.02.03.01

The organization provides resident education and training based on each resident's needs and abilities.

Elements of Performance for PC.02.03.01

	EP	Requirement	Category
(M)	1.	The organization performs a learning needs assessment for each resident. This assessment includes the resident's cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.	C
(M)	10.	Based on the resident's assessed needs, the education and training provided to the resident by the organization include, but are not limited to, the following: - Education regarding his or her illness - An explanation of the plan for care, treatment, and services - Basic health practices and safety - Information on the safe and effective use of medications - Nutrition interventions (for example, supplements) and modified diets - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management - Information on oral health - Information on the safe and effective use of medical and nonmedical equipment or supplies provided by the organization - Habilitation or rehabilitation techniques to help the resident reach maximum independence - Physical risks within the environment of care	C
(M)	27.	The organization provides the resident education on how to communicate concerns about resident safety issues that occur before, during, and after care is received.	C

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Performance Improvement

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Standard PI.01.01.01

The organization collects data to monitor its performance.

Elements of Performance for PI.01.01.01

	EP	Element	Category
	1.	The leaders set priorities for data collection. (See also LD.04.04.01, EP 1)	A
	2.	The organization identifies the frequency for data collection.	A
M	3.	The organization collects data on the following: Performance improvement priorities identified by leaders. (See also LD.04.04.01, EP 1)	C
	9.	The organization collects data on the following: The use of restraints. (See also LD.04.04.01, EP 2)	A
	12.	The organization collects data on the following: Behavior management and treatment. (See also LD.04.04.01, EP 2)	A
	13.	The organization collects data on the following: Quality control activities. Note: Examples of topics for quality control activities include the delivery and content of food trays and laundry services.	A
	14.	The organization collects data on the following: Significant medication errors. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)	A
	15.	The organization collects data on the following: Significant adverse drug reactions. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)	A
M	16.	The organization collects data on the following: Resident (and, as needed, the family) perception of the safety and quality of care, treatment, and services.	C
	30.	The organization considers collecting data on the following: - Staff opinions and needs - Staff perceptions of risk to individuals - Staff suggestions for improving resident safety - Staff willingness to report adverse events Note: If the organization has not collected data on this topic, consideration can be demonstrated through methods such as interviews or meeting minutes.	A

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Standard PI.02.01.01

The organization compiles and analyzes data.

Elements of Performance for PI.02.01.01

(M)	1.	The organization compiles data into formats that enable them to be analyzed.	C
	2.	The organization identifies the frequency for data analysis.	A
(M)	3.	The organization uses statistical tools and techniques to analyze and display data.	C
	4.	The organization analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.	A
	5.	The organization compares data with external sources, when available.	A
	8.	The organization uses the results of data analysis to identify improvement opportunities. (See also LD.03.02.01, EP 5; PI.03.01.01, EP 1)	A

Standard PI.03.01.01

The organization improves performance.

Elements of Performance for PI.03.01.01

1.	Leaders prioritize the identified improvement opportunities. (See also PI.02.01.01, EP 8)	A
2.	The organization takes action on improvement priorities.	A
3.	The organization evaluates whether action(s) taken resulted in improvement.	A
4.	The organization takes action when it does not achieve or sustain planned improvements.	A

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Standard PI.04.01.01

The organization uses clinical/service and human resource indicators to assess the effectiveness of staff in meeting resident needs.
Note: This standard is not in effect at this time.

Elements of Performance for PI.04.01.01

1. The organization identifies two or more inpatient populations/settings for which data on staffing effectiveness are to be collected.
Note: This element of performance is not in effect at this time. **A**

2. The organization identifies the inpatient populations/settings for staffing effectiveness data collection based on an assessment of relevant information or risk including the following: **A**
- Type of setting
- Resident population served
- Knowledge about staffing issues likely to affect resident safety or quality of care
- Existing data (for example, incident logs, sentinel event data, performance improvement reports)
- Input from clinical staff who provide resident care
Note 1: If the organization has only one population/setting, it need not apply these criteria.
Note 2: This element of performance is not in effect at this time.

3. A minimum set of four indicators is selected for each of the identified inpatient populations/settings. **A**
Note 1: Organizations may choose the same set, the same set in part, or completely different measure sets for each identified population/setting.
Note 2: This element of performance is not in effect at this time.

4. Of the four indicators required for each population/setting, two must be clinical/service indicators and two must be human resource indicators. **A**
Note: This element of performance is not in effect at this time.

5. One of the human resource indicators and one of the clinical/service indicators for each population/setting must be selected from The Joint Commission's list of approved indicators. (Refer to the "Staffing Effectiveness Indicators" (SEI) chapter.) **A**
Note 1: Additional indicators may be selected from among the organization's own indicators.
Note 2: The Joint Commission's list of approved screening indicators consists of National Quality Forum (NQF)–endorsed voluntary consensus standards for nursing home care and Joint Commission consensus measures.
Note 3: This element of performance is not in effect at this time.

