

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 NURSING CARE CENTER ACCREDITATION PROGRAM

Effective January 1, 2024

Standard EC.02.03.01

The organization manages fire risks.

EC.02.03.01, EP 9

The organization has a written fire response plan that 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 fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate patients, and how to evacuate to areas of refuge.

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

Standard EC.02.03.03

The organization conducts fire drills.

EC.02.03.03, EP 8

For organizations that have hyperbaric facilities, emergency procedures and fire training drills are conducted annually. (For full text, refer to NFPA 99-2012: 14.2.4.5.4; 14.3.1.4.5)

Note 1: This drill includes recording the time to evacuate all persons from the area, involves applicable staff ~~and licensed practitioners~~, and focuses on prevention as well as simulated extinguishment and evacuation. Response procedures for fires within and outside the hyperbaric chamber address the role of the inside observer, the chamber operator, medical personnel, and other personnel, as applicable. For additional guidance, refer to NFPA 99-2012: B.14.2 and B.14.3.

Note 2: If the organization conducts an unannounced drill, it may serve as one of the required fire drills.

Standard EM.02.02.01

As part of its Emergency Operations Plan, the organization prepares for how it will communicate during emergencies.

EM.02.02.01, EP 2

The Emergency Operations Plan describes the following: How the organization will communicate information and instructions to its staff ~~and licensed independent practitioners~~ during an emergency.

Standard EM.02.02.07

As part of its Emergency Operations Plan, the organization prepares for how it will manage staff during an emergency.

EM.02.02.07, EP 9

The Emergency Operations Plan describes how the organization will identify ~~licensed independent practitioners,~~ staff and authorized volunteers during emergencies.

Note: This identification could include identification cards, wristbands, vests, hats, or badges.

Standard EM.02.02.13

During disasters, the organization may permit volunteer physicians or other licensed ~~independent~~ practitioners to provide care, treatment, and services.

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 patient and resident care, safety, or security functions.

EM.02.02.13, EP 1

The organization permits volunteer physicians or other licensed ~~independent~~ practitioners to provide care, treatment, and services only when the Emergency Operations Plan has been activated in response to a disaster and the organization is unable to meet immediate patient or resident needs.

~~Note: Refer to the Glossary for the definition of licensed independent practitioner.~~

EM.02.02.13, EP 4

The organization describes, in writing, how it will oversee the performance of volunteer physicians and other licensed ~~independent~~ practitioners who are permitted to provide care, treatment, and services (for example, by direct observation, mentoring, clinical record review).

EM.02.02.13, EP 5

Before a volunteer ~~practitioner~~ is considered eligible to function as a volunteer physician and other licensed ~~independent~~ practitioner, the organization obtains the ~~volunteer practitioner's~~ volunteer's 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 physician or other licensed ~~independent~~ practitioner currently providing care, treatment, and services at the organization or a staff member with personal knowledge of the ~~volunteer practitioner's~~ volunteer's ability to act as a physician or other licensed ~~independent~~ practitioner during a disaster

EM.02.02.13, EP 6

During a disaster, the organization oversees the performance of each volunteer physician or other licensed ~~independent~~ practitioner.

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.

EM.02.02.15, EP 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 patient or resident needs.

EM.02.02.15, EP 2

The organization identifies, in writing, those individuals responsible for assigning disaster responsibilities to volunteer practitioners ~~who are not licensed independent practitioners.~~

EM.02.02.15, EP 4

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.

EM.02.02.15, EP 5

Before a volunteer practitioner ~~who is not a licensed independent~~ is considered eligible to function as a practitioner, the organization obtains the volunteer practitioner's 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 patient or 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

EM.02.02.15, EP 6

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

Standard HR.01.01.01

The organization defines and verifies staff qualifications.

HR.01.01.01, EP 2

The organization verifies and documents the following:

- Credentials of staff providing care ~~providers~~ using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed.
- Credentials of staff providing care ~~providers~~ (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed.

Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented.

Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source.

Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.

HR.01.01.01, EP 7

Before providing care, treatment, and services, the organization confirms that nonemployees who are brought into the organization by a physician or other licensed ~~independent~~ practitioner to provide care, treatment, and services have the same qualifications and competencies required of employed individuals performing the same or similar services at the organization.

Note 1: This confirmation can be accomplished either through the organization's regular process or with the physician or other licensed ~~independent~~ practitioner who brought in the individual.

Note 2: When the care, treatment, and services provided by the nonemployee are not currently performed by anyone employed by the organization, leadership consults the appropriate professional organization guidelines for the required credentials and competencies.

Standard HR.01.07.01

The organization evaluates staff performance.

HR.01.07.01, EP 5

When a physician or other 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 physician or other licensed ~~independent~~ practitioner who brought staff into the organization.

