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-edition®), 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 HOSPITAL ACCREDITATION PROGRAM

Effective February 19, 2023

Environment of Care (EC) Chapter

Standard EC.02.03.01

The hospital manages fire risks.

EC.02.03.01, EP 9

The written fire response plan describes the specific roles of staff and licensed 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 patients, how to evacuate to areas of refuge, and how staff and licensed practitioners will cooperate with firefighting authorities. Staff and licensed practitioners are periodically instructed on and kept informed of their duties under the plan, including cooperation with firefighting authorities. A copy of the plan is readily available with the telephone operator or security.

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

Standard EC.02.03.03

The hospital conducts fire drills.

EC.02.03.03, EP 7

The hospital conducts annual fire exit drills for operating rooms/surgical suites. (For full text, refer to NFPA 99-2012: 15.13.3.10.3)

Note 1: This drill involves applicable staff and licensed practitioners and focuses on prevention as well as simulated extinguishment and evacuation.

Note 2: An announced annual fire exit drill cannot be used to meet one of the unannounced quarterly fire drills required by NFPA 101-2012: 18/19.7.1.6.
EC.02.03.03, EP 8

For hospitals 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 hospital conducts an unannounced drill, it may serve as one of the required fire drills.

Standard EC.03.01.01

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

EC.03.01.01, EP 2

Staff and licensed independent practitioners Staff can describe or demonstrate actions to take in the event of an environment of care incident.

Emergency Management (EM) Chapter

Standard EM.12.01.01

The hospital develops an emergency operations plan based on an all-hazards approach.

Note: The hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.

EM.12.01.01, EP 1

The hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff, and volunteers, physicians, and other licensed practitioners on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following:
- Mobilizing incident command
- Communications plan
- Maintaining, expanding, curtailing, or closing operations
- Protecting critical systems and infrastructure
- Conserving and/or supplementing resources
- Surge plans (such as flu or pandemic plans)
- Identifying alternate treatment areas or locations
- Sheltering in place
- Evacuating (partial or complete) or relocating services
- Safety and security
- Securing information and records

EM.12.01.01, EP 3

The hospital's emergency operations plan includes written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, patients, and volunteers, and patients.

Note 1: Shelter-in-place plans may vary by department and facility and may vary based on the type of emergency.
or situation.

Note 2: Safe evacuation from the hospital includes consideration of care, treatment, and service needs of evacuees, staff responsibilities, and transportation.

**EM.12.01.01, EP 4**

The emergency operations plan includes written procedures for how the hospital will provide essential needs for its staff, volunteers, and patients, whether they shelter in place or evacuate, that includes, but is not limited to, the following:
- Food and other nutritional supplies
- Medications and related supplies
- Medical/surgical supplies
- Medical oxygen and supplies
- Potable or bottled water

**Standard EM.12.02.01**

The hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency.

Note: The hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.

**EM.12.02.01, EP 2**

The hospital’s communications plan describes how it will establish and maintain communications in order to deliver coordinated messages and information during an emergency or disaster incident to the following individuals:
- Staff, licensed practitioners, and volunteers (including individuals providing care at alternate sites)
- Patients and family members, including people with disabilities and other access and functional needs
- Community partners (such as fire department, emergency medical services, police, public health department)
- Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff)
- Media and other stakeholders

Note: Examples of means of communication include text messaging, phone system alerts, email, social media, and augmentative and alternative communication (AAC) for those with difficulties communicating using speech.

**Standard EM.12.02.03**

The hospital has a staffing plan for managing all staff and volunteers during an emergency or disaster incident.

Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a staffing plan.

**EM.12.02.03, EP 1**

The hospital develops a staffing plan for managing all staff and volunteers to meet patient care needs during the duration of an emergency or disaster incident or during a patient surge. The plan includes the following:
- Methods for contacting off-duty staff, physicians, and other licensed practitioners
- Acquiring staff, physicians, and other licensed practitioners from its other health care facilities
- Use of volunteer staffing, such as staffing agencies, health care coalition support, and those deployed as part of the disaster medical assistance teams

Note: If the hospital determines that it will never use volunteers during disasters, this is documented in its plan.
The hospital identifies the individual(s) responsible for granting disaster privileges to volunteer physicians and other licensed practitioners (such as advanced practice registered nurses and physician assistants) and has a process for granting these privileges. This is documented in the medical staff bylaws, rules and regulations, or policies and procedures.

**Standard EM.12.02.07**

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

**EM.12.02.07, EP 2**

The hospital’s plan for safety and security measures includes a system to track the location of its on-duty staff and volunteers and patients when sheltered in place, relocated, or evacuated. If on-duty staff and volunteers and patients are relocated during an emergency, the hospital documents the specific name and location of the receiving facility or evacuation location. Note: Examples of systems used for tracking purposes include the use of established technology or tracking systems or taking head counts at defined intervals.

**Standard EM.15.01.01**

The hospital has an emergency management education and training program. Note: The hospital considers its prioritized hazards identified as part of its hazard vulnerability assessment when developing education and training.

**EM.15.01.01, EP 2**

The hospital provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, and volunteers, physicians, and other licensed practitioners that is consistent with their roles and responsibilities in an emergency. The initial education and training include the following:
- Activation and deactivation of the emergency operations plan
- Communications plan
- Emergency response policies and procedures
- Evacuation, shelter-in-place, lockdown, and surge procedures
- Where and how to obtain resources and supplies for emergencies (such as procedures manuals or equipment)
Documentation is required.

