

Prepublication Requirements



Revisions to Eliminate Term “Licensed Independent Practitioner”

The Joint Commission has approved the following revisions for prepublication. While revised requirements are published in the semiannual updates to the print manuals (as well as in the online *E-dition*[®]), accredited organizations and paid subscribers can also view them in the monthly periodical *The Joint Commission Perspectives*[®]. To begin your subscription, call 800-746-6578 or visit <http://www.jcrinc.com>.

Please note: Where applicable, this report shows deleted language struckthrough and new language underlined.

APPLICABLE TO THE BEHAVIORAL HEALTH CARE AND HUMAN SERVICES ACCREDITATION PROGRAM

Effective January 1, 2024

Standard CTS.01.01.01

The organization accepts for care, treatment, or services only those individuals whose identified care, treatment, or service needs it can meet.

Note 1: For opioid treatment programs: If an individual eligible for treatment applies for admission to a comprehensive maintenance treatment program but cannot be placed within 14 days in a program that is within a reasonable geographic area, an opioid treatment program’s program sponsor may place the individual in interim maintenance treatment.

Note 2: For opioid treatment programs: There may be individuals in special populations who have a history of opioid use but are not currently physiologically dependent. Federal regulations waive the one-year history of addiction for these special populations, because these individuals are susceptible to relapse to opioid addiction, leading to high-risk behaviors with potentially life-threatening consequences. These populations include the following:

- Persons recently released from a penal institution
- Persons recently discharged from a chronic care facility
- Pregnant patients
- Previously treated patients

CTS.01.01.01, EP 16

For opioid treatment programs: Admission procedures include use of a central registry system (if applicable) or an alternative mechanism to prevent patients from enrolling in treatment provided by more than one clinic or ~~individual practitioner~~licensed provider.

Note: In some cases, the program may, after obtaining the patient’s consent, contact other opioid treatment programs within a reasonable geographic distance (100 miles) to verify that the patient is not enrolled in another program.

Standard CTS.02.01.03

The organization performs screenings and assessments as defined by the organization's policy.

CTS.02.01.03, EP 6

For acute 24-hour settings: A qualified, licensed ~~independent~~ practitioner is responsible for determining the degree of assessment and care for each individual treated in an emergency care area.

Note: "Acute 24-hour settings" includes inpatient crisis stabilization or ~~medical detoxification~~ medically supervised withdrawal management.

Standard CTS.02.01.05

For organizations providing care, treatment, or services in non-24-hour settings: The organization implements a written process requiring a physical health screening to determine the individual's need for a medical history and physical examination.

Note 1: This standard does not apply to traditional or treatment foster care. (For more information, refer to Standard CTS.02.04.01)

Note 2: If the organization conducts a physical examination on all individuals served, it is in compliance with this standard.

CTS.02.01.05, EP 3

For organizations providing care, treatment, or services in non-24-hour settings: The organization has a licensed practitioner qualified by the scope of their license participate in developing the data to be collected and the physical health screening process.

Standard CTS.02.01.06

For organizations providing residential care: The organization screens all individuals served to determine the individual's need for a medical history and physical examination.

Note 1: This standard does not apply to traditional or treatment foster care or emergency shelters. (For more information, refer to Standard CTS.02.04.01)

Note 2: If the organization conducts a physical examination on all individuals served, it is in compliance with this standard.

Note 3: "Residential care" includes residential settings, group home settings, and 24-hour therapeutic schools.

CTS.02.01.06, EP 2

For organizations providing residential care: A licensed practitioner qualified by the scope of the license approves the organization's screening process.

CTS.02.01.06, EP 3

For organizations providing residential care: Individuals who need a physical examination by a licensed practitioner qualified by the scope of their license are either examined in the organization or referred to an outside source. The examination is conducted within 30 calendar days after admission, or sooner if warranted by the individual's physical health needs, and in accordance with law and regulation.

CTS.02.01.06, EP 4

For organizations providing residential care: When the organization accepts a physical examination completed by a qualified licensed practitioner within the 12 months prior to the individual's admission, the organization notes any changes to the individual's physical health condition and documents it in the individual's clinical/case record. If any changes(s) to the individual's physical health condition prompts any of the screening process triggers, a new medical history and physical examination is conducted.