Standard HR.02.01.04

The organization permits physicians and other licensed practitioners to provide care, treatment, and services.

HR.02.01.04, EP 1

Before permitting physicians or other licensed ~~independent~~ practitioners new to the organization to provide care, treatment, and services, the organization does the following:

- Documents current licensure and any disciplinary actions against the license available through the primary source.
- Verifies the identity of the individual by viewing a valid state or federal government-issued picture identification (for example, a driver's license or passport).
- Obtains and documents information from the National Practitioner Data Bank (NPDB). The medical director evaluates this information.
- Determines and documents that the physician or other licensed practitioner is currently privileged at a Joint Commission–accredited organization; this determination is verified through the accredited organization. If the organization cannot verify that the practitioner is currently privileged at a Joint Commission–accredited organization, the medical director oversees the monitoring of the practitioner's performance and reviews the results of the monitoring. This monitoring continues until it is determined that the practitioner is able to provide the care, treatment, and services that they are being permitted to provide.

Note 1: The methodology used to ~~perform monitoring of~~ monitor the physician or other licensed ~~independent~~ practitioner is determined by the organization. Some methods for monitoring that ~~can be used by~~ the organization can use include periodic chart review, direct observation, and discussion with others involved in the care of the patient or resident such as physicians, nurses, and administrative personnel. Some areas to monitor might include patient or resident care, clinical knowledge, interpersonal and communication skills, and professionalism.

Note 2: If the medical director is new to the organization and will be providing care, treatment, and services to patients or residents, results of the monitoring of the medical director's performance may be reviewed by a physician providing care, treatment, and services in the organization or at another health care organization.

HR.02.01.04, EP 5

At least every three years or within the period required by law and regulation if shorter, before permitting physicians and other licensed practitioners to continue to provide care, treatment, and services, the organization does the following:

- Documents current licensure and any disciplinary actions against the license available through the primary source.
- Obtains and documents information from the National Practitioner Data Bank (NPDB). The medical director evaluates this information.
- Reviews any clinical performance in the organization that is outside acceptable standards. The medical director evaluates this information.
- Reviews information from any of the organization's performance improvement activities pertaining to professional performance, judgment, and clinical or technical skills. The medical director evaluates this information.
- Confirms the physician's or other licensed practitioner's adherence to organization policies, procedures, rules, and regulations.

HR.02.01.04, EP 10

The ~~Medical Director~~ medical director provides the physician or other licensed ~~independent~~ practitioner with a written list of any limitations on the care, treatment, and services the practitioner can provide.

HR.02.01.04, EP 11

The physician or other licensed-~~independent~~ practitioner provides only the care, treatment, and services that they have been permitted to perform.

HR.02.01.04, EP 12

The organization grants a physician or other licensed- practitioner permission to provide care, treatment, and services for three years or for the period required by law and regulation if shorter.

HR.02.01.04, EP 13

In order to make a decision to allow a physician or other licensed-~~independent~~ practitioner to provide or continue to provide care, treatment, and services, the governing body reviews the following:

- Recommendations made by the medical director
- Documentation on which the recommendations are based

Note: The organization administrator or a committee of two or more governing body members may substitute for a governing body.

(See also LD.01.06.01, EP 3)

HR.02.01.04, EP 14

The governing body designates, in writing, those physicians and other licensed-~~independent~~ practitioners who it has determined can provide care, treatment, and services.

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 designate these individuals.

HR.02.01.04, EP 15

All physicians and other licensed-~~independent~~ practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation.

HR.02.01.04, EP 16

At the time of licensure expiration, the organization documents the physician's or other licensed-~~independent~~ practitioner's current licensure and any disciplinary actions against the license available through the primary source.

Standard HR.02.01.05

The organization may permit physicians and other licensed-~~independent~~ practitioners to provide care, treatment, and services on a temporary basis.

HR.02.01.05, EP 2

Before the organization permits physicians ~~or~~ and other licensed ~~independent~~ practitioners to provide care, treatment, and services on a temporary basis to meet important patient or resident needs, the organization does the following:

- Documents required current licensure using primary sources, if available
- Uses primary source verification to document current competency

Note 1: Primary source verification of competency can be obtained through peer references or verification that the practitioner is privileged at a Joint Commission–accredited organization.

Note 2: The administrator or the administrator's designee grants temporary privileges upon recommendation of clinical leadership or the medical director.

Standard HR.02.02.01

The organization provides orientation to physicians and other licensed practitioners.

HR.02.02.01, EP 1

The organization orients its physicians and other licensed ~~independent~~ practitioners to the key safety content it identifies before they provide care, treatment, and services. Completion of this orientation is documented.

Note 1: Key safety content may include specific processes and procedures related to the provision of care, the environment of care, and infection control.

