

Prepublication Requirements

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Select Retired and Revised Accreditation Requirements

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 HOSPITAL ACCREDITATION PROGRAM

Effective February 19, 2023

RETIRED ELEMENTS OF PERFORMANCE

Environment of Care (EC) Chapter

Standard EC.02.01.03

The hospital prohibits smoking except in specific circumstances.

EC.02.01.03, EP 1

The hospital develops a written policy prohibiting smoking in all buildings. Exceptions for patients in specific circumstances are defined.

Note: The scope of this EP is concerned with all smoking types—tobacco, electronic, or other.

Human Resources (HR) Chapter

Standard HR.01.02.07

The hospital determines how staff function within the organization.

HR.01.02.07, EP 5

Staff supervise students when they provide patient care, treatment, and services as part of their training.

Standard HR.01.07.01

The hospital evaluates staff performance.

HR.01.07.01, EP 5

When a licensed independent practitioner brings a nonemployee individual into the hospital to provide care, treatment, and services, the hospital reviews the individual's competencies and performance at the same frequency as individuals employed by the hospital.

Note: This review can be accomplished either through the hospital's regular process or with the licensed independent practitioner who brought staff into the hospital.

Information Management (IM) Chapter

Standard IM.02.02.03

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

IM.02.02.03, EP 13

For hospitals in California that provide computed tomography (CT) services: The hospital complies with radiation event reporting requirements specified in section 115113 of the California Health and Safety Code.

Leadership (LD) Chapter

Standard LD.03.06.01

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

LD.03.06.01, EP 5

Those who work in the hospital adapt to changes in the environment.

Standard LD.04.02.01

The leaders address any conflict of interest involving licensed independent practitioners and/or staff that affects or has the potential to affect the safety or quality of care, treatment, and services.

LD.04.02.01, EP 2

The leaders follow a written policy that defines situations that represent a conflict of interest involving licensed independent practitioners and/or staff and how the hospital will address these conflicts of interest.

LD.04.02.01, EP 3

Existing or potential conflicts of interest involving licensed independent practitioners and/or staff, as defined by the hospital, are disclosed.

LD.04.02.01, EP 4

The hospital reviews its relationships with other care providers, educational institutions, manufacturers, and payers to determine whether conflicts of interest exist and whether they are within law and regulation.

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 those individuals who work in the hospital, including staff and licensed independent practitioners.

Standard LD.04.02.03

Ethical principles guide the hospital's business practices.

LD.04.02.03, EP 1

The hospital follows a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.

Standard LD.04.02.05

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

LD.04.02.05, EP 1

Decisions regarding the provision of ongoing care, treatment, and services, discharge, or transfer are based on the assessed needs of the patient, regardless of the recommendations of any internal or external review.

Standard LD.04.03.11

The hospital manages the flow of patients throughout the hospital.

LD.04.03.11, EP 9

When the hospital determines that it has a population at risk for boarding due to behavioral health emergencies, hospital leaders communicate with behavioral health care providers and/or authorities serving the community to foster coordination of care for this population.

Life Safety (LS) Chapter**Standard LS.02.01.40**

The hospital provides and maintains special features to protect individuals from the hazards of fire and smoke.

LS.02.01.40, EP 2

The hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012: 18/19.4.2.

Medication Management (MM) Chapter**Standard MM.03.01.01**

The hospital safely stores medications.

MM.03.01.01, EP 9

The hospital keeps concentrated electrolytes present in patient care areas only when patient safety necessitates their immediate use, and precautions are used to prevent inadvertent administration.

Standard MM.03.01.03

The hospital safely manages emergency medications.

MM.03.01.03, EP 6

When emergency medications or supplies are used or expired, the hospital replaces them as soon as possible to maintain a full stock.

Standard MM.05.01.11

The hospital safely dispenses medications.

MM.05.01.11, EP 1

The hospital dispenses quantities of medications that are consistent with patient needs.