Standard CTS.02.01.07

The organization completes a physical health assessment, including a medical history and physical examination.

Note: This standard does not apply to traditional or treatment foster care.

CTS.02.01.07, EP 1

For inpatient crisis stabilization: A physical health examination is performed by a physician or other licensed independent practitioner within 24 hours of admission.

Note 1: Some physical health needs require completion of a physical health assessment within a shorter time frame.

Note 2: If a medical history and physical examination has been completed by a physician or other licensed independent practitioner within 30 days before admission, a legible copy of this report may be used in the clinical/case record as the physical health assessment. Changes to the condition of the individual served since completion of the history and physical are recorded at the time of admission.

CTS.02.01.07, EP 2

For organizations that conduct outdoor/wilderness experiences: A physical health examination is performed by a physician or other licensed independent practitioner within 30 days prior to participating in an outdoor/wilderness experience. (For more information on a physical health examination for a child or youth, refer to CTS.02.03.03, EP 2)

Note 1: Some physical health needs require completion of a physical health assessment within a shorter time frame.

Note 2: If a medical history and physical examination has been completed by a physician or other licensed independent practitioner within 30 days before participating in an outdoor/wilderness experience, a legible copy of this report may be used in the clinical/case record as the physical health assessment. Changes to the condition of the individual served since completion of the history and physical are recorded at the time of admission to the program.

CTS.02.01.07, EP 6

For opioid treatment programs: Based on the patient's history and physical examination, the program evaluates the possibility of various conditions (such as infectious disease, liver or pulmonary conditions, cardiac abnormalities, psychiatric problems, dermatologic sequelae of addiction, and concurrent surgical problems).

Note: This may be accomplished within the program itself, or by referring the patient to a cooperating agency or a consultant clinician/provider.

Standard CTS.02.01.09

The organization screens all individuals served for physical pain.

CTS.02.01.09, EP 2

Individuals for whom a physical pain assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment.

Note: Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect an approach centered on the individual and consider the individual's current presentation, the ~~health care~~health care licensed practitioner's clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.

Standard CTS.02.02.09

The organization has a process to provide medical histories, physical examinations, and diagnostic and laboratory tests.

CTS.02.02.09, EP 9

For opioid treatment programs: The program's ~~clinicians~~physicians and other licensed practitioners determine the ongoing drug-testing regime by analyzing individual circumstances and community drug use patterns.

Note: Testing might include, but is not limited to, opiates, benzodiazepines, barbiturates, cocaine, marijuana, methadone and its metabolites, amphetamines, and alcohol.

CTS.02.02.09, EP 13

For opioid treatment programs: ~~Clinicians~~Physicians and other licensed practitioners determine the frequency of ongoing toxicological testing by evaluating the need for testing in relation to the patient's stage in treatment.

CTS.02.02.09, EP 14

For opioid treatment programs: ~~Clinicians~~Physicians and other licensed practitioners intervene when the patient discloses illicit drug use, has a positive drug test, or is suspected of diversion of opioid medication as evidenced by a lack of opioids or related metabolites in drug toxicology tests.

Standard CTS.02.04.21

For child welfare: Resource parents providing treatment foster care services receive ongoing training, support, and supervision to maintain safe care for the individual in treatment foster care.

CTS.02.04.21, EP 5

For child welfare: A physician or other licensed ~~independent~~ practitioner with broad clinical knowledge is available to provide and coordinate care when an individual served is in treatment foster care.

Standard CTS.04.02.03

For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization provides for the health maintenance of all individuals with intellectual and developmental disabilities, including early detection and remediation of health needs.

CTS.04.02.03, EP 2

For organizations providing 24-hour care to individuals with intellectual and developmental disabilities: Weight is monitored at least quarterly, or more frequently if needed, as determined by the individual's physical health care ~~practitioner~~provider.

CTS.04.02.03, EP 4

For organizations prescribing anticonvulsant drugs to individuals with intellectual and developmental disabilities and seizure activity: Physicians or other licensed practitioners define the frequency and method of monitoring anticonvulsant drug levels. (For more information, refer to Standard MM.07.01.01)

Standard CTS.04.02.29

For organizations that provide eating disorders care, treatment, or services: The multidisciplinary care, treatment, or services team supports the continuity and provision of care, treatment, or services.