Note 2: The organization determines the specific responsibilities included in orientation. For example, a covering physician or other licensed ~~independent~~ practitioner may have different or fewer responsibilities than an attending physician or other licensed ~~independent~~ practitioner.

HR.02.02.01, EP 3

The organization orients physicians and other licensed ~~independent~~ practitioners on the following:

- Relevant policies and procedures.
- Their specific responsibilities, including those related to infection prevention and control and assessing and managing pain

Note: The organization determines the specific responsibilities included in orientation. For example, a covering physician or other licensed ~~independent~~ practitioner may have different or fewer responsibilities than a physician or other licensed ~~independent~~ practitioner who is privileged.

- Sensitivity to cultural diversity based on their specific responsibilities

Completion of this orientation is documented.

Standard IC.02.01.01

The organization implements its infection prevention and control plan.

IC.02.01.01, EP 7

The organization implements its methods to communicate responsibilities for preventing and controlling infection to ~~licensed independent practitioners,~~ staff, visitors, patients, residents, and families. Information for visitors, patients and residents, and families includes hand and respiratory hygiene practices.

Note: Information may be provided via different forms of media, such as posters or pamphlets.

Standard IC.02.03.01

The organization works to prevent the spread of infectious disease among patients and staff.

IC.02.03.01, EP 1

The organization makes screening for exposure and/or immunity to infectious disease available to ~~licensed independent practitioners and~~ staff who may come in contact with infections at the workplace.

IC.02.03.01, EP 2

~~When licensed independent practitioners or~~ When staff have, are suspected of having, or have been occupationally exposed to an infectious disease that puts others at risk, the organization provides them with or refers them for assessment and potential testing, prophylaxis/treatment, or counseling.

Standard IC.02.04.01

The organization offers vaccination against vaccine-preventable diseases prevalent in the community (for example, influenza and COVID-19) to its **staff**.

Note: This standard is applicable to ~~staff, physicians, and other licensed practitioners~~ only when care, treatment, or services are provided on site. When care, treatment, or services are provided off site, such as with telemedicine or telephone consultation, this standard is not applicable to off-site ~~staff, physicians, or other licensed practitioners~~.

Standard LD.01.06.01

A medical director oversees the care, treatment, and services provided to patients and residents.

LD.01.06.01, EP 3

The medical director provides clinical leadership by doing the following:

- Directing and coordinating medical care in the organization
 - Participating in the creation of policies, procedures, and guidelines for clinical care, treatment, and services and the development of emergency treatment procedures for patients and residents
 - Participating in the provision of in-service training programs
 - Making recommendations to governance on whether or not a physician or other licensed ~~independent~~ practitioner can provide care, treatment, and services at the organization
 - Monitoring the performance of medical services
 - Understanding the policies and programs of public health agencies that affect patient and resident care programs
 - Acting as the organization's medical representative in the community
- (See also HR.02.01.04, EP 13)

LD.01.06.01, EP 5

The medical director provides physician leadership in the following ways:

- By helping to arrange and internally communicate physician availability and coverage
- By communicating medical staff responsibilities and medical care policies, procedures, and guidelines to all physicians and other licensed ~~independent~~ practitioners providing or ordering care
- By serving as a member of the organized medical staff if the organization has one
- By collaborating with the administrator and the organized medical staff, if the organization has one, to formulate the bylaws and the rules and regulations
- By being responsible, when there is no medical staff, for the written rules and regulations for all physicians and other licensed ~~independent~~ practitioners who attend patients or residents in the organization

Note: This standard does not require the creation of a medical staff where one does not exist. The nursing care center chooses whether or not to create a medical staff.

Standard LD.04.01.05

The organization effectively manages its programs, services, sites, or departments.

LD.04.01.05, EP 2

Programs, services, sites, or departments providing patient or resident care are directed by one or more qualified professionals or by a qualified physician or other licensed ~~independent~~ practitioner with clinical privileges.

Standard LD.04.02.01

The leaders address any conflict of interest that affects or has the potential to affect the safety or quality of care, treatment, and services.

LD.04.02.01, EP 5

Policies, procedures, and information about the relationship between care, treatment, and services and financial incentives are available upon request to all patients and residents and those individuals who work in the organization, ~~including staff and licensed independent practitioners.~~

Standard LD.04.02.03

Ethical principles guide the organization's business practices.

LD.04.02.03, EP 5

Care, treatment, and services are provided based on patient and resident needs, regardless of compensation or financial risk-sharing with those who work in the organization, ~~including staff and licensed independent practitioners.~~

Standard LD.04.03.09

Care, treatment, and 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 patient or resident care, treatment, and services to be provided off site, it can do the following:

- Verify that all ~~physicians and other~~ licensed ~~independent~~ practitioners who will be providing patient or 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 ~~physicians and other~~ licensed ~~independent~~ practitioners will be within the scope of their privileges.

