


Effective 1 April 2014

A large, glowing, wireframe globe graphic with several bright starburst effects, serving as a background for the title text.

**Joint
Commission
International
Accreditation
Standards
for
Hospitals**

Including Standards for Academic Medical Center Hospitals

5th Edition

Standards-Only Version

Section I: Accreditation Participation Requirements





Accreditation Participation Requirements (APR)

Overview

This section, new to this accreditation manual, consists of specific requirements for participation in the Joint Commission International accreditation process and for maintaining an accreditation award.

For a hospital seeking accreditation for the first time, compliance with many of the APRs is assessed during the initial survey. For the already-accredited hospital, compliance with the APRs is assessed throughout the accreditation cycle, through on-site surveys, the Strategic Improvement Plan (SIP), and periodic updates of hospital-specific data and information.

Organizations are either compliant or not compliant with the APRs. When a hospital does not comply with certain APRs, the hospital may be asked to submit an SIP, or the noncompliance may result in being placed At Risk for Denial of Accreditation, or may lead to the loss of accreditation as with any refusal to permit performance of a survey. How the requirement is evaluated and the consequences of noncompliance are noted with each APR.

Please note that the APR requirements are not scored similarly to the standards chapters, and their evaluation does not directly impact the outcome of an on-site initial or triennial accreditation survey.

Requirements

Requirement: APR.1

The hospital meets all requirements for timely submissions of data and information to Joint Commission International (JCI).

Requirement: APR.2

The hospital provides JCI with accurate and complete information through all phases of the accreditation process.

Requirement: APR.3

The hospital reports within 15 days any changes in the hospital's profile (electronic database) or information provided to JCI via the E-App before and between surveys.

Requirement: APR.4

The hospital permits on-site evaluations of standards and policy compliance or verification of quality and safety concerns, reports, or regulatory authority sanctions at the discretion of JCI.

Requirement: APR.5

The hospital allows JCI to request (from the hospital or outside agency) and review an original or authenticated copy of the results and reports of external evaluations from publicly recognized bodies.

Requirement: APR.6

The hospital allows JCI Accreditation Program staff and members of JCI's Board of Directors to observe the on-site survey.

Requirement: APR.7

The hospital participates in the Joint Commission International Library of Measures quality improvement measurement system. The hospital's leadership selects clinical measures from the Library applicable to the hospital's patient populations and services. When Library measures are not applicable to the hospital's patient populations and services, the hospital consults with JCI staff regarding an exemption from the measure requirements of APR.7.

The hospital uses the current Library measure specifications and follows Library measure selection, use, and data submission requirements as found on the JCI Library of Measures website, which can be accessed directly from the JCI Direct Connect customer portal. The JCI Library of Measures website describes current requirements related to the following:

- 1) Any required minimum number of measures sets or individual measures that must be selected and implemented
 - 2) The process for obtaining an exemption from APR.7 requirements when the Library measures are not applicable to the hospital's patient populations and services provided
 - 3) The collection and aggregation process for Library measure data
 - 4) The effective date and the process for submission of quarterly discharge data
 - 5) The use of Library measure data in the accreditation process
 - 6) The criteria for determining continued use or replacement of Library measures
 - 7) How data quality issues are to be managed
-

Requirement: APR.8

The hospital accurately represents its accreditation status and the programs and services to which JCI accreditation applies.

Requirement: APR.9

Any individual hospital staff member (clinical or administrative) can report concerns about patient safety and quality of care to JCI without retaliatory action from the hospital.

To support this culture of safety, the hospital must communicate to staff that such reporting is permitted. In addition, the hospital must make it clear to staff that no formal disciplinary actions (**for example**, demotions, reassignments, or change in working conditions or hours) or informal punitive actions (**for example**, harassment, isolation, or abuse) will be threatened or carried out in retaliation for reporting concerns to JCI.

Requirement: APR.10

Translation and interpretation services arranged by the hospital for an accreditation survey and any related activities are provided by licensed and/or qualified translation and interpretation professionals who have no relationship to the hospital.

Requirement: APR.11

The hospital notifies the public it serves about how to contact its hospital management and JCI to report concerns about patient safety and quality of care.

Methods of notice may include, but are not limited to, distribution of information about JCI, including contact information in published materials such as brochures and/or posting this information on the hospital's website.

Requirement: APR.12

The hospital provides patient care in an environment that poses no risk of an immediate threat to patient safety, public health, or staff safety.