Note: This element of performance is also applicable to sample medications.

Standard MM.05.01.19

The hospital safely manages returned medications.

MM.05.01.19, EP 1

The hospital determines under what circumstances unused, expired, or returned medications will be managed by the pharmacy or the hospital.

Note: This element of performance is also applicable to sample medications.

MM.05.01.19, EP 3

The hospital determines if and when outside sources are used for destruction of medications.

Note: This element of performance is also applicable to sample medications.

Standard MM.06.01.05

The hospital safely manages investigational medications.

MM.06.01.05, EP 1

The hospital follows a written process addressing the use of investigational medications that includes review, approval, supervision, and monitoring.

MM.06.01.05, EP 3

The written process for the use of investigational medications specifies that when a patient is involved in an investigational protocol that is independent of the hospital, the hospital evaluates and, if no contraindication exists, accommodates the patient's continued participation in the protocol.

National Patient Safety Goals (NPSG) Chapter**Standard NPSG.03.04.01**

Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

Note: Medication containers include syringes, medicine cups, and basins.

NPSG.03.04.01, EP 6

Immediately discard any medication or solution found unlabeled.

NPSG.03.04.01, EP 7

Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.

Note: This does not apply to multiuse vials that are handled according to infection control practices.

NPSG.03.04.01, EP 8

All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.

Standard NPSG.03.05.01

Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

Note: This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for preventing venous thromboembolism (for example, related to procedures or hospitalization).

NPSG.03.05.01, EP 1

The hospital uses approved protocols and evidence-based practice guidelines for the initiation and maintenance of anticoagulant therapy that address medication selection; dosing, including adjustments for age and renal or liver function; drug–drug and drug–food interactions; and other risk factors as applicable.

NPSG.03.05.01, EP 4

The hospital has a written policy addressing the need for baseline and ongoing laboratory tests to monitor and adjust anticoagulant therapy.

Note: For all patients receiving warfarin therapy, use a current international normalized ratio (INR) to monitor and adjust dosage. For patients on a direct oral anticoagulant (DOAC), follow evidence-based practice guidelines regarding the need for laboratory testing.

NPSG.03.05.01, EP 5

The hospital addresses anticoagulation safety practices through the following:

- Establishing a process to identify, respond to, and report adverse drug events, including adverse drug event outcomes
- Evaluating anticoagulation safety practices, taking actions to improve safety practices, and measuring the effectiveness of those actions in a time frame determined by the hospital

NPSG.03.05.01, EP 6

The hospital provides education to patients and families specific to the anticoagulant medication prescribed, including the following:

- Adherence to medication dose and schedule
- Importance of follow-up appointments and laboratory testing (if applicable)
- Potential drug–drug and drug–food interactions
- The potential for adverse drug reactions

NPSG.03.05.01, EP 8

When heparin is administered intravenously and continuously, the hospital uses programmable pumps in order to provide consistent and accurate dosing.

Standard NPSG.06.01.01

Improve the safety of clinical alarm systems.

NPSG.06.01.01, EP 4

Educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible.

Standard UP.01.01.01

Conduct a preprocedure verification process.

UP.01.01.01, EP 3

Match the items that are to be available in the procedure area to the patient.

Provision of Care, Treatment, and Services (PC) Chapter**Standard PC.01.01.01**

The hospital accepts the patient for care, treatment, and services based on its ability to meet the patient's needs.

PC.01.01.01, EP 4

Hospitals that do not primarily provide psychiatric or substance abuse services follow a written plan that defines the care, treatment, and services or the referral process for patients who are emotionally ill or who suffer the effects of alcoholism or substance abuse.