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 LD.04.03.13

Pain assessment and pain management, including safe opioid prescribing, are identified as an organizational priority.

LD.04.03.13, EP 3

The organization provides staff ~~and licensed independent practitioners~~ with educational resources to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient or resident population.

LD.04.03.13, EP 6

The organization facilitates ~~practitioner and pharmacist~~ access to the Prescription Drug Monitoring Program databases.

Note: This element of performance is applicable in any state that has a Prescription Drug Monitoring Program database, whether querying is voluntary or is mandated by state regulations for all patients prescribed opioids.

Standard MM.01.01.01

The organization plans its medication management processes.

MM.01.01.01, EP 1

The organization makes information about the patient or resident accessible to ~~licensed independent practitioners and~~ staff who participate in the management of the patient's and resident's medications.

Note: This element of performance does not apply in emergency situations.

Standard MM.03.01.01

The organization safely stores medications.

MM.03.01.01, EP 4

The organization follows a written policy addressing the control of medication between receipt by ~~an individual health care provider~~ staff and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage.

Standard MM.03.01.03

The organization safely manages emergency medications.

MM.03.01.03, EP 1

Organization leaders, in conjunction with the medical director, licensed ~~independent~~ practitioners, pharmacists, and other clinical staff, decide which emergency medications and their associated supplies will be readily accessible based on the population served. Whenever possible, emergency medications are available in unit-dose, age-specific, and ready-to-administer forms.

Standard MM.03.01.05

The organization safely controls medications brought into the organization by patients, residents, their families, or licensed ~~independent~~ practitioners.

MM.03.01.05, EP 1

The organization determines whether medications brought into the organization by patients, residents, their families, or licensed ~~independent~~ practitioners can be used or administered.

MM.03.01.05, EP 2

Before use or administration of a medication brought into the organization by a patient or resident, their family, or a licensed ~~independent~~ practitioner, the organization identifies the medication and visually evaluates the medication's

integrity.

(See also MM.06.01.01, EP 3)

Standard MM.04.01.01

Medication orders are clear and accurate.

MM.04.01.01, EP 1

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 pre-written medication order and specific instructions from the physician or other licensed ~~independent~~ practitioner to administer a medication to a person in clearly defined circumstances
- Automatic stop orders: Orders that include a date or time to discontinue a medication
- Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's or resident's status
- Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval
- Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or the patient's or resident's status
- 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 a patient or resident in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s)
- Orders for compounded drugs or drug mixtures not commercially available
- Orders for medication-related devices (for example, nebulizers, catheters)
- Orders for investigational medications
- Orders for herbal products
- Orders for medications at discharge or transfer

MM.04.01.01, EP 14

The organization requires a physician or other licensed practitioner order or, in accordance with law and regulation, a physician-approved, organization-specific protocol(s) to administer influenza and pneumococcal polysaccharide vaccines.

Standard MM.05.01.01

A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the organization.

Note: This standard applies to all organizations, whether they have an on-site pharmacy or contract for pharmacy services.

MM.05.01.01, EP 1

Before dispensing or removing medications from floor stock or from an automated storage and distribution device, a pharmacist reviews all medication orders or prescriptions unless a physician or other licensed ~~independent~~ practitioner controls the ordering, preparation, and administration of the medication or when a delay would harm the resident in an urgent situation (including sudden changes in a resident's clinical status), in accordance with law and regulation.

Standard MM.06.01.01

The organization safely administers medications.

MM.06.01.01, EP 1

Only authorized ~~licensed independent practitioners and~~ clinical staff administer medications. The organization defines, in writing, those who are authorized to administer medication, with or without supervision, in accordance with law and regulation.

Note: This does not prohibit self-administration of medications by patients and residents, when indicated.
(See also MM.06.01.03, EP 1)

MM.06.01.01, EP 3

Before administration, the individual administering the medication does the following:

- Verifies that the medication selected matches the medication order and product label
- Visually inspects the medication for particulates, discoloration, or other loss of integrity
- Verifies that the medication has not expired
- Verifies that no contraindications exist
- Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route

- Discusses any unresolved concerns about the medication with the patient's or resident's physician or other licensed independent-practitioner, prescriber (if different from the ~~licensed independent~~patient's or resident's practitioner), and/or staff involved with the patient's care, treatment, and services

(See also MM.03.01.05, EP 2)

Standard MM.07.01.01

The organization monitors patients and residents to determine the effects of their medication(s).

MM.07.01.01, EP 2

The organization monitors the patient's or resident's response to medication(s) by taking into account clinical information from the clinical record, relevant lab values, clinical response, and medication profile.

Note: Monitoring the patient's or resident's response to medications is an important assessment activity for ~~nurses, physicians, and pharmacists~~licensed practitioners providing care. In particular, monitoring the patient's or resident's response to the first dose of a new medication is essential to their safety because any adverse reactions, including serious ones, are more unpredictable if the medication has never been used before with the patient or resident.