**EM.15.01.01, EP 3**

The hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers, physicians, and other licensed practitioners that is consistent with their roles and responsibilities in an emergency:
- At least every two years
- When roles or responsibilities change
- When there are significant revisions to the emergency operations plan, policies, and/or procedures
- When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training
Documentation is required.
Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well
as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization.

Note 2: Hospitals are not required to retrain staff on the entire emergency operations plan but can choose to provide education and training specific to the new or revised elements of the emergency management program.

Human Resources (HR) Chapter

**Standard HR.01.01.01**

The hospital defines and verifies staff qualifications.

**HR.01.01.01, EP 2**

The hospital verifies and documents the following:
- Credentials of care providersstaff 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 care providersstaff (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 hospital confirms that nonemployees who are brought into the hospital by a physician or other licensed independent practitioner to provide care, treatment, or services have the same qualifications and competencies required of employed individuals performing the same or similar services at the hospital.

Note 1: This confirmation can be accomplished either through the hospital'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 hospital, leadership consults the appropriate professional hospital guidelines for the required credentials and competencies.

**Standard HR.01.02.01**

Physician assistants and advanced practice registered nurses who practice within the hospital are credentialed, privileged, and reprivileged through the medical staff process or an equivalent process.

Note: Advanced practice registered nurses who are licensed independent practitioners are credentialed and privileged only through the medical staff credentialing and privileging process. (See the “Medical Staff” [MS] chapter)
Infection Control (IC) Chapter

Standard IC.01.06.01
The hospital prepares to respond to an influx of potentially infectious patients.

IC.01.06.01, EP 3
The hospital has a method for communicating critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients.

Standard IC.02.01.01
The hospital implements its infection prevention and control plan.

IC.02.01.01, EP 7
The hospital implements its methods to communicate responsibilities for preventing and controlling infection to licensed independent practitioners, staff, visitors, patients, and families. Information for visitors, patients, 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 hospital works to prevent the transmission of infectious disease among patients, licensed independent practitioners, and staff.

IC.02.03.01, EP 1
The hospital 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 staff have, are suspected of having, or have been occupationally exposed to an infectious disease that puts others at risk, the hospital provides them with or refers them for assessment and potential testing, prophylaxis/treatment, or counseling.

Standard IC.02.04.01
The hospital offers vaccination against influenza to licensed independent practitioners and staff.
Note: This standard is applicable to staff 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.

IC.02.04.01, EP 1
The hospital establishes an annual influenza vaccination program that is offered to licensed independent practitioners and staff.

IC.02.04.01, EP 2
The hospital educates licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.
IC.02.04.01, EP 3
The hospital provides influenza vaccination at sites and times accessible to licensed independent practitioners and staff.

IC.02.04.01, EP 7
The hospital evaluates the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually.

IC.02.04.01, EP 9
The hospital provides influenza vaccination rate data to key stakeholders which may include leaders, physicians and other licensed independent practitioners, nursing staff, and other staff at least annually.

Information Management (IM) Chapter

Standard IM.01.01.03
The hospital plans for continuity of its information management processes.

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

(See also IM.03.01.01, EP 1)

Standard IM.02.02.07
For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets requirements for the electronic exchange of patient health information.
Note: This standard only applies to hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).

IM.02.02.07, EP 2
For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital demonstrates that its electronic health records system (or other electronic administrative system) sends notifications that include at least the patient’s name, treating licensed practitioner’s name, and sending institution’s name.

IM.02.02.07, EP 5
For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post-acute care services providers and suppliers, as well as any of the following who need to receive notification of the patient’s status for treatment, care coordination, or quality improvement purposes:
- The patient’s established primary care licensed practitioner
- The patient’s established primary care practice group or entity
- Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible
for the patient's care
Note: The term "reasonable effort" means that a hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which a hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with a hospital system’s capabilities.

Leadership (LD) Chapter

**Standard LD.03.04.01**

The hospital communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.

**Standard LD.04.01.05**

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

**LD.04.01.05, EP 2**

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

**Standard LD.04.02.03**

Ethical principles guide the hospital’s business practices.

**LD.04.02.03, EP 5**

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

**Standard LD.04.03.08**

Reducing health care disparities for the hospital’s patients is a quality and safety priority.

**LD.04.03.08, EP 6**

At least annually, the hospital informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to reduce identified health care disparities.

**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 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off
site, it can do the following:
- Verify that all physicians and other licensed practitioners who will be providing patient 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 practitioners will be within the scope of their privileges.

Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body.

(See also MS.13.01.01, EP 1)

LD.04.03.09, EP 9

For hospitals that do not use Joint Commission accreditation for deemed status purposes: When using the services of physicians or other licensed independent practitioners from a Joint Commission–accredited ambulatory care organization through a telemedical link for interpretive services, the hospital accepts the credentialing and privileging decisions of a Joint Commission–accredited ambulatory provider only after confirming that those decisions are made using the process described in Standards MS.06.01.03 through MS.06.01.07, excluding MS.06.01.03, EP 2.