PC.01.01.01, EP 24

If a patient is boarded while awaiting care for emotional illness and/or the effects of alcoholism or substance abuse, the hospital does the following:

- Provides for a location for the patient that is safe, monitored, and clear of items that the patient could use to harm themselves or others. (Refer to LD.04.03.11, EP 6; NPSG.15.01.01, EPs 1 and 2)
- Provides orientation and training to any clinical and nonclinical staff caring for such patients in effective and safe care, treatment, and services (for example, medication protocols, de-escalation techniques). (Refer to HR.01.06.01, EP 1)
- Conducts assessments and reassessments, and provides care consistent with the patient's identified needs.

Standard PC.01.03.03

The hospital defines its patient behavior management policies.

PC.01.03.03, EP 1

The hospital's written behavior management policies describe the conditions under which specific behavior management procedures can and cannot be used.

PC.01.03.03, EP 2

The hospital's written behavior management policies disallow the use of any procedure that could physically harm the patient or place the patient at psychological risk.

PC.01.03.03, EP 3

The hospital's written behavior management policies include the following:

- Limit patient time-outs to no more than 30 minutes in an unlocked room.
- Prohibit the use of intimidation, force, or threat.
- Require that the patient receive education about the conditions under which time-outs are used.

PC.01.03.03, EP 4

The hospital prohibits the following:

- The denial of the patient's basic needs, such as the denial of a nutritious diet and water
- The denial of shelter
- The denial of essential, safe clothing
- The use of corporal punishment
- The use of fear-eliciting techniques
- The use of mechanical restraint and seclusion
- Any procedures that allow another patient to implement behavior management and treatment techniques on other patients

Note 1: The use of mechanical restraint and seclusion as treatment interventions is prohibited except for patients who exhibit intractable behavior that is severely self-injurious or injurious to others, who have not responded to traditional interventions, and who are unable to contract with staff for safety (that is, understand the concept of, and act on, criteria for the discontinuation of restraint or seclusion).

Note 2: When restraint or seclusion is used in an emergency situation, its use needs to be in compliance with Standards PC.03.05.01 through PC.03.05.17.

PC.01.03.03, EP 5

The hospital's written behavior management policies on the use of aversive procedures are reviewed and approved by clinical leaders and a person(s) external to the hospital, such as an expert in the use of aversive procedures, a patient advocate, or a human rights committee.

Standard PC.01.03.05

The hospital's use of behavior management procedures adhere to the patient's plan for care, treatment, and services and organization policy.

PC.01.03.05, EP 4

Qualified staff review, evaluate, and approve the use of all behavior management procedures.

PC.01.03.05, EP 6

Time-outs and procedures using restraining devices or aversive techniques are used only in a manner consistent with the patient's plan of care, policies and procedures, and state and federal laws.

PC.01.03.05, EP 8

When restrictive behavior management techniques are necessary, the hospital chooses the least restrictive technique from among those that are approved for use before progressing to more restrictive behavior management techniques.

Standard PC.02.02.03

The hospital makes food and nutrition products available to its patients.

PC.02.02.03, EP 9

When possible, the hospital accommodates the patient's cultural, religious, or ethnic food and nutrition preferences, unless contraindicated.

Standard PC.02.02.13

The patient's comfort and dignity receive priority during end-of-life care.

PC.02.02.13, EP 1

To the extent possible, the hospital provides care and services that accommodate the patient's and their family's comfort, dignity, psychosocial, emotional, and spiritual end-of-life needs.

PC.02.02.13, EP 2

The hospital provides staff with education about the unique needs of dying patients and their families.

Standard PC.03.01.09

The hospital provides electroconvulsive therapy safely.

PC.03.01.09, EP 1

The hospital follows a written policy that addresses the use of electroconvulsive therapy.

PC.03.01.09, EP 2

The hospital obtains written consent for electroconvulsive therapy from the patient and documents it in the medical record.

PC.03.01.09, EP 3

Before initiating electroconvulsive therapy for a child or youth, two qualified, experienced child psychiatrists who are not directly involved in treating the child or youth examine the child or youth; consult with the child's or youth's psychiatrist; and document in the medical record their concurrence with the decision to use electroconvulsive therapy.