(See also RC.02.01.27, EPs 1, 2)

MM.07.01.01, EP 6

The clinical or consultant pharmacist communicates to the physician or other licensed practitioner, prescriber (if different from the ~~physician~~patient's or resident's practitioner), and those involved in the patient's or resident's care the findings, conclusions, and recommendations that result from monitoring the medication regimen.

Standard MM.09.01.01

The organization has an antimicrobial stewardship program based on current scientific literature.

MM.09.01.01, EP 2

The organization educates staff ~~and licensed independent practitioners~~ involved in antimicrobial ordering, dispensing, administration, and monitoring about antimicrobial resistance and antimicrobial stewardship practices. Education occurs upon hire or granting of initial privileges and periodically thereafter, based on organizational need.

MM.09.01.01, EP 4

The organization has an antimicrobial stewardship multidisciplinary team that includes the following members, when available in the setting:

- Infectious disease physician
- Infection preventionist(s)
- Pharmacist(s)
- ~~Practitioner~~ Licensed practitioner(s)

Note 1: Part-time or consultant staff are acceptable as members of the antimicrobial stewardship multidisciplinary team.

Note 2: Telehealth staff are acceptable as members of the antimicrobial stewardship multidisciplinary team.

MM.09.01.01, EP 5

The organization's antimicrobial stewardship program includes the following core elements:

- Leadership commitment: Demonstrate support and commitment to safe and appropriate antibiotic use in your facility.
- Accountability: Identify physician, ~~other licensed practitioner,~~ nursing, and pharmacy leads responsible for promoting and overseeing antibiotic stewardship activities in your facility.
- Drug expertise: Establish access to consultant pharmacists or other individuals with experience or training in antibiotic stewardship for your facility.
- Action: Implement policy or practice changes to improve antibiotic use.
- Tracking: Monitor and measure the use of antibiotic use and at least one outcome from antibiotic use in your facility.
- Reporting: Regularly reporting information on the antimicrobial stewardship program, which may include antibiotic use and resistance, to ~~physicians and other practitioners, nurses, and~~ relevant staff.
- Education: Provide resources to ~~physicians and other practitioners, nursing~~ staff, residents, and families about antibiotic resistance and opportunities for improving antibiotic use. (See also IC.02.01.01, EP 1)

Note: These core elements were cited from the Centers for Disease Control and Prevention's The Core Elements of Antibiotic Stewardship for Nursing Homes (<http://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html>). The Joint Commission recommends that nursing care centers use this document when designing their antimicrobial stewardship program.

(For more information, refer to Standard IC.01.05.01)

Standard NPSG.01.01.01

Use at least two patient or 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 individual providing care~~ knows the patient or resident, one identifier can be facial recognition.

Standard NPSG.03.06.01

Maintain and communicate accurate patient and resident medication information.

NPSG.03.06.01, EP 5

Explain the importance of managing medication information to the patient or resident when they leave the organization's care.

Note: Examples include instructing the patient or resident to give a list to their primary care physician/provider; 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 medication education, refer to Standards MM.06.01.03, PC.02.03.01, and PC.04.01.05.)

Standard PC.01.02.01

The organization assesses and reassesses its patients and residents.

PC.01.02.01, EP 41

When assessing patients or residents for changes in cognition, a qualified clinician/licensed practitioner uses evidence-based cognitive and functional assessment tools.

Note 1: For a clinician/licensed practitioner to be qualified, they must have received training on the assessment tool they are administering.

Note 2: Assessment tool examples include the Confusion Assessment Method (CAM), Clock Test, Global Deterioration Scale (GDS), Functional Activities Questionnaire (FAQ), Montreal Cognitive Assessment (MoCA), and Allen Cognitive Disability Scale.

Standard PC.01.02.03

The organization assesses and reassesses the patient or resident and the patient's or resident's condition according to defined time frames.

PC.01.02.03, EP 4

The attending physician or other licensed ~~independent~~ practitioner performs the patient's or resident's medical history and physical examination within 24 hours prior to or 72 hours after the patient's or resident's admission or readmission to the organization.

Note: When permitted by law and regulation, a medical history and physical examination performed by the attending physician or other licensed ~~independent~~ practitioner within 30 days prior to the patient's or resident's admission or readmission can be used, provided it is updated with a summary of the patient's or resident's condition and course of care during the 30-day time period.