Section II: Patient-Centered Standards





International Patient Safety Goals (IPSG)

Goals and Standards

Goal 1: Identify Patients Correctly

Standard IPSG.1

The hospital develops and implements a process to improve accuracy of patient identifications.

Goal 2: Improve Effective Communication

Standard IPSG.2

The hospital develops and implements a process to improve the effectiveness of verbal and/or telephone communication among caregivers.

Standard IPSG.2.1

The hospital develops and implements a process for reporting critical results of diagnostic tests.

Standard IPSG.2.2

The hospital develops and implements a process for handover communication.

Goal 3: Improve the Safety of High-Alert Medications

Standard IPSG.3

The hospital develops and implements a process to improve the safety of high-alert medications.

Standard IPSG.3.1

The hospital develops and implements a process to manage the safe use of concentrated electrolytes.

Goal 4: Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery

Standard IPSG.4

The hospital develops and implements a process for ensuring correct-site, correct-procedure, and correct-patient surgery.

Standard IPSG.4.1

The hospital develops and implements a process for the time-out that is performed in the operating theatre immediately prior to the start of surgery to ensure correct-site, correct-procedure, and correct-patient surgery.

Goal 5: Reduce the Risk of Health Care–Associated Infections

Standard IPSG.5

The hospital adopts and implements evidence-based hand-hygiene guidelines to reduce the risk of health care–associated infections.

Goal 6: Reduce the Risk of Patient Harm Resulting from Falls

Standard IPSG.6

The hospital develops and implements a process to reduce the risk of patient harm resulting from falls.



Access to Care and Continuity of Care (ACC)

Standards

Screening for Admission to the Hospital

Standard ACC.1

Patients who may be admitted to the hospital or who seek outpatient services are screened to identify if their health care needs match the hospital's mission and resources.

Standard ACC.1.1

Patients with emergent, urgent, or immediate needs are given priority for assessment and treatment.

Standard ACC.1.2

The hospital considers the clinical needs of patients and informs patients when there are waiting periods or delays for diagnostic and/or treatment services.

Admission to the Hospital

Standard ACC.2

The hospital has a process for admitting inpatients and for registering outpatients.

Standard ACC.2.1

Patient needs for preventive, palliative, curative, and rehabilitative services are prioritized based on the patient's condition at the time of admission as an inpatient to the hospital.

Standard ACC.2.2

At admission as an inpatient, patients and families receive information on the proposed care, the expected outcomes of care, and any expected cost to the patient for care.

Standard ACC.2.2.1

The hospital develops a process to manage the flow of patients throughout the hospital.

Standard ACC.2.3

Admission to units providing intensive or specialized services is determined by established criteria.

Standard ACC.2.3.1

Discharge from units providing intensive or specialized services is determined by established criteria.

Continuity of Care

Standard ACC.3

The hospital designs and carries out processes to provide continuity of patient care services in the hospital and coordination among health care practitioners.

Standard ACC.3.1

During all phases of inpatient care, there is a qualified individual identified as responsible for the patient's care.

Standard ACC.3.2

Information related to the patient's care is transferred with the patient.

Discharge, Referral, and Follow-Up

Standard ACC.4

There is a process for the referral or discharge of patients that is based on the patient's health status and the need for continuing care or services.

Standard ACC.4.1

Patient and family education and instruction are related to the patient's continuing care needs.

Standard ACC.4.2

The hospital cooperates with health care practitioners and outside agencies to ensure timely referrals.

Standard ACC.4.3

The complete discharge summary is prepared for all inpatients.

Standard ACC.4.3.1

Patient education and follow-up instructions are given in a form and language the patient can understand.

Standard ACC.4.3.2

The clinical records of inpatients contain a copy of the discharge summary.

Standard ACC.4.4

The records of outpatients requiring complex care or with complex diagnoses contain profiles of the medical care and are made available to health care practitioners providing care to those patients.

Standard ACC.4.5

The hospital has a process for the management and follow-up of patients who notify hospital staff that they intend to leave against medical advice.

Standard ACC.4.5.1

The hospital has a process for the management of patients who leave the hospital against medical advice without notifying hospital staff.

Transfer of Patients

Standard ACC.5

Patients are transferred to other organizations based on status, the need to meet their continuing care needs, and the ability of the receiving organization to meet patients' needs.

Standard ACC.5.1

The referring hospital develops a transfer process to ensure that patients are transferred safely.

Standard ACC.5.2

The receiving organization is given a written summary of the patient's clinical condition and the interventions provided by the referring hospital.

Standard ACC.5.3

The transfer process is documented in the patient's record.

Transportation

Standard ACC.6

The process for referring, transferring, or discharging patients, both inpatients and outpatients, includes planning to meet patients' transportation needs.



Patient and Family Rights (PFR)

Standards

Standard PFR.1

The hospital is responsible for providing processes that support patients' and families' rights during care.

Standard PFR.1.1

The hospital seeks to reduce physical, language, cultural, and other barriers to access and delivery of services.

Standard PFR.1.2

The hospital provides care that is respectful of the patient's personal values and beliefs and responds to requests related to spiritual and religious beliefs.

Standard PFR.1.3

The patient's rights to privacy and confidentiality of care and information are respected.

Standard PFR.1.4

The hospital takes measures to protect patients' possessions from theft or loss.

Standard PFR.1.5

Patients are protected from physical assault, and populations at risk are identified and protected from additional vulnerabilities.

Standard PFR.2

The hospital supports patients' and families' rights to participate in the care process.

Standard PFR.2.1

Patients are informed about all aspects of their medical care and treatment.

Standard PFR.2.2

The hospital informs patients and families about their rights and responsibilities to refuse or discontinue treatment, withhold resuscitative services, and forgo or withdraw life-sustaining treatments.

Standard PFR.2.3

The hospital supports the patient's right to assessment and management of pain and respectful compassionate care at the end of life.

Standard PFR.3

The hospital informs patients and families about its process to receive and to act on complaints, conflicts, and differences of opinion about patient care and the patient's right to participate in these processes.

Standard PFR.4

All patients are informed about their rights and responsibilities in a manner and language they can understand.

General Consent

Standard PFR.5

General consent for treatment, if obtained when a patient is admitted as an inpatient or is registered for the first time as an outpatient, is clear in its scope and limits.

Informed Consent

Standard PFR.5.1

Patient informed consent is obtained through a process defined by the hospital and carried out by trained staff in a manner and language the patient can understand.

Standard PFR.5.2

Informed consent is obtained before surgery, anesthesia, procedural sedation, use of blood and blood products, and other high-risk treatments and procedures.

Standard PFR.5.3

Patients and families receive adequate information about the illness, proposed treatment(s), and health care practitioners so that they can make care decisions.

Standard PFR.5.4

The hospital establishes a process, within the context of existing law and culture, for when others can grant consent.

Organ Donation

Note: The following standards are intended to be used in situations in which organ or tissue transplantation will not occur but during those times when patients request information about organ and tissue donation and/or when organ or tissue donation may occur. When organ or tissue donation and transplantation are performed, the standards for organ and tissue transplant programs (found in COP.8 through COP.9.3) apply.

Standard PFR.6

The hospital informs patients and families about how to choose to donate organs and other tissues.

Standard PFR.6.1

The hospital provides oversight for the process of organ and tissue procurement.



Assessment of Patients (AOP)

Standards

Standard AOP.1

All patients cared for by the hospital have their health care needs identified through an assessment process that has been defined by the hospital.

Standard AOP.1.1

Each patient's initial assessment includes an evaluation of physical, psychological, social, and economic factors, including a physical examination and health history.

Standard AOP.1.2

The patient's medical and nursing needs are identified from the initial assessments, which are completed and documented in the clinical record within the first 24 hours after admission as an inpatient or earlier as indicated by the patient's condition.

Standard AOP.1.2.1

The initial medical and nursing assessments of emergency patients are based on their needs and conditions.

Standard AOP.1.3

The hospital has a process for accepting initial medical assessments conducted in a physician's private office or other outpatient setting prior to admission or outpatient procedure.

Standard AOP.1.3.1

A preoperative assessment is documented before anesthesia or surgical treatment and includes the patient's medical, physical, psychological, and spiritual/cultural needs.

Standard AOP.1.4

Patients are screened for nutritional status, functional needs, and other special needs and are referred for further assessment and treatment when necessary.

Standard AOP.1.5

All inpatients and outpatients are screened for pain and assessed when pain is present.

Standard AOP.1.6

The hospital conducts individualized initial assessments for special populations cared for by the hospital.

Standard AOP.1.7

Dying patients and their families are assessed and reassessed according to their individualized needs.

Standard AOP.1.8

The initial assessment includes determining the need for discharge planning.

Standard AOP.2

All patients are reassessed at intervals based on their condition and treatment to determine their response to treatment and to plan for continued treatment or discharge.

Standard AOP.3

Qualified individuals conduct the assessments and reassessments.

Standard AOP.4

Medical, nursing, and other individuals and services responsible for patient care collaborate to analyze and integrate patient assessments and prioritize the most urgent/important patient care needs.

Laboratory Services

Standard AOP.5

Laboratory services are available to meet patient needs, and all such services meet applicable local and national standards, laws, and regulations.

Standard AOP.5.1

A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service.

Standard AOP.5.2

All laboratory staff have the required education, training, qualifications, and experience to administer and perform the tests and interpret the results.

Standard AOP.5.3

A laboratory safety program is in place, followed, and documented, and compliance with the facility management and infection control programs is maintained.

Standard AOP.5.3.1

The laboratory uses a coordinated process to reduce the risks of infection as a result of exposure to biohazardous materials and waste.

Standard AOP.5.4

Laboratory results are available in a timely way as defined by the hospital.

Standard AOP.5.5

All equipment and medical technology used for laboratory testing is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.

Standard AOP.5.6

Essential reagents and other supplies are regularly available and evaluated to ensure accuracy and precision of results.

Standard AOP.5.7

Procedures for collecting, identifying, handling, safely transporting, and disposing of specimens are established and implemented.

Standard AOP.5.8

Established norms and ranges are used to interpret and to report clinical laboratory results.

Standard AOP.5.9

Quality control procedures for laboratory services are in place, followed, and documented.

Standard AOP.5.9.1

There is a process for proficiency testing of laboratory services.

Standard AOP.5.10

Reference (contract) laboratories used by the hospital are licensed, accredited, or certified by a recognized authority.

Standard AOP.5.10.1

The hospital identifies measures for monitoring the quality of the services to be provided by the reference (contract) laboratory.

Blood Bank and/or Transfusion Services

Standard AOP.5.11

A qualified individual is responsible for blood bank and/or transfusion services and ensures that services adhere to laws and regulations and recognized standards of practice.

Radiology and Diagnostic Imaging Services

Standard AOP.6

Radiology and diagnostic imaging services are available to meet patient needs, and all such services meet applicable local and national standards, laws, and regulations.

Standard AOP.6.1

A qualified individual(s) is responsible for managing the radiology and diagnostic imaging services.

Standard AOP.6.2

Individuals with proper qualifications and experience perform diagnostic imaging studies, interpret the results, and report the results.

Standard AOP.6.3

Radiation safety program is in place, followed, and documented, and compliance with the facility management and infection control programs is maintained.

Standard AOP.6.4

Radiology and diagnostic imaging study results are available in a timely way as defined by the hospital.

Standard AOP.6.5

All equipment and medical technology used to conduct radiology and diagnostic imaging studies is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.

Standard AOP.6.6

X-ray film and other supplies are regularly available.

Standard AOP.6.7

Quality control procedures are in place, followed, and documented.

Standard AOP.6.8

The hospital regularly reviews quality control results for all outside sources of diagnostic services.



Care of Patients (COP)

Standards

Care Delivery for All Patients

Standard COP.1

Uniform care of all patients is provided and follows applicable laws and regulations.

Standard COP.2

There is a process to integrate and to coordinate the care provided to each patient.

Standard COP.2.1

An individualized plan of care is developed and documented for each patient.

Standard COP.2.2

The hospital develops and implements a uniform process for prescribing patient orders.

Standard COP.2.3

Clinical and diagnostic procedures and treatments performed, and the results or outcomes, are documented in the patient's record.

Care of High-Risk Patients and Provision of High-Risk Services

Standard COP.3

The care of high-risk patients and the provision of high-risk services are guided by professional practice guidelines, laws, and regulations.

Recognition of Changes to Patient Condition

Standard COP.3.1

Clinical staff are trained to recognize and respond to changes in a patient's condition.

Resuscitation Services

Standard COP.3.2

Resuscitation services are available throughout the hospital.

Standard COP.3.3

Clinical guidelines and procedures are established and implemented for the handling, use, and administration of blood and blood products.

Food and Nutrition Therapy

Standard COP.4

A variety of food choices, appropriate for the patient's nutritional status and consistent with his or her clinical care, is available.

Standard COP.5

Patients at nutrition risk receive nutrition therapy.

Pain Management

Standard COP.6

Patients are supported in managing pain effectively.

End-of-Life Care

Patients who are approaching the end of life require care focused on their unique needs. Dying patients may experience symptoms related to the disease process or curative treatments or may need help in dealing with psychosocial, spiritual, and cultural issues associated with death and dying. Their families and caregivers may require respite from caring for a terminally