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.

Revisions to Deeming Requirements for Critical Access Hospitals

**APPLICABLE TO CRITICAL ACCESS HOSPITALS**

**Effective September 1, 2012**

**Human Resources (HR)**

**Standard HR.01.02.01**
The critical access hospital defines staff qualifications.

**Deleted Element of Performance for HR.01.02.01**

A 19. For rehabilitation and psychiatric distinct part units in critical access hospitals:

If blood transfusions and intravenous medications are administered by staff other than doctors of medicine or osteopathy, the staff members have special training for this duty.

**Leadership (LD)**

**Standard LD.01.02.01**
The critical access hospital identifies the responsibilities of its leaders.

**Revised Element of Performance for LD.01.02.01**

C 4. For rehabilitation and psychiatric distinct part units in critical access hospitals: The chief executive officer, medical staff, and nurse executive make certain that the critical access hospital-wide quality assessment and performance improvement and training programs address problems identified by the individual responsible for infection prevention and control and that corrective action plans are successfully implemented. (See also IC.03.01.01, EP 7)

**Standard LD.01.05.01**
The critical access hospital has an organized medical staff that is accountable to the governing body.

**Revised Element of Performance for LD.01.05.01**

A 7. For rehabilitation and psychiatric distinct part units in critical access hospitals: A doctor of medicine or osteopathy, or, if permitted by state law, a doctor of dental surgery or dental medicine, or a doctor of podiatric medicine is responsible for the organization and conduct of the medical staff.

**Standard LD.04.01.05**
The critical access hospital effectively manages its programs, services, sites, or departments.

**Revised Element of Performance for LD.04.01.05**

A 8. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital assigns one or more individuals who are responsible for outpatient services.

**Standard LD.04.03.01**
The critical access hospital provides services that meet patient needs.

**Revised Elements of Performance for LD.04.03.01**

A 8. The critical access hospital furnishes direct services that include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.

A 9. The critical access hospital provides, as direct services, the following basic laboratory services essential to the immediate diagnosis and treatment of the patient:

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**Key:**
- A indicates scoring category A;
- C indicates scoring category C;
- ▲ indicates an Immediate Threat to Health or Safety;
- △ indicates situational decision rules apply;
- ▶ indicates direct impact requirements apply;
- ◊ indicates Measure of Success is needed;
- ☛ indicates that documentation is required.
The chemical examination of urine by the stick method, the tablet method, or both
• Hemoglobin or hematocrit tests
• Blood glucose tests
• Examination of stool specimens for occult blood
• Pregnancy tests
• Primary culturing for transmittal to a certified laboratory.

A 10. The critical access hospital provides radiology services as direct services, by staff qualified in accordance with state law. These services do not expose patients or staff to radiation hazards.

A 11. The critical access hospital provides medical emergency producers as direct services as a first response to common life-threatening injuries and acute illnesses.

### Medication Management (MM)

#### Standard MM.04.01.01
Medication orders are clear and accurate.

#### New Element of Performance for MM.04.01.01
A 15. For rehabilitation and psychiatric distinct part units in critical access hospitals: Processes for the use of pre-printed 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 critical access 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 critical access 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 practitioner or another 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.

#### Revised Elements of Performance for MM.06.01.03

**C 4.** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital educates patients and families involved in self-administration about how to administer medication, including process, time, frequency, route, and dose. (See also MM.06.01.01, EP 9; PC.02.03.01, EP 10)

**C 7.** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital determines that the patient or the family member who administers the medication is competent at medication administration before allowing him or her to administer medications.

#### Standard MM.07.01.03
The critical access hospital responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.

#### Revised Element of Performance for MM.07.01.03
A 6. For rehabilitation and psychiatric distinct part units in critical access hospitals: Medication administration errors, adverse drug reactions, and medication incompatibilities as defined by the critical access hospital are reported to the attending physician or clinical psychologist, immediately when possible, and as appropriate to the organization-wide 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 PC.02.01.03
The critical access hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.
Revised Element of Performance for PC.02.01.03

A 1. For rehabilitation and psychiatric distinct part units in critical access hospitals: Prior to providing care, treatment, and services, the critical access hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; and law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations.*

*For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).

Standard PC.03.05.19

For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital reports deaths associated with the use of restraint and seclusion.

Revised and New Elements of Performance for PC.03.05.19

A 1. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital reports the following information to the Centers for Medicare & Medicaid Services (CMS) regarding deaths related to restraints (this does not apply to deaths related to the use of soft wrist restraints, for more information refer to see EP 3 in this standard):

● Each death that occurs while a patient is in restraint or seclusion
● Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
● Each death known to the critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death

Note: In this element of performance “reasonable to assume” includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.

A 2. For rehabilitation and psychiatric distinct part units in critical access hospitals: The deaths addressed in PC.03.05.19, EP 1 are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone, facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.

A 3. For rehabilitation and psychiatric distinct part units in critical access hospitals: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the critical access hospital does the following:

● Records in a log or other system, any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient
● Records in a log or other system, any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient
● Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed independent practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es)*

*For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).

Record of Care, Treatment, and Services (RC)

Standard RC.01.02.01

Entries in the medical record are authenticated.

Revised Element of Performance for RC.01.02.01

C 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 critical access hospital policy. For electronic records, electronic signatures will be date-stamped.

Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: For a five-year period following January 26, 2007. All orders, including verbal orders, are dated and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient (as specified at 42 CFR 482.12...
(e)), and who, in accordance with critical access hospital policy and law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders.

**Standard RC.02.03.07**

Qualified staff receive and record verbal orders.

**Revised Element of Performance for RC.02.03.07**

| C 4 | Verbal orders are authenticated within the time frame specified by law and regulation. |

**Note 1:** For rehabilitation and psychiatric distinct part units in critical access hospitals: If there is no state law that designates a specific time frame for authentication of verbal orders, the verbal orders are authenticated within 48 hours.

**Note 2:** For rehabilitation and psychiatric distinct part units in critical access hospitals: In some instances, the ordering practitioner may not be able to authenticate his or her verbal order (for example, the ordering practitioner gives a verbal order that is written and transcribed, and then he or she is “off duty” for the weekend or an extended period of time). In such cases, for a temporary period expiring on January 26, 2012, it is acceptable for another practitioner who is responsible for the patient’s care to authenticate the verbal order of the ordering practitioner.