PC.01.02.03, EP 5

When the medical history and physical examination is performed by someone other than the attending physician or other licensed ~~independent~~ practitioner within 30 days of admission, the attending physician or other licensed ~~independent~~ practitioner does the following within 24 hours prior to or 72 hours after the patient's or resident's admission or readmission to the organization:

- Reviews the patient's or resident's medical history
- Reexamines the patient or resident

- Updates any findings or other information as needed and provides a summary of the patient's or resident's physical condition and psychosocial status subsequent to the initial medical history and physical examination
- Signs and dates the updated information and findings

PC.01.02.03, EP 18

For organizations that elect The Joint Commission Post–Acute Care Certification option: The attending physician or licensed ~~independent~~ practitioner performs the patient's medical history and physical examination within 24 hours prior to or 48 hours after the patient's admission or readmission to the organization.

Note 1: When permitted by law and regulation, a medical history and physical examination performed by the attending physician or licensed ~~independent~~ practitioner within 30 days prior to the patient's admission or readmission can be used, provided it is updated with a summary of the patient's condition and course of care during the 30-day time period.

Note 2: This element of performance applies only for those patients receiving post-acute care under the optional certification.

PC.01.02.03, EP 19

For organizations that elect The Joint Commission Post–Acute Care Certification option: When the medical history and physical examination is performed by someone other than the attending physician or licensed ~~independent~~ practitioner within 30 days of admission, the attending physician or licensed ~~independent~~ practitioner does the following within 24 hours prior to or 48 hours after the patient's or resident's admission or readmission to the organization:

- Reviews the patient's medical history
- Reexamines the patient
- Updates any findings or other information as needed and provides a summary of the patient's physical condition and psychosocial status
- Signs and dates the updated information and findings

Note: This element of performance applies only for those patients receiving post-acute care under the optional certification.

PC.01.02.03, EP 30

For organizations that elect The Joint Commission Memory Care Certification option: A qualified ~~provider~~licensed practitioner reassesses residents diagnosed with dementia every six months or more frequently if there is a change in condition.

Standard PC.01.02.05

Qualified ~~staff~~, physicians, or other licensed practitioners assess and reassess the patient or resident.

PC.01.02.05, EP 8

A qualified physician or other licensed ~~independent~~ practitioner conducts a behavioral health assessment at least quarterly for patients or residents on a psychotropic medication.

PC.01.02.05, EP 9

All patient and resident assessments and screenings obtained for the use of determining care, treatment, and services or the level of care needed are conducted by qualified ~~staff~~, physicians, or other licensed practitioners in accordance with law and regulation.

Standard PC.02.01.03

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

PC.02.01.03, EP 1

Orders are obtained from a physician or other ~~authorized individual~~ licensed practitioner, in accordance with law and regulation and professional practice acts, before care, treatment, and services are provided.

Note: For information on the credentialing process for physicians and other licensed practitioners, refer to Standard HR.02.01.04.

Standard PC.02.01.05

The organization provides interdisciplinary, collaborative care, treatment, and services.

PC.02.01.05, EP 9

Information about the patient or resident is shared among all members of the interdisciplinary team, including the physician or other licensed practitioner, within the organization's defined time frames.

Note: Examples of this information include changes in the patient's or resident's condition, consultation and evaluation reports, and diagnostic testing results.

PC.02.01.05, EP 13

Changes in the patient's or resident's condition are communicated to the attending physician or other authorized health care ~~professional~~ provider(s), the patient or resident, and the patient's or resident's family.

PC.02.01.05, EP 29

For organizations that elect The Joint Commission Post–Acute Care Certification option: An attending or other on-call licensed ~~independent~~ practitioner is available 24 hours a day, 7 days a week.

Note: This element of performance applies only for those patients receiving post-acute care under the optional certification.

PC.02.01.05, EP 30

For organizations that elect The Joint Commission Post–Acute Care Certification option: The organization has a written plan to access a physician or other licensed ~~independent~~ practitioner should the organization be unable to communicate with the attending or other on-call licensed ~~independent~~ practitioner regarding a change in a patient's condition.

Note: This element of performance applies only for those patients receiving post-acute care under the optional certification.

Standard PC.02.01.15

Patients and residents at risk for health-related complications receive preventive care.

PC.02.01.15, EP 1

The organization provides preventive care to avoid complications resulting from the patient's or resident's inactivity, including the following:

- Encouraging and helping patients and residents to spend time out of bed, except when prohibited by a physician's

or other licensed practitioner's order or if this would contradict the individualized plan of care

- Maintaining proper body position and alignment
- Helping with ambulation, including maintenance of gait training
- Providing active and passive range-of-motion exercises

Standard PC.03.02.13

When alternatives to restraint are ineffective, restraint is safely used.

PC.03.02.13, EP 3

Medication to control the patient's or resident's behavior is part of a therapeutic plan and is only used after a physician or qualified licensed ~~independent~~ practitioner assesses the patient or resident.

PC.03.02.13, EP 5

A physician or other licensed ~~independent~~ practitioner provides a written order that does not exceed 30 days for the use of restraint.