(See also MS.13.01.01, EP 1)

LD.04.03.09, EP 23

For hospitals that use Joint Commission accreditation for deemed status purposes: When telemedicine services are furnished to the hospital’s patients, the originating site has a written agreement with the distant site that specifies the following:
- The distant site is a contractor of services to the hospital.
- The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation.
- The originating site makes certain through the written agreement that all distant-site telemedicine providers’ credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4).

Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply:
- The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the “Medical Staff” (MS) chapter (Standards MS.06.01.01 through MS.06.01.13).
- The governing body of the originating site grants privileges to a distant site physician or other licensed practitioner based on the originating site’s medical staff recommendations, which rely on information provided by the distant site.

(See also MS.13.01.01, EP 1)

Standard LD.04.03.13

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

LD.04.03.13, EP 3

The hospital provides staff and licensed independent practitioners with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population.
LD.04.03.13, EP 4
The hospital provides information to staff and licensed independent practitioners on available services for consultation and referral of patients with complex pain management needs.

LD.04.03.13, EP 6
The hospital facilitates licensed 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.

Medication Management (MM) Chapter

Standard MM.01.01.01
The hospital plans its medication management processes.

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

Note 1: This element of performance does not apply in emergency situations.
Note 2: This element of performance is also applicable to sample medications.
(See also IM.02.01.01, EP 3; MM.04.01.01, EP 10)

Standard MM.02.01.01
The hospital selects and procures medications.

MM.02.01.01, EP 1
Members of the medical staff, licensed independent practitioners, pharmacists, and other staff involved in ordering, dispensing, administering, and/or monitoring the effects of medications develop written criteria for determining which medications are available for dispensing or administering to patients.
Note: This element of performance is also applicable to sample medications.

MM.02.01.01, EP 10
The hospital follows a process to communicate medication shortages and outages to licensed independent practitioners and staff who participate in medication management.
MM.02.01.01, EP 14
The hospital follows a process to communicate the medication substitution protocols for shortages or outages to licensed independent practitioners and staff who participate in medication management.

**Standard MM.03.01.01**
The hospital safely stores medications.

**MM.03.01.01, EP 4**
The hospital follows a written policy addressing the control of medication between receipt by an individual health care provider staff member and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. 
Note: This element of performance is also applicable to sample medications.

**Standard MM.03.01.03**
The hospital safely manages emergency medications.

**MM.03.01.03, EP 1**
Hospital leaders, in conjunction with members of the medical staff and licensed independent practitioners, decide which emergency medications and their associated supplies will be readily accessible in patient care areas 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 hospital safely controls medications brought into the hospital by patients, their families, or licensed independent practitioners.

**MM.03.01.05, EP 1**
The hospital defines when medications brought into the hospital by patients, their families, or licensed independent practitioners can be administered. 
Note: This element of performance is also applicable to sample medications.

**MM.03.01.05, EP 2**
Before use or administration of a medication brought into the hospital by a patient, their family, or a licensed independent practitioner, the hospital identifies the medication and visually evaluates the medication's integrity. 
Note: This element of performance is also applicable to sample medications. 
(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 hospital 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 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 status
- Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval
- Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient’s status
- Signed and held orders: New prewritten (held) medication orders and specific instructions from a physician or other licensed independent practitioner to administer medication(s) to a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s)
- Orders for compounded drugs or drug mixtures not commercially available
- Orders for medication-related devices (for example, nebulizers, catheters)
- Orders for investigational medications
- Orders for herbal products
- Orders for medications at discharge or transfer

**MM.04.01.01, EP 15**

For hospitals that use Joint Commission accreditation for deemed status purposes: Processes for the use of preprinted and electronic standing orders, order sets, and protocols for medication orders include the following:
- Review and approval of standing orders and protocols by the medical staff and the hospital’s nursing and pharmacy leadership
- Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines
- Regular review of such standing orders and protocols by the medical staff and the hospital’s nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols
- Dating, timing, and authenticating of standing orders and protocols by the ordering physician or other licensed independent practitioner or another licensed practitioner responsible for the patient’s care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.

**Standard MM.05.01.01**

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

**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 patient in an urgent situation (including sudden changes in a patient’s clinical status), in accordance with law and regulation.

Note 1: The Joint Commission permits emergency departments to broadly apply two exceptions in regard to Standard MM.05.01.01, EP 1. These exceptions are intended to minimize treatment delays and patient backup. The first exception allows medications ordered by a physician or other licensed independent practitioner to be administered by staff who are permitted to do so by virtue of education, training, and organization policy (such as a registered nurse) and in accordance with law and regulation. A physician or other licensed independent practitioner is not required to remain at the bedside when the medication is administered. However, a physician or other licensed independent practitioner must be available to provide immediate intervention should a patient experience an adverse drug event. The second exception allows medications to be administered in urgent situations when a
delay in doing so would harm the patient.
Note 2: A hospital's radiology service (including hospital-associated ambulatory radiology) will be expected to define, through protocol or policy, the role of the physician or other licensed independent practitioner in the direct supervision of a patient during and after IV contrast media is administered including the physician or other licensed independent practitioner’s timely intervention in the event of a patient emergency.

**Standard MM.06.01.01**

The hospital safely administers medications.