CTS.04.02.29, EP 1

For organizations that provide eating disorders care, treatment, or services: The organization has a multidisciplinary care, treatment, or services team that consists of at least the following:

- A licensed ~~clinician~~practitioner with experience and/or training in treating eating disorders
- A doctor of medicine or osteopathy with experience and/or training in treating eating disorders, either on staff or available to the team during regular hours of operation. If individuals served are under the age of 13, the MD or DO is a pediatrician. If the MD or DO is not on staff, an advanced practice nurse with experience and/or training in treating eating disorders and licensed to prescribe medications is on staff.
- A psychiatrist or clinical psychologist with experience and/or training in treating eating disorders, either on staff or available to the team 24 hours a day, 7 days a week
- A registered dietitian
- A registered nurse, unless there is an advanced practice nurse on staff

Note: The MD or DO who is part of the team does not need to be employed by the organization or on the organization's staff, but the organization does need to have an established relationship with an MD or DO who has experience or training in treating eating disorders to whom the organization can refer individuals when needed. The MD or DO could be the individual's primary care physician, if the MD or DO has experience or training in treating eating disorders.

Standard CTS.05.05.05

For organizations that use physical holding on a child or youth: Staff are trained and competent to minimize the use of physical holding of children and youth and, when use is indicated, to use physical holding safely.

Note: Requirements related to ongoing education and the continuous assessment of staff competence are addressed in the "Human Resources Management" (HRM) chapter.

CTS.05.05.05, EP 4

For organizations that use physical holding on a child or youth: The staff assigned to monitor the physical well-being of the child or youth being physically held demonstrate competence in the following:

- Recognizing signs and symptoms of breathing difficulties
- Providing hydration as needed
- Checking circulation

- Recognizing signs of any incorrect application of physical holding
 - Recognizing when to contact a medically trained licensed practitioner or emergency medical services to evaluate and/or treat the physical status of the child or youth
- (See also CTS.05.05.09, EP 4)

Standard CTS.05.06.05

For organizations that use restraint or seclusion: Staff are trained and competent to minimize the use of restraint and seclusion and, when use is indicated, to use restraint or seclusion safely.

CTS.05.06.05, EP 6

For organizations that use restraint or seclusion: Staff authorized to perform 15-minute assessments receive ongoing training and demonstrate competence in the following:

- Taking vital signs and interpreting their relevance to the physical safety of the individual in restraint or seclusion
- Note: Taking vital signs may include the use of a pulse oximeter to assess the oxygenation status of the individual in restraint or seclusion.
- Recognizing nutritional and hydration needs
 - Checking circulation and range of motion in the extremities
 - Addressing hygiene and elimination
 - Addressing physical and psychological status and comfort
 - Helping individuals meet behavior criteria for discontinuing restraint or seclusion
 - Recognizing readiness for discontinuing restraint or seclusion
 - Recognizing signs of any incorrect application of restraints
 - Recognizing when to contact a medically trained licensed independent practitioner or emergency medical services to evaluate and/or treat the physical status of the individual

CTS.05.06.05, EP 7

For organizations that use restraint or seclusion: Staff who, in the absence of a physician or other licensed independent practitioner, are authorized to initiate restraint or seclusion, and/or perform evaluations/re-evaluations of individuals in restraint or seclusion to assess their readiness for discontinuation or establish the need to secure a new order, receive training and demonstrate competence as required in Standard CTS.05.06.05, EPs 1–6.

Standard CTS.05.06.13

For organizations that use restraint or seclusion: A physician or other licensed independent practitioner orders the use of restraint or seclusion.

~~Note: This standard is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to physician assistants and advanced practice nurses to the extent recognized under state law or a state's regulatory mechanism and allowed by the organization.~~

CTS.05.06.13, EP 1

For organizations that use restraint or seclusion: All restraint and seclusion are applied and continued pursuant to an order by ~~the licensed independent practitioner who is primarily responsible for the ongoing care of the individual served,~~ or a licensed independent practitioner designee, physician or other licensed independent practitioner.