PC.03.02.13, EP 12

The interdisciplinary team requests a new physician or other licensed practitioner order if there are changes in the patient's or resident's condition that require removing or modifying restraint.

Standard PC.04.01.01

The organization follows a process that addresses transitions in the patient's or resident's care.

PC.04.01.01, EP 1

The organization documents the following:

- The reason(s) for and conditions under which the patient or resident is discharged or transferred
- The method for shifting responsibility for a patient's or resident's care from one ~~clinician~~ licensed practitioner, organization, program, or service to another

PC.04.01.01, EP 14

The organization transfers or discharges a patient or resident upon order of their attending physician or other licensed ~~independent~~ practitioner.

PC.04.01.01, EP 27

For organizations that elect The Joint Commission Post–Acute Care Certification option: A staff member designated by the organization discusses the patient's discharge plan with the family and relevant licensed practitioners across different care settings. (Refer to PC.04.01.03, EP 3)

Note: This element of performance applies only for those patients receiving post-acute care under the optional certification.

PC.04.01.01, EP 34

For organizations that elect The Joint Commission Memory Care Certification option: The organization documents the process for transitioning the responsibility for a patient's or resident's care from one ~~clinician~~ licensed practitioner, organization, program, or service to another. The process includes the following:

- Identification of potential underlying cause(s) of behavioral symptoms
- Successful personalized approaches to care
- Successful communication techniques with the patient or resident
- The patient's or resident's cognitive, sensory, and physical capabilities
- Advanced care planning

PC.04.01.01, EP 35

For organizations that elect The Joint Commission Memory Care Certification option: The organization discusses the patient's or resident's discharge plan with the family and relevant licensed practitioners across different care settings. (For more information, refer to PC.04.01.03, EP 3)

Standard PC.04.01.03

The organization transfers or discharges the patient or resident based on the patient's or resident's assessed needs and the organization's ability to meet those needs.

PC.04.01.03, EP 3

The patient or resident, the patient's or resident's family, licensed ~~independent~~ practitioners, and staff involved in the patient's or resident's care, treatment, and services participate in planning the patient's or resident's transfer or discharge.

(See also RI.01.01.01, EP 19)

Standard RC.01.01.01

The organization maintains complete and accurate clinical records.

RC.01.01.01, EP 5

The clinical record includes the following:

- Information needed to support the patient's or resident's diagnosis and condition
- Information needed to justify the patient's or resident's care, treatment, and services
- Information that documents the course and result of the patient's or resident's care, treatment, and services
- Information about the patient's or resident's care, treatment, and services needed to provide continuity of care among providersstaff

Standard RC.01.02.01

Entries in the clinical record are authenticated.

RC.01.02.01, EP 2

The organization defines the types of entries in the clinical record made by ~~nonindependent~~licensed practitioners that require countersigning, in accordance with law and regulation.

Standard RC.02.01.01

The clinical record contains information that reflects the patient's or resident's care, treatment, and services.

RC.02.01.01, EP 4

As needed to provide care, treatment, and services, the clinical record contains the following additional information:

- Any advance directives
- Orders, renewal of orders, and documentation that resuscitative services are to be withheld or life-sustaining treatment withdrawn
- Any informed consent, when required by organization policy
- Any records of communication with the patient or resident, such as telephone calls or e-mail
- Any patient- or resident-generated information (for example, choices, habits, routine)
- Referrals or communication made to external or internal care providers and community agencies
- Any physician's or other licensed practitioner's summary and final diagnosis when the patient or resident is admitted either from a hospital or from another health care organization
- The discharge plan or the reason for lack of an ongoing plan when discharge potential does not exist

Standard RC.02.01.09

Clinical record documentation includes the provision of and response to the activities program at least quarterly.

RC.02.01.09, EP 1

The activity providersstaff document the following about the activity program in the clinical record:

- The provision of activities to the patient or resident based on the interdisciplinary care plan, at least quarterly
- The patient's or resident's response to the activities based on the interdisciplinary care plan, at least quarterly
- Any report given to the primary nurse of changes in the patient's or resident's response to an activity provided

Standard RC.02.01.15

Clinical record documentation includes the provision of and response to medical treatment and care, and changes in the patient's or resident's condition.

RC.02.01.15, EP 1

The following are documented in the patient's or resident's clinical record:

- The provision of medical treatment and care
- The patient's or resident's response to medical treatment and care
- Medical observations and recommendations made after the initial medical assessment, as well as progress notes that are reported at the time of observation
- Progress notes recorded by the physician or other licensed practitioner at each visit
- Evidence that the attending physician or other licensed practitioner has reviewed the consulting physician's orders for consistency with the interdisciplinary plan of care
- Significant changes, as determined by the organization, in the patient's or resident's condition, care, treatment, and services

Standard RC.02.01.27

Effects of medications on patients and residents, and associated pharmacist evaluation and physician or other licensed practitioner consultation, are documented in the clinical record.