**MM.06.01.01, EP 1**

Only authorized licensed independent practitioners and clinical staff administer medications. The hospital defines, in writing, those who are authorized to administer medication, with or without supervision, in accordance with law and regulation. 
Note: This does not prohibit self-administration of medications by patients, when indicated.  
(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 physician or other licensed independent practitioner, prescriber (if different from the physician or other licensed independent practitioner), and/or staff involved with the patient's care, treatment, and services
(See also MM.03.01.05, EP 2)

**Standard MM.07.01.03**

The hospital responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.

**MM.07.01.03, EP 6**

For hospitals that use Joint Commission accreditation for deemed status purposes: Medication administration errors, adverse drug reactions, and medication incompatibilities as defined by the hospital are immediately reported to the attending physician or clinical psychologist and as appropriate to the organizationwide quality assessment and performance improvement program.
Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

**Standard MM.09.01.01**

The hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.
MM.09.01.01, EP 12

The leader(s) of the antibiotic stewardship program is responsible for the following:
- Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics
- Documenting antibiotic stewardship activities, including any new or sustained improvements
- Communicating and collaborating with the medical staff, nursing leaders, and pharmacy leaders, as well as with the hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues
- Providing competency-based training and education for staff, including medical staff, on the practical applications of antibiotic stewardship guidelines, policies, and procedures

Medical Staff (MS) Chapter

Standard MS.01.01.01

Medical staff bylaws address self-governance and accountability to the governing body.

MS.01.01.01, EP 13

The medical staff bylaws include the following requirements: Qualifications for appointment to the medical staff. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff must be composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians as listed at 482.12(c)(1) and nonphysicianother licensed practitioners who are determined to be eligible for appointment by the governing body.

MS.01.01.01, EP 14

The medical staff bylaws include the following requirements: The process for privileging and re-privileging physicians and other licensed practitioners, which may include the process for privileging and re-privileging other practitioners. (See also MS.06.01.13, EP 1)

MS.01.01.01, EP 16

For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed individualpractitioner in accordance with state law and hospital policy. Note: For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6–11. For more information on completion time of the history and physical examination, refer to Standard PC.01.02.03, EPs 4 and 5.

MS.01.01.01, EP 22

The medical staff bylaws include the following requirements: That the medical executive committee includes physicians and may include other licensed practitioners and any other individuals as determined by the organized medical staff.
MS.01.01.01, EP 26

The medical staff bylaws include the following requirements: The process for credentialing and re-credentialing licensed independent practitioners, which may include the process for credentialing and re-credentialing physicians and other licensed practitioners.

MS.01.01.01, EP 28

The medical staff bylaws include the following requirements: Indications for automatic suspension of a physician's or other licensed practitioner’s medical staff membership or clinical privileges.

MS.01.01.01, EP 29

The medical staff bylaws include the following requirements: Indications for summary suspension of a physician's or other licensed practitioner’s medical staff membership or clinical privileges.

MS.01.01.01, EP 31

The medical staff bylaws include the following requirements: The process for automatic suspension of a physician's or other licensed practitioner’s medical staff membership or clinical privileges.

MS.01.01.01, EP 32

The medical staff bylaws include the following requirements: The process for summary suspension of a physician's or other licensed practitioner’s medical staff membership or clinical privileges.

MS.01.01.01, EP 36

The medical staff bylaws include the following requirements: If departments of the medical staff exist, the qualifications and roles and responsibilities of the department chair, which are defined by the organized medical staff, include the following:

Qualifications:
- Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process

Roles and responsibilities:
- Clinically related activities of the department
- Administratively related activities of the department, unless otherwise provided by the hospital
- Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges
- Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department
- Recommending clinical privileges for each member of the department
- Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization
- Integration of the department or service into the primary functions of the organization
- Coordination and integration of interdepartmental and intradepartmental services
- Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services
- Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services
- Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and staff who provide patient care, treatment, and services but are not licensed to practice
independently
- Continuous assessment and improvement of the quality of care, treatment, and services
- Maintenance of quality control programs, as appropriate
- Orientation and continuing education of all persons in the department or service
- Recommending space and other resources needed by the department or service

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: When departments of the medical staff do not exist, the medical staff is responsible for the development of policies and procedures that minimize medication errors. The medical staff may delegate this responsibility to the organized pharmaceutical service.

**Standard MS.02.01.01**

There is a medical staff executive committee.

**MS.02.01.01, EP 7**

The medical staff executive committee requests evaluations of physicians and other licensed practitioners privileged through the medical staff process in instances where there is doubt about an applicant’s ability to perform the privileges requested.

**MS.02.01.01, EP 11**

The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: The delineation of privileges for each physician and other licensed practitioner privileged through the medical staff process.

**Standard MS.03.01.01**

The organized medical staff oversees the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.

**MS.03.01.01, EP 1**

Licensed independent practitioners, physician members of the organized medical staff are designated to perform the oversight activities of the organized medical staff.

**MS.03.01.01, EP 2**

Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.

**MS.03.01.01, EP 3**

Licensed independent practitioners, physicians are responsible for the oversight activities of the organized medical staff.

**MS.03.01.01, EP 8**

The medical staff requires that a physician or other licensed practitioner who has been granted privileges by the hospital to do so performs a patient’s medical history and physical examination and required updates.