Note: Because restraint and seclusion use is limited to emergencies (in which a physician or other licensed

~~independent~~ practitioner may not be immediately available), the organization may authorize qualified, trained staff members ~~who are not licensed independent practitioners~~ to initiate restraint or seclusion before an order is obtained from ~~the~~ physician or other licensed ~~independent~~ practitioner. ~~In addition, restraint and seclusion may be ordered by licensed practitioners (for example, registered nurses, licensed social workers) if permitted by state law and by the organization.~~

CTS.05.06.13, EP 2

For organizations that use restraint or seclusion: As soon as possible, but no longer than one hour after the initiation of restraint or seclusion, qualified staff do the following:

- Notify and obtain an order (verbal or written) from the physician or other licensed ~~independent~~ practitioner
- Consult with the physician or other licensed ~~independent~~ practitioner about the physical and psychological condition of the individual served

CTS.05.06.13, EP 3

For organizations that use restraint or seclusion: The physician and other licensed ~~independent~~ practitioner does the following:

- Reviews with staff the physical and psychological status of the individual served
- Determines whether restraint or seclusion should be continued
- Supplies staff with guidance in identifying ways to help the individual regain control so that restraint or seclusion can be discontinued
- Supplies an order for restraint or seclusion

Standard CTS.05.06.17

For organizations that use restraint or seclusion: A physician or other licensed ~~independent~~ practitioner sees and evaluates the individual in restraint or seclusion in person.

CTS.05.06.17, EP 1

For organizations that use restraint or seclusion: ~~The licensed independent practitioner primarily responsible for the ongoing care, treatment, or services of the individual served, or a licensed independent practitioner designee, or other licensed independent practitioner,~~ A physician or other licensed practitioner evaluates the individual in restraint or seclusion in person within four hours of the initiation of restraint or seclusion for individuals ages 18 or older, and within two hours of initiation for children and youth ages 17 and under.

CTS.05.06.17, EP 2

For organizations that use restraint or seclusion: At the time of the in-person evaluation of the individual in restraint or seclusion, the physician or other licensed ~~independent~~ practitioner does the following:

- Works with the individual and staff to identify ways to help the individual regain control
- Revises the individual's plan for care, treatment, or services as needed
- If necessary, provides a new written order

CTS.05.06.17, EP 3

For organizations that use restraint or seclusion: The physician or other licensed ~~independent~~ practitioner evaluates the individual in restraint or seclusion in person within 24 hours of the initiation of restraint or seclusion if the individual is no longer in restraint or seclusion when an original verbal order expires.

Standard CTS.05.06.19

For organizations that use restraint or seclusion: Written and verbal orders for initial and continuing use of restraint and seclusion are time limited.

CTS.05.06.19, EP 3

For organizations that use restraint or seclusion: If restraint or seclusion use needs to continue beyond the expiration of the time-limited order, a new order for restraint or seclusion is obtained from ~~the licensed independent practitioner primarily responsible for ongoing care, treatment, or services of the individual served, or a licensed independent practitioner designee, or other licensed independent~~ a physician or other licensed practitioner.

Standard CTS.05.06.21

For organizations that use restraint or seclusion: Individuals in restraint or seclusion are regularly re-evaluated.

CTS.05.06.21, EP 1

For organizations that use restraint or seclusion: By the time the order for restraint or seclusion expires, the individual served is evaluated in person by one of the following:

- The physician or other licensed ~~independent~~ practitioner primarily responsible for the ongoing care, treatment, or services of the individual served
- A physician or other licensed ~~independent~~ practitioner designee
- Another physician or other licensed ~~independent~~ practitioner or qualified, trained individual authorized by the organization to perform this function

CTS.05.06.21, EP 2

For organizations that use restraint or seclusion: In conjunction with reevaluation of the individual in restraint or seclusion, a new written or verbal order is given by the physician or other licensed ~~independent~~ practitioner primarily responsible for the individual's ongoing care, treatment, or services, or a licensed ~~independent~~ practitioner designee, or other licensed ~~independent~~ practitioner if the restraint or seclusion is to be continued.