PC.03.01.09, EP 4

The hospital justifies the use of electroconvulsive therapy in the patient's medical record.

Performance Improvement (PI) Chapter

Standard PI.03.01.01

The hospital compiles and analyzes data.

PI.03.01.01, EP 7

The hospital analyzes its organ procurement conversion rate data as provided by the organ procurement organization (OPO).

Note: Conversion rate is defined as the number of actual organ donors over the number of eligible donors defined by the OPO, expressed as a percentage.

PI.03.01.01, EP 19

The hospital monitors the use of opioids to determine if they are being used safely (for example, the tracking of adverse events such as respiratory depression, naloxone use, and the duration and dose of opioid prescriptions).

PI.03.01.01, EP 20

For hospitals that provide fluoroscopic services: The hospital reviews and analyzes instances where the radiation exposure and skin dose threshold levels identified by the organization are exceeded.

Note: Radiation exposure thresholds may be established based on metrics such as reference-air kerma, cumulative-air kerma, kerma-area product, or fluoroscopy time.

PI.03.01.01, EP 21

The hospital provides incidence data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians on the following:

- Multidrug-resistant organisms (MDRO)
- Central line–associated bloodstream infections (CLABSI)
- Surgical site infections (SSI)

Rights and Responsibilities of the Individual (RI) Chapter

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 15

When required by policy or upon patient request, the hospital documents the patient's wishes concerning organ donation and honors the wishes within the limits of its capability, policy, and law and regulation.

Waived Testing (WT) Chapter

Standard WT.01.01.01

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

WT.01.01.01, EP 4

The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, approves in writing policies and procedures for waived testing at the following times:

- Before initial use of the test for patient testing
- Periodically thereafter, as defined by the person whose name appears on the CLIA certificate but at least once every three years
- When changes in procedures occur (for example, when manufacturers' updates to package inserts include procedural changes or when a different manufacturer is used)

Standard WT.02.01.01

The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate identifies the staff responsible for performing and supervising waived testing.

Note 1: Responsible staff may be employees of the hospital, contracted staff, or employees of a contracted service.

Note 2: Responsible staff may be identified within job descriptions or by listing job titles or individual names.

WT.02.01.01, EP 2

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

Standard WT.04.01.01

The hospital performs quality control checks for waived testing on each procedure.

Note: Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.

WT.04.01.01, EP 1

The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate establishes a written quality control plan for waived testing that specifies the method(s) for controlling procedures for quality, establishes timetables, and explains the rationale for choice of procedures and timetables.

Standard WT.05.01.01

The hospital maintains records for waived testing.

WT.05.01.01, EP 2

Test results for waived testing are documented in the patient's medical record.

REVISED ELEMENTS OF PERFORMANCE**Standard LD.02.02.01**

The governing body, senior managers and leaders of the organized medical staff address any conflict of interest involving leaders that affect or could affect the safety or quality of care, treatment and services.

~~Note: This standard addresses conflict of interest involving individual members of leadership groups. For conflicts of interest among staff and licensed independent practitioners who are not members of leadership groups, see Standard LD.04.02.01.~~

LD.02.02.01, EP 1

The governing body, senior managers, and leaders of the organized medical staff work together to define in writing conflicts of interest involving leaders that could affect safety and quality of care, treatment, and services.

LD.02.02.01, EP 2

The governing body, senior managers, and leaders of the organized medical staff work together to develop a written policy that defines how conflict of interest involving leaders will be addressed.

LD.02.02.01, EP 3

Conflicts of interest involving leaders are disclosed as defined by the hospital.

Standard WT.02.01.01

The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate identifies the staff responsible for performing and supervising waived testing.

Note 1: Responsible staff may be employees of the hospital, contracted staff, or employees of a contracted service.

Note 2: Responsible staff may be identified within job descriptions or by listing job titles or individual names.

WT.02.01.01, EP 1

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