**MS.03.01.01, EP 9**

As permitted by state law and policy, the organized medical staff may choose to allow individual practitioners who are not licensed independent practitioners to practice independently to perform part or all of a patient’s medical
history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified doctor of medicine or osteopathy who is accountable for the patient’s medical history and physical examination.

**MS.03.01.01, EP 10**
The organized medical staff defines when a medical history and physical examination must be validated and countersigned by a licensed independent practitionerphysician with appropriate privileges.

**MS.03.01.01, EP 18**
For hospitals that elect The Joint Commission Primary Care Medical Home option: Through the privileging process, the organized medical staff determines which licensed practitioners are qualified to serve in the role of primary care clinician.

(See also LD.04.01.06, EP 1)

**Standard MS.03.01.03**
The management and coordination of each patient’s care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.

**MS.03.01.03, EP 4**
The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a doctor of medicine or osteopathy, or other licensed independent practitioner, is required.

**MS.03.01.03, EP 6**
There is coordination of the care, treatment, and services among the practitionersstaff involved in a patient’s care, treatment, and services.

**Standard MS.04.01.01**
In hospitals participating in a professional graduate education program(s), the organized medical staff has a defined process for supervision by a licensed independent practitionerphysician with appropriate clinical privileges of each member in the program in carrying out their patient care responsibilities.

**MS.04.01.01, EP 1**
The organized medical staff has a defined process for supervision by a licensed independent practitionerphysician with appropriate clinical privileges of each participant in the program in carrying out patient care responsibilities.

**MS.04.01.01, EP 4**
Organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so (without prohibiting licensed independent practitioners from writing orders), and what entries, if any, must be countersigned by a supervising licensed independent practitionerphysician.

**Standard MS.05.01.01**
The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.
MS.05.01.01, EP 1
The organized medical staff provides leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more physicians or other licensed independent practitioners, and other practitioners credentialed and privileged through the medical staff process. 
(See also PI.04.01.01, EPs 2, 5)

MS.05.01.01, EP 3
The medical staff is actively involved in the measurement, assessment, and improvement of the following: Use of information about adverse privileging decisions for any physician or other licensed practitioner privileged through the medical staff process. 
(See also PI.04.01.01, EPs 2, 5)

Standard MS.05.01.03
The organized medical staff participates in organizationwide performance improvement activities.

MS.05.01.03, EP 2
The organized medical staff participates in the following activities: Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient.

MS.05.01.03, EP 4
The organized medical staff participates in the following activities: Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluations of a physician's or other licensed practitioner's competence.

Standard MS.06.01.03
The hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.

MS.06.01.03, EP 5
The hospital verifies that the physician or other licensed practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following:
- A current picture hospital ID card
- A valid picture ID issued by a state or federal agency (for example, a driver's license or passport)

Standard MS.06.01.05
The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.

MS.06.01.05, EP 1
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.

MS.06.01.05, EP 2
The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a physician's or other licensed practitioner's ability to provide patient care,
treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria:
- Current licensure and/or certification, as appropriate, verified with the primary source
- The applicant’s specific relevant training, verified with the primary source
- Evidence of physical ability to perform the requested privilege
- Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
- Peer and/or faculty recommendation
- When renewing privileges, review of the physician's or other licensed practitioner's performance within the hospital

**MS.06.01.05, EP 3**
All of the criteria used are consistently evaluated for all physicians and other licensed practitioners holding that privilege.

**MS.06.01.05, EP 8**
Peer recommendation includes written information regarding the physician's or other licensed practitioner’s current:
- Medical/clinical knowledge
- Technical and clinical skills
- Clinical judgment
- Interpersonal skills
- Communication skills
- Professionalism

Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of physician- or other licensed practitioner-specific data collected from various sources for the purpose of validating current competence.

**MS.06.01.05, EP 9**
Before recommending privileges, the organized medical staff also evaluates the following:
- Challenges to any licensure or registration
- Voluntary and involuntary relinquishment of any license or registration
- Voluntary and involuntary termination of medical staff membership
- Voluntary and involuntary limitation, reduction, or loss of clinical privileges
- Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
- Documentation as to the applicant’s health status
- Relevant physician- or other licensed practitioner-specific data as compared to aggregate data, when available
- Morbidity and mortality data, when available

**MS.06.01.05, EP 12**
Information regarding each physician's or other licensed practitioner’s scope of privileges is updated as changes in clinical privileges for each practitioner are made.

**Standard MS.06.01.07**
The organized medical staff reviews and analyzes all relevant information regarding each requesting physician's or other licensed practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege.
MS.06.01.07, EP 5
The hospital’s privilege granting/denial criteria are consistently applied for each requesting physician or other licensed practitioner.

**Standard MS.06.01.09**

The decision to grant, limit, or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting physician or other licensed practitioner within the time frame specified in the medical staff bylaws.

**MS.06.01.09, EP 1**
Requesting physicians and other licensed practitioners are notified regarding the granting decision.

**MS.06.01.09, EP 5**
The hospital makes the physician or other licensed practitioner aware of available due process or, when applicable, the option to implement the Fair Hearing and Appeal Process for Adverse Privileging Decisions. (See also MS.10.01.01, EPs 1, 2, 3, 4, 5)

**Standard MS.07.01.03**

Deliberations by the medical staff in developing recommendations for appointment to or termination from the medical staff and for the initial granting, revision, or revocation of clinical privileges include information provided by peer(s) of the applicant.