CTS.05.06.21, EP 3

For organizations that use restraint or seclusion: The physician or other licensed ~~independent~~ practitioner or other qualified, authorized staff member re-evaluates the efficacy of the treatment plan of the individual served and works with the individual to identify ways to help the individual regain control.

CTS.05.06.21, EP 4

For organizations that use restraint or seclusion: ~~If~~ When restraint or seclusion is continued and the physician or other licensed independent practitioner of who wrote the individual served order is not primarily responsible for the individual's ongoing care, treatment, or a licensed independent services, the practitioner designee, is not notifies the physician or other licensed ~~independent~~ practitioner who gave the order, the licensed independent practitioner is primarily responsible for the individual of the individual's status and the continuation of the individual served is notified of the individual's status if the restraint or seclusion is continued order.

CTS.05.06.21, EP 6

For organizations that use restraint or seclusion: The physician or other licensed ~~independent~~ practitioner conducts an in-person re-evaluation of the individual in restraint or seclusion at least every eight hours for adults ages 18 and older and every four hours for children and youth ages 17 and younger.

Standard CTS.05.06.33

For organizations that use restraint or seclusion: The organization collects data on the use of restraint and seclusion.

CTS.05.06.33, EP 8

For organizations that use restraint or seclusion: ~~Licensed independent~~Physician and other licensed practitioners participate in measuring and assessing use of restraint and seclusion for all individuals served.

Standard CTS.05.06.35

For organizations that use restraint or seclusion: Organization policies and procedures address prevention of restraint and seclusion and, when employed, guide their use.

CTS.05.06.35, EP 1

For organizations that use restraint or seclusion: The organization follows its written policies and procedures regarding restraint or seclusion that include details about the following:

- Staffing
- Staff competence and training
- Initial assessment of the individual served
- The role of nonphysical techniques in behavioral contingencies
- Limiting the use of restraint or seclusion to emergencies
- Notification of the family of the individual served when restraint or seclusion is initiated
- Ordering of restraint and seclusion by a physician or other licensed ~~independent~~ practitioner
- In-person evaluations of the individual in restraint or seclusion
- Initiation of restraint or seclusion by staff other than a physician or other licensed ~~independent~~ practitioner
- Time-limited orders
- Reassessment of the individual in restraint or seclusion
- Monitoring the individual in restraint or seclusion
- Discontinuation of restraint or seclusion
- Post-restraint or seclusion practices
- Reporting injuries and deaths to the organization's leadership and external agencies in accordance with law and regulation
- Documentation of restraint or seclusion
- Data collection and the integration of restraint or seclusion data into performance improvement activities
- Debriefing

Standard CTS.06.01.15

For organizations directly providing both housing support services and behavioral or physical health care, treatment, or services to homeless individuals: A multidisciplinary care, treatment, or services team coordinates the provision of care, treatment, or services.

CTS.06.01.15, EP 1

For organizations directly providing both housing support services and behavioral or physical health care, treatment, or services to homeless individuals: The organization has a multidisciplinary care, treatment, or services team that is comprised of licensed practitioners who meet the needs of the individual served and consists of at least the following:

- Physician or advanced practice nurse or physician assistant
- Social worker or case manager

Standard CTS.06.02.01

Continuity of care, treatment, or services is maintained when an individual served is transferred or after discharge/termination of care, treatment, or services.

CTS.06.02.01, EP 9

For opioid treatment programs: When a pregnant patient is discharged, the program refers the patient for prenatal care and documents the name, address, and telephone number of the physician provider who will be caring for the patient after discharge.

Standard EC.02.03.01

The organization manages fire risks.

EC.02.03.01, EP 9

The written fire response plan describes the specific roles of staff ~~and licensed independent practitioners~~ at and away from a fire's point of origin, including when and how to sound and report fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate individuals served, and how to evacuate to areas of refuge.

Note: For full text, refer to NFPA 101-2012: 18/19.7.1; 7.2.

Standard HRM.01.01.03

The organization determines how staff function within the organization.

HRM.01.01.03, EP 2

Staff practice within the scope of their license, certification, or registration and as required by law and regulation and organization policy.