Standard RC.02.04.01

The patient's or resident's clinical record contains discharge information.

RC.02.04.01, EP 2

The patient's or resident's discharge information includes the following:

- The reason for transfer, discharge, or referral
- Treatment provided, diet, medication orders, and orders for the patient's or resident's immediate care
- Referrals provided to the patient or resident, the referring physician's or other licensed ~~independent~~ practitioner's name, and the name of the physician or other licensed ~~independent~~ practitioner who has agreed to be responsible for the patient's or resident's medical care and treatment, if this person is someone other than the referring physician or other licensed ~~independent~~ practitioner
- Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals
- Information about the patient's or resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation
- Nursing information that is useful in the patient's or resident's care
- Any advance directives
- Instructions given to the patient or resident before discharge

Standard RI.01.02.01

The organization respects the patient's or resident's right to participate in decisions about their care, treatment, and services.

RI.01.02.01, EP 2

When a patient or resident is unable to make decisions about their care, treatment, and services, or chooses to delegate decision making to another, the organization involves the surrogate decision-maker in making these decisions.

Note: A surrogate decision-maker is someone appointed to make decisions on behalf of the patient or resident. This individual may be a family member or may be someone unrelated to the patient or resident. A surrogate decision-maker makes decisions when the patient or resident is without decision-making capacity, or when the patient or resident has given permission to the surrogate to make decisions. In exercising this responsibility on the patient's or resident's behalf, the surrogate decision-maker may need to receive information, provide information, or participate in processes such as informed consent, education, and complaint resolution. In situations in which the patient or resident has decision-making capacity but has chosen to use a surrogate decision-maker, the patient or resident may reserve the right to involve the surrogate in some activities (such as coordinating information with the physician or other licensed ~~independent~~ practitioner) but not others (such as receiving education in self-care). (See also RI.01.01.01, EP 18; RI.01.06.13, EP 4)

Standard RI.01.05.01

The organization addresses patient or resident decisions about care, treatment, and services received at the end of life.

RI.01.05.01, EP 3

The organization does the following regarding advance directives, including “do not hospitalize” orders, “do not resuscitate” orders, and organ-donation request procedures:

- Informs patients of relevant laws and regulations
- Provides patients and residents with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services
- Provides the patient or resident with information upon admission on the extent to which the organization is able, unable, or unwilling to honor advance directives
- Informs staff ~~and licensed independent practitioners~~ who are involved in the patient’s or resident’s care, treatment, and services of whether or not the patient or resident has an advance directive
- Honors the patient’s or resident’s right to review and revise their advance directives
- Honors advance directives, in accordance with law and regulation and the organization’s capabilities

Standard RI.01.06.09

The patient or resident has the right to choose their medical, ~~dental, and other licensed independent practitioner~~ and dental care providers.

RI.01.06.09, EP 1

The organization supports the patient’s or resident’s right to choose an attending physician, ~~dentist, and other licensed independent practitioner~~ and dentist.

RI.01.06.09, EP 3

The organization makes reasonable attempts to respond to requests from patients and residents to choose a different ~~licensed independent practitioner~~ physician upon admission and throughout the course of care.

Note: In facilities with a closed medical staff (such as Veterans Affairs or chronic disease hospitals), the choice may be limited to the ~~licensed independent practitioners~~ physician within the system.

Standard RI.01.06.11

The patient or resident has the right to communicate with their medical, dental, and other ~~licensed independent practitioner~~ care providers.

RI.01.06.11, EP 1

The organization provides the patient or resident and the patient’s or resident’s surrogate decision-maker with the name and telephone number of the physician or other licensed practitioner primarily responsible for the patient’s or resident’s care.

Note: The surrogate decision-maker can be a family member.

RI.01.06.11, EP 3

The organization helps the patient or resident make and keep appointments with medical, dental, and other licensed ~~independent~~ practitioners.

Standard RI.01.07.13

The patient or resident has the right to transportation services, as appropriate to their care or service plan.

RI.01.07.13, EP 1

The organization arranges transportation for the patient or resident to and from physician-~~or~~, dentist, or other care provider appointments and other activities identified in the patient's or resident's care or service plan.

Standard WT.03.01.01

Staff ~~and licensed independent practitioners~~ performing waived tests are competent.

WT.03.01.01, EP 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.

WT.03.01.01, EP 2

~~Staff and licensed independent practitioners~~ Staff who perform waived testing have received orientation in accordance with the organization's specific services. The orientation for waived testing is documented.

WT.03.01.01, EP 3

~~Staff and licensed independent practitioners~~ Staff who perform waived testing have been trained for each test that they are authorized to perform. The training for each waived test is documented.

WT.03.01.01, EP 4

~~Staff and licensed independent practitioners~~ Staff 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.