**MS.07.01.03, EP 2**
Upon renewal of privileges, when insufficient physician- or other licensed practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations.

**MS.07.01.03, EP 4**
Peer recommendations are obtained from a physician or other licensed practitioner in the same professional discipline as the applicant with personal knowledge of the applicant’s ability to practice.

**Standard MS.08.01.01**
The organized medical staff defines the circumstances requiring monitoring and evaluation of a physician’s or other licensed practitioner’s professional performance.

**MS.08.01.01, EP 2**
The organized medical staff develops criteria to be used for evaluating the performance of physicians or other licensed practitioners when issues affecting the provision of safe, high quality patient care are identified.

**MS.08.01.01, EP 6**
The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a physician’s or other licensed practitioner’s current clinical competence, practice behavior, and ability to perform the requested privilege.

Note: Other existing privileges in good standing should not be affected by this decision.
Standard MS.08.01.03

Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

**MS.08.01.03, EP 1**

The process for the ongoing professional practice evaluation includes the following: There is a clearly defined process in place that facilitates the evaluation of each physician's or other licensed practitioner’s professional practice.

Standard MS.09.01.01

The organized medical staff, pursuant to the medical staff bylaws, evaluates and acts on reported concerns regarding a privileged physician’s or other licensed practitioner’s clinical practice and/or competence.

**MS.09.01.01, EP 2**

Reported concerns regarding a privileged physician’s or other licensed practitioner’s professional practice are uniformly investigated and addressed, as defined by the hospital and applicable law.

Standard MS.11.01.01

The medical staff implements a process to identify and manage matters of individual health for physicians and other licensed independent practitioners which is separate from actions taken for disciplinary purposes.

**MS.11.01.01, EP 1**

Process design addresses the following issues: Education of physicians or other licensed independent practitioners and other organization staff about illness and impairment recognition issues specific to licensed independent practitioners (at-risk criteria).

**MS.11.01.01, EP 2**

Process design addresses the following issues: Self referral by a physician or other licensed independent practitioner.

**MS.11.01.01, EP 4**

Process design addresses the following issues: Referral of the physician or other licensed independent practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.

**MS.11.01.01, EP 5**

Process design addresses the following issues: Maintenance of confidentiality of the physician or other licensed independent practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened.

**MS.11.01.01, EP 7**

Process design addresses the following issues: Monitoring the physician or other licensed independent practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required.
MS.11.01.01, EP 8

Process design addresses the following issues: Reporting to the organized medical staff leadership instances in which a physician or other licensed independent practitioner is providing unsafe treatment.

MS.11.01.01, EP 9

Process design addresses the following issues: Initiating appropriate actions when a physician or other licensed independent practitioner fails to complete the required rehabilitation program.

MS.11.01.01, EP 10

The medical staff implements its process to identify and manage matters of individual health for physicians and other licensed independent practitioners.

Standard MS.12.01.01

All licensed independent practitioners physicians and other licensed practitioners privileged through the medical staff process participate in continuing education.

Standard MS.13.01.01

For originating sites only: Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.

MS.13.01.01, EP 1

All physicians or other licensed practitioners who are responsible for the patient’s care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms:
- The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13.
Or
- The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited or a Medicare-participating organization. The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.
Or
- The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:
  - The distant site is a Joint Commission–accredited or a Medicare-participating organization.
  - The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site.
  - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of the physician’s or other licensed practitioner's privileges.
  - The originating site has evidence of an internal review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant site information that is useful to assess the physician's or other licensed practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve
any confidentiality or privilege of information established by applicable law.

- The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.

Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care.

Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers’ credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.

(See also LD.04.03.09, EPs 4, 9, 23)

**Standard MS.13.01.03**

For originating and distant sites: The medical staffs at both the originating and distant sites recommend the clinical services to be provided by physicians or other licensed independent practitioners through a telemedical link at their respective sites.

**MS.13.01.03, EP 1**

The medical staff recommends which clinical services are appropriately delivered by physicians or other licensed independent practitioners through this medium.

**National Patient Safety Goals (NPSG) Chapter**

**NPSG.03.06.01**

Maintain and communicate accurate patient medication information.

**NPSG.03.06.01, EP 5**

Explain the importance of managing medication information to the patient when they are discharged from the hospital or at the end of an outpatient encounter.

Note: Examples include instructing the patient to give a list to their primary care physician; 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 patient education on medications, refer to Standards MM.06.01.03, PC.02.03.01, and PC.04.01.05.)
UP.01.02.01
Mark the procedure site.

UP.01.02.01, EP 3
The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications:
- An individual in a medical postgraduate education program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed.
- A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed.
Note: The hospital's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications.

Provision of Care, Treatment, and Services (PC) Chapter

Standard PC.01.02.05
Qualified staff or licensed independent practitioners assess and reassess the patient.

Standard PC.02.01.03
The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

PC.02.01.03, EP 1
For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.
Note 1: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the physician or other licensed practitioner meets the following:
- Responsible for the care of the patient
- Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements.
- Acting within the practitioner’s scope of practice under state law
- Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services
Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient’s care, or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals.
Standard PC.03.01.07

The hospital provides care to the patient after operative or other high-risk procedures and/or the administration of moderate or deep sedation or anesthesia.