Note: For opioid treatment programs: The organization will have a federal exemption in place to allow midlevel medical licensed practitioners to write medication orders in opioid treatment programs.

Standard HRM.01.03.01

The organization provides orientation to staff.

HRM.01.03.01, EP 2

The organization orients its staff to the key safety content before ~~staff provide~~they provide care, treatment, or services. Completion of this orientation is documented.

Standard HRM.01.05.01

Staff participate in education and training.

HRM.01.05.01, EP 12

For acute 24-hour settings: ~~Practitioners~~Staff providing direct care, treatment, or services participate in education and training on pain assessment and pain management consistent with the scope of their license.

Note: “Acute 24-hour settings” includes inpatient crisis stabilization or ~~medical detoxification~~medically supervised withdrawal management.

Standard HRM.01.06.03

Staff who assess individuals with substance abuse, dependence, and other addictive behaviors and who plan services for and deliver services to these individuals have specific competencies.

HRM.01.06.03, EP 7

For opioid treatment programs: The staff members responsible for establishing referrals with other ~~health care organizations and practitioners~~providers are knowledgeable about pharmacotherapy treatment (drug interactions, acute withdrawal, and overdose), actively seek patient consent to talk with other providers, and check their state’s prescription drug monitoring program (PDMP).

Standard IC.01.01.01

The organization identifies the individual(s) responsible for managing infection prevention and control.

IC.01.01.01, EP 3

The organization assigns responsibility for the management of infection prevention and control activities.

~~Note: The assigned individual need not be a nurse or other medical practitioner.~~

Standard IC.01.02.01

Organization leaders allocate needed resources for infection prevention and control activities.

IC.01.02.01, EP 2

For 24-hour care settings: The organization arranges for laboratory services when needed to prevent the spread of infection within the organization.

Note: The role taken by the behavioral health care or human services organization in coordinating laboratory services will depend on the services provided. In many cases, the organization can refer the individual served only to a ~~licensed independent practitioner~~provider who is qualified to order laboratory testing. In some cases, the organization may have a physician or other ~~licensed independent~~ practitioner on staff who is qualified to order laboratory testing, or it may have arrangements in place for sending laboratory tests out.

Standard LD.04.01.05

The organization effectively manages its programs or services.

LD.04.01.05, EP 2

Programs or services providing care are directed by one or more qualified professionals or by a qualified physician or other ~~licensed independent~~ practitioner with clinical responsibilities.

LD.04.01.05, EP 20

For opioid treatment programs: The medical director either directly provides the required services to the program's patients or assures that the needed services are provided by appropriately trained and licensed ~~providers~~practitioners in compliance with federal and state regulation.

Standard LD.04.01.09

Policies and procedures guide the provision of programs or services and define the goals and scope of programs or services offered.

LD.04.01.09, EP 9

For opioid treatment programs: Procedures are in place to ensure continuity of care for patients in the event of the voluntary or involuntary closure of the program. The procedures provide for orderly transfer of patients, records, and assets to other programs or ~~practitioners~~providers.

Standard LD.04.03.09

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

LD.04.03.09, EP 4

Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note: When the organization contracts with another accredited organization for care, treatment, or services to be provided off site, it can do the following:

- Verify that all physicians and other licensed ~~independent~~ practitioners who will be providing care, treatment, or services have appropriate clinical responsibilities by obtaining, for example, a copy of the list of clinical responsibilities.
- Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed ~~independent~~ practitioners will be within the scope of their clinical responsibilities.

LD.04.03.09, EP 5

Leaders monitor contracted services by communicating the expectations in writing to the ~~provider of~~licensed practitioner providing the contracted services.

Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it.

Standard MM.01.01.01

The organization plans its medication management processes.

Note: This standard is applicable to organizations that engage in any of the medication management processes.

MM.01.01.01, EP 2

For organizations that prescribe medications: The organization facilitates ~~practitioner~~staff access to the Prescription Drug Monitoring Program databases.

Standard MM.04.01.01

Medication orders are clear and accurate.

Note: This standard is applicable only to organizations that prescribe medications. The elements of performance in this standard do not apply to prescriptions written by a prescriber who is not affiliated with the organization.

MM.04.01.01, EP 1

For organizations that prescribe medications: The organization follows a written policy that identifies the specific types of medication orders that it deems acceptable for use.