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6. The organization selects the indicators for each population/setting based on an assessment of relevant information or risk including the following: **A**
- Type of setting
- Resident population served
- Knowledge about staffing issues likely to affect resident safety or quality of care
- Existing data (for example, incident logs, sentinel event data, performance improvement reports)
- Input from clinical staff who provide resident care

Note: This element of performance is not in effect at this time.

7. The human resource indicators for all identified populations/settings include all nursing staff (including registered nurses, licensed practical nurses, and nursing assistants or aides). **A**
Note 1: Decisions regarding stratification of data by discipline are left to the organization. When the organization chooses to include other practitioner groups in addition to nursing staff, this decision is based on the impact such care/service providers have on resident outcomes.
Note 2: This element of performance is not in effect at this time.

8. When the organization chooses indicators for staffing effectiveness, it performs the following: **A**
- Defines the numerator and denominator
- Standardizes the data element definitions for each indicator, including those indicators applied in more than one setting
- Determines acceptable ranges, parameters, or trigger levels

Note 1: Acceptable ranges, parameters, or trigger levels may be reflective of past performance, expert opinion, expert literature, or a combination of these. The ranges, parameters, or trigger levels should be reasonable goals that are possible to attain. When desired ranges, parameters, or trigger levels are not met, an investigation into the cause(s) is needed.
Note 2: This element of performance is not in effect at this time.

9. For each inpatient population/setting selected the organization analyzes the collected data for all indicators, investigates to identify any staffing effectiveness issues when data varies from expected, and takes action to improve. **A**
Note: This element of performance is not in effect at this time.

10. The organization reports to the leaders at least annually on the status of staffing effectiveness and any actions taken to resolve identified problems. **A**
Note: This element of performance is not in effect at this time.

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Standard RC.02.01.21

Clinical record documentation includes resident education.

Elements of Performance for RC.02.01.21

(M)	1.	The provision of resident education is documented in the clinical record.	**C**
(M)	2.	The resident's response to education is documented in the clinical record.	**C**

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Waived Testing

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Standard WT.01.01.01

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

Elements of Performance for WT.01.01.01

1. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate approves a consistent approach for when waived test results can be used for diagnosis and treatment and when follow-up testing is required. (See also LD.04.01.01, EP 1) — **A**

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

   Note: The designee should be knowledgeable by virtue of training, experience, and competence about the waived testing performed.

3. (D) If manufacturers' manuals or package inserts are used as the policies or procedures for each waived test, they are enhanced to include specific operational policies (that is, detailed quality control protocols and any other institution-specific procedures regarding the test or instrument). — **A**

4. (D) The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, approves in writing policies and procedures for waived testing at the following times: — **A**
   - Before initial use of the test for resident testing
   - Periodically thereafter, as defined by the person whose name appears on the CLIA certificate but at least once every three years
   - When changes in procedures occur (for example, when manufacturers' updates to package inserts include procedural changes or when a different manufacturer is used)

5. Current and complete policies and procedures are available for use during testing to the person performing the waived test. — **A**

6. (M) Written policies, procedures, and manufacturers' instructions for waived testing are followed. (See also WT.04.01.01, EPs 3-5) — (3) **C**

   Note: Manufacturers' recommendations and suggestions are surveyed as requirements.

KEY: A indicates scoring category A; C indicates scoring category C; (2) indicates situational decision rules apply; (3) indicates direct impact requirements apply; (M) indicates Measure of Success if needed; (D) indicates that documentation is required

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7. The criteria for confirmatory testing are followed as specified in the waived testing written procedures. C

8. Clinical use of results is consistent with the organization's policies and the manufacturers' recommendations for waived tests. C

Standard WT.02.01.01

The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate identifies the staff responsible for performing and supervising waived testing.
Note 1: Responsible staff may be employees of the organization, contracted staff, or employees of a contracted service.
Note 2: Responsible staff may be identified within job descriptions or by listing job titles or individual names.

Elements of Performance for WT.02.01.01

1. (D) The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, identifies, in writing, the staff responsible for performing waived testing. **A**
2. (D) The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, identifies, in writing, the staff responsible for supervising waived testing. **A**

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Standard WT.03.01.01

Staff and licensed independent practitioners performing waived tests are competent.

Elements of Performance for WT.03.01.01

1. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, provides orientation and training to, and assesses the competency of, staff and licensed independent practitioners who perform waived testing. **A**

(M) 2. (D) Staff and licensed independent practitioners who perform waived testing have received orientation in accordance with the organization's specific services. The orientation for waived testing is documented. **C**

(M) 3. (D) Staff and licensed independent practitioners who perform waived testing have been trained for each test that they are authorized to perform. The training for each waived test is documented. **C**

(M) 4. (D) Staff and licensed independent practitioners who perform waived testing that requires the use of an instrument have been trained on its use and operator maintenance. The training on the use and operator maintenance of an instrument for waived testing is documented. **C**

5. Competency for waived testing is assessed using at least two of the following methods per person per test: (3) **A**
- Performance of a test on a blind specimen
- Periodic observation of routine work by the supervisor or qualified designee
- Monitoring of each user's quality control performance
- Use of a written test specific to the test assessed

(M) 6. (D) Competence for waived testing is assessed according to organization policy at defined intervals, but at least at the time of orientation and annually thereafter. This competency is documented. **C**
Note: Provider-performed microscopy (PPM) procedures are not waived tests.