PC.03.01.07, EP 4

A qualified physician or other licensed independent practitioner discharges the patient from the recovery area or from the hospital. In the absence of a qualified licensed independent practitioner, patients are discharged according to criteria approved by clinical leaders. (See also RC.02.01.03, EPs 9, 10)

Standard PC.04.01.01

The hospital follows a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer.

PC.04.01.01, EP 1

The hospital describes the following:
- The reason(s) for and conditions under which the patient is discharged or transferred
- The method for shifting responsibility for a patient’s care from one clinician provider, hospital, program, or service to another

Standard PC.04.01.03

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

PC.04.01.03, EP 3

The patient, the patient’s family, physicians, other licensed independent practitioners, physicians, clinical psychologists, and staff involved in the patient’s care, treatment, and services participate in planning the patient’s discharge or transfer.

Note 1: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Note 2: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the hospital.

Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move in writing. The hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the hospital is safe and orderly. The hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman.

Note 4: For hospitals that use Joint Commission accreditation for deemed status purposes: Discharge planning is performed by, or under the supervision of, a registered nurse, social worker, or other qualified person.

Standard PC.04.02.01

When a patient is discharged or transferred, the hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.
PC.04.02.01, EP 1

At the time of the patient's discharge or transfer, the hospital informs other service providers who will provide care, treatment, and services to the patient about the following:
- The reason for the patient's discharge or transfer
- The patient's physical and psychosocial status
- A summary of care, treatment, and services it provided to the patient
- The patient’s progress toward goals
- A list of community resources or referrals made or provided to the patient

Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital also informs other service providers of the patient's treatment preferences.

Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The information sent to the receiving provider also includes the following:
- Contact information of the physician or other licensed practitioner responsible for the care of the resident
- Resident representative information, including contact information
- Advance directive information
- All special instructions or precautions for ongoing care, when appropriate
- Comprehensive care plan goals
(See also PC.02.02.01, EP 1)

Standard PC.06.01.01

Reduce the likelihood of harm related to maternal hemorrhage.

PC.06.01.01, EP 4

Provide education to all staff and providers who treat pregnant and postpartum patients about the hospital’s hemorrhage procedure. At a minimum, education occurs at orientation, whenever changes to the procedure occur, or every two years.

Note: Education provided should be role-specific.

Standard PC.06.03.01

Reduce the likelihood of harm related to maternal severe hypertension/preeclampsia.

PC.06.03.01, EP 3

Provide role-specific education to all staff and providers who treat pregnant/postpartum patients about the hospital’s evidence-based severe hypertension/preeclampsia procedure. At a minimum, education occurs at orientation, whenever changes to the procedure occur, or every two years.

Note: The emergency department is often where patients with symptoms or signs of severe hypertension present for care after delivery. For this reason, education should be provided to staff and providers in emergency departments regardless of the hospital’s ability to provide labor and delivery services.

Record of Care, Treatment, and Services (RC) Chapter

Standard RC.01.01.01

The hospital maintains complete and accurate medical records for each individual patient.
RC.01.01.01, EP 5

The medical record includes the following:
- Information needed to support the patient’s diagnosis and condition
- Information needed to justify the patient’s care, treatment, and services
- Information that documents the course and result of the patient's care, treatment, and services
- Information about the patient’s care, treatment, and services that promotes continuity of care among staff and providers

Note: For hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers.
(See also RI.01.01.03, EP 3)

Standard RC.01.02.01

Entries in the medical record are authenticated.

RC.01.02.01, EP 2

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

RC.01.02.01, EP 4

Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author.

Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.

Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped.

Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering practitioner physician or another licensed practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders.

Standard RC.02.01.01

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

RC.02.01.01, EP 18

The medical record of a patient who receives urgent or immediate care, treatment, and services contains all of the following:
- The time and means of arrival
- Indication that the patient left against medical advice, when applicable
- Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services
- A copy of any information made available to the practitioner or medical organization provider providing follow-up care, treatment, or services
Standard RC.02.01.03

The patient’s medical record contains documentation on any operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.

RC.02.01.03, EP 2

A physician or other licensed independent practitioner involved in the patient's care documents the provisional diagnosis in the medical record before an operative or other high-risk procedure is performed.

RC.02.01.03, EP 5

An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.

Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital.

Note 2: If the physician or other licensed practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

RC.02.01.03, EP 6

The operative or other high-risk procedure report includes the following information:
- The name(s) of the physician or other licensed independent practitioner(s) who performed the procedure and their assistant(s)
- The name of the procedure performed
- A description of the procedure
- Findings of the procedure
- Any estimated blood loss
- Any specimen(s) removed
- The postoperative diagnosis

RC.02.01.03, EP 9

The medical record contains documentation that the patient was discharged from the post-sedation or postanesthesia care area either by the physician or other licensed independent practitioner responsible for the patient's care or according to discharge criteria.

(See also PC.03.01.07, EP 4)

RC.02.01.03, EP 11

The postoperative documentation contains the name of the physician or other licensed independent practitioner responsible for discharge.

Standard RC.02.04.01

The patient’s medical record contains discharge information.