Note: There are several different types of medication orders. Medication orders commonly used include the following:

- As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom
- Standing orders: A prewritten medication order and specific instructions from the prescriber to administer a medication to an individual in clearly defined circumstances as specified in the instructions
- Automatic stop orders: Orders that include a date or time to discontinue a medication
- Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval
- Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or status of the individual served
- Signed and held orders: New prewritten (held) medication orders and specific instructions from a physician or other licensed ~~independent~~ practitioner to administer medication(s) to an individual served or patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s)
- Orders for medication-related devices (for example, inhalers, nebulizers, glucometers)
- Orders for investigational medications
- Orders for herbal products
- Orders for medications at discharge or transfer

MM.04.01.01, EP 27

For opioid treatment programs: The program's physicians and other ~~health care providers~~ licensed practitioners, as permitted, register to use their state's prescription drug monitoring program (PDMP) and query it for each newly admitted patient prior to initiating dosing.

Standard NPSG.03.06.01

Maintain and communicate accurate medication information for the individual served.

NPSG.03.06.01, EP 5

For organizations that prescribe medications: Explain the importance of managing medication information to the individual served.

Note: Examples include instructing the individual served to give a list to their primary care physician or other licensed practitioner; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on education of the individual served, refer to Standard CTS.04.01.03.)

Standard RC.01.01.01

The organization maintains complete and accurate clinical/case records.

RC.01.01.01, EP 5

The clinical/case record includes the following:

- Information needed to support the diagnosis or condition of the individual served
- Information needed to justify the care, treatment, or services provided to the individual served
- Information that documents the course and result of the care, treatment, or services provided to the individual served
- Information about the care, treatment, or services provided to the individual served that promotes continuity among staff and providers

Standard RC.02.01.05

The clinical/case record contains documentation of the use of restraint and/or seclusion and documentation of physical holding of a child or youth.

RC.02.01.05, EP 3

The organization documents the use of restraint and/or seclusion for behavioral health purposes in the clinical/case record, including the following:

- Each episode of restraint and/or seclusion
- The circumstances that led to the use of restraint and/or seclusion
- Consideration or failure of nonphysical interventions
- The rationale for the type of physical intervention used
- Written orders for the use of restraint and/or seclusion
- Each verbal order received from a physician or other licensed ~~independent~~ practitioner
- Each in-person evaluation and reevaluation of the individual served
- Each 15-minute assessment of the status of the individual served
- Continuous monitoring of the individual served
- Any preexisting medical conditions or any physical disabilities that would place the individual served at greater risk during restraint and/or seclusion
- Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint and/or seclusion
- That the individual served and/or their family was informed of the organization's policy on the use of behavioral restraint and/or seclusion
- That the individual served was notified of the use of restraint and/or seclusion
- Behavior criteria for discontinuing restraint and/or seclusion
- That the individual served was informed of the behavior criteria they needed to meet in order for restraint and/or seclusion to be discontinued
- Assistance provided to the individual served to help them meet the behavior criteria for discontinuing the use of restraint and/or seclusion
- Debriefing the individual served with staff following an episode of restraint and/or seclusion
- Any injuries the individual served sustained and the treatment for these injuries
- The death of the individual served while in restraint or seclusion

Standard RI.01.03.01

The organization honors the right of the individual served to give or withhold informed consent.

RI.01.03.01, EP 18

For opioid treatment programs: The program informs patients that the ~~provider~~physician will periodically discuss with them their present level of functioning, course of treatment, and future goals.

Note: These discussions are not intended to place pressure on the patient to either withdraw from medication or remain on medication maintenance.

Standard RI.01.04.01

The organization respects the right of the individual served to receive information about the staff responsible for the individual's care, treatment, or services.

RI.01.04.01, EP 1

The organization informs the individual served of the following:

- The name of the staff member who has primary responsibility for the individual's care, treatment, or services
- The name of the staff member(s) who will provide the individual's care, treatment, or services

Note: Staff may be under the supervision of a ~~clinician. This clinician~~licensed practitioner. This licensed practitioner will be identified in accordance with RI.01.04.01, EP 1.