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Standard WT.04.01.01

The organization performs quality control checks for waived testing on each procedure.
Note: Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.

Elements of Performance for WT.04.01.01

1. (D) The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate establishes a written quality control plan for waived testing that specifies the method(s) for controlling procedures for quality, establishes timetables, and explains the rationale for choice of procedures and timetables. (See also LD.04.01.01, EP 1) **A**

2. The documented quality control rationale for waived testing is based on the following:
   - How the test is used
   - Reagent stability
   - Manufacturers' recommendations
   - The organization's experience with the test
   - Currently accepted guidelines

   A

3. (M) For non–instrument-based waived testing, quality control checks are performed at the frequency and number of levels recommended by the manufacturer and as defined by the organization's policies. (See also WT.01.01.01, EP 6)
   Note: If these elements are not defined by the manufacturer, the organization defines the frequency and number of levels for quality control. (3) **C**

4. (M) For instrument-based waived testing, quality control checks are performed each day on each instrument used for resident testing or per manufacturers' instructions, if more stringent. (See also WT.01.01.01, EP 6)
   Note: Quality control checks are not required on an individual instrument on days when it is not used for resident testing. (3) **C**

5. For instrument-based waived testing, quality control checks require two levels of control, if commercially available. (See also WT.01.01.01, EP 6) (3) **A**

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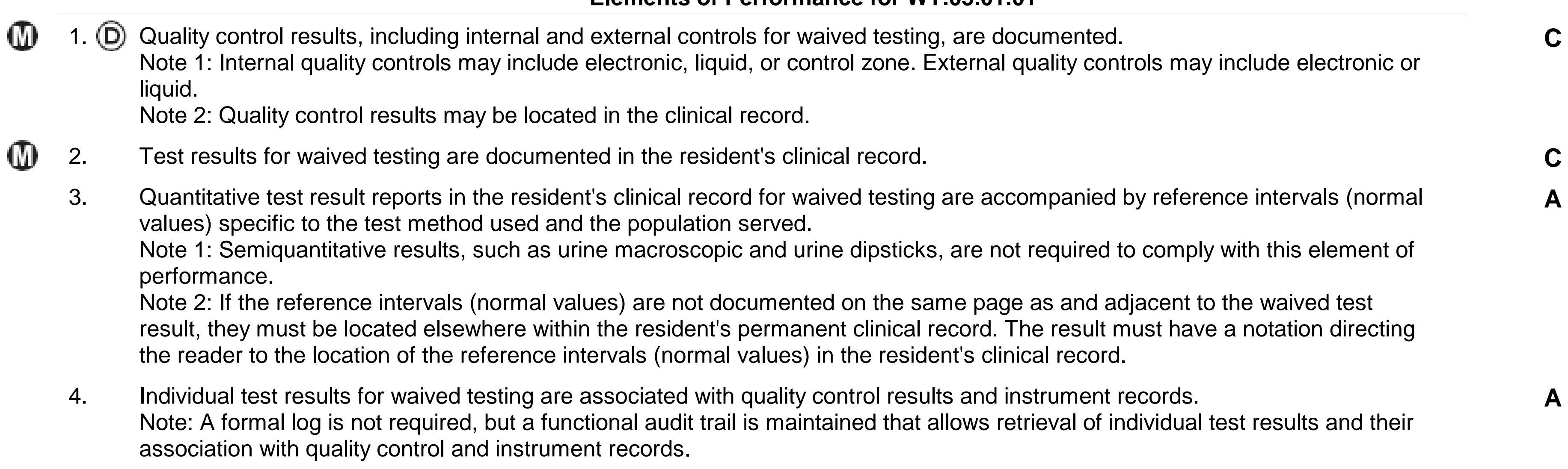
Standard WT.05.01.01

The organization maintains records for waived testing.



Elements of Performance for WT.05.01.01

		Element	Category
M	1. D	Quality control results, including internal and external controls for waived testing, are documented. Note 1: Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid. Note 2: Quality control results may be located in the clinical record.	C
M	2.	Test results for waived testing are documented in the resident's clinical record.	C
	3.	Quantitative test result reports in the resident's clinical record for waived testing are accompanied by reference intervals (normal values) specific to the test method used and the population served. Note 1: Semiquantitative results, such as urine macroscopic and urine dipsticks, are not required to comply with this element of performance. Note 2: If the reference intervals (normal values) are not documented on the same page as and adjacent to the waived test result, they must be located elsewhere within the resident's permanent clinical record. The result must have a notation directing the reader to the location of the reference intervals (normal values) in the resident's clinical record.	A
	4.	Individual test results for waived testing are associated with quality control results and instrument records. Note: A formal log is not required, but a functional audit trail is maintained that allows retrieval of individual test results and their association with quality control and instrument records.	A
	5.	Quality control result records, test result records, and instrument records for waived testing are retained for at least two years.	A

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