RC.02.04.01, EP 2

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident’s discharge information includes the following:
- The reason for transfer, discharge, or referral
- Treatment provided, diet, medication orders, and orders for the resident’s immediate care
- Referrals provided to the 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 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 resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation
- Nursing information that is useful in the resident's care
- Any advance directives
- Instructions given to the resident before discharge

Rights and Responsibilities of the Individual (RI) Chapter

Standard RI.01.02.01

The hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

RI.01.02.01, EP 1

The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge from the hospital.

Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post-acute care services providers and suppliers. The hospital has a process for documenting a patient’s refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations.

Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to be informed in advance of changes to their plan of care.

RI.01.02.01, EP 20

The hospital provides the patient or surrogate decision-maker with the information about the following:
- Outcomes of care, treatment, and services that the patient needs in order to participate in current and future health care decisions.
- Unanticipated outcomes of the patient's care, treatment, and services that are sentinel events as defined by The Joint Commission. This information is provided by the physician or other licensed independent practitioner responsible for managing the patient's care, treatment, and services, or the practitioner's designee. (Refer to the Glossary for a definition of sentinel event.)

Note: In settings where there is no licensed independent practitioner, the staff member responsible for managing the care of the patient is responsible for sharing information about such outcomes.
Standard RI.01.03.01

The hospital honors the patient's right to give or withhold informed consent.

RI.01.03.01, EP 1

The hospital follows a written policy on informed consent that describes the following:
- The specific care, treatment, and services that require informed consent
- Circumstances that would allow for exceptions to obtaining informed consent
- The process used to obtain informed consent
- The physician or other licensed practitioner permitted to conduct the informed consent discussion in accordance with law and regulation
- How informed consent is documented in the patient record
Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record.
- When a surrogate decision-maker may give informed consent
(See also RI.01.02.01, EP 2)

Standard RI.01.04.01

The hospital respects the patient's right to receive information about the individual(s) responsible for, as well as those providing, the patient's care, treatment, and services.

RI.01.04.01, EP 1

The hospital informs the patient of the following:
- The name of the physician, clinical psychologist, or other licensed practitioner who has primary responsibility for the patient's care, treatment, and services
- The name of the physician(s), clinical psychologist(s), or other licensed practitioner(s) who will provide the patient's care, treatment, and services
Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Standard RI.01.05.01

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

RI.01.05.01, EP 1

The hospital follows written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services that address the following:
- Providing patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services.
- Providing the patient upon admission with information on the extent to which the hospital is able, unable, or unwilling to honor advance directives.
- For outpatient hospital settings: Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided.
- Whether the hospital will honor advance directives in its outpatient settings.
- That the hospital will honor the patient's right to formulate or review and revise the patient's advance directives.
- Informing staff and licensed independent practitioners who are involved in the patient's care, treatment, and services whether or not the patient has an advance directive.
Standard RI.01.06.09

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to choose their medical, dental, and other licensed independent practitioner care providers.

RI.01.06.09, EP 1

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident’s right to choose an attending physician, dentist, and other licensed independent practitioner care providers. Note: The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative physician participation with the resident and honors the resident’s preferences, if any, among the options.

Standard RI.01.06.11

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to communicate with their medical, dental, and other licensed independent practitioner care providers.

RI.01.06.11, EP 1

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides the resident and the resident's family with the name, specialty, and telephone number of the physician or other licensed independent practitioner primarily responsible for the resident’s care.

RI.01.06.11, EP 3

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital helps the resident make and keep appointments with medical, dental, and other licensed independent practitioner care providers.

Standard RI.01.07.13

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to transportation services, as appropriate to their care or service plan.

RI.01.07.13, EP 1

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital arranges transportation for the resident to and from physician medical or dentist dental appointments and other activities identified in the resident’s care or service plan.

Standard RI.02.01.01

The hospital informs the patient about the patient's responsibilities related to their care, treatment, and services.

RI.02.01.01, EP 1

The hospital has a written policy that defines patient responsibilities, including but not limited to the following: - Providing information that facilitates their care, treatment, and services - Asking questions or acknowledging when they do not understand the treatment course or care decision - Following instructions, policies, rules, and regulations in place to support quality care for patients and a safe environment for all individuals in the hospital - Supporting mutual consideration and respect by maintaining civil language and conduct in interactions with staff
Waived Testing (WT) Chapter

**Standard WT.03.01.01**

*Staff and licensed independent practitioners* staff performing waived tests are competent.

**WT.03.01.01, EP 1**

*Staff and licensed independent practitioners* staff performing waived testing are competent. The person from the hospital 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 hospital’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 maintenance. The training on the use and maintenance of an instrument for waived testing is documented.

**WT.03.01.01, EP 6**

Competence for waived testing is assessed according to hospital policy at defined intervals, but at least at the time of orientation and annually thereafter. This competency is documented.

Note 1: When a physician or other licensed independent practitioner performs waived testing that does not involve an instrument and the test falls within their specialty, the hospital may use the medical staff credentialing and privileging process to document evidence of training and competency in lieu of annual competency assessment. In this circumstance, individual practitioner privileges include the specific waived tests appropriate to the scope of practice that they are authorized to perform. At the discretion of the person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate or according to hospital policy, more stringent competency requirements may be implemented.

Note 2: Provider-performed microscopy (PPM) procedures are not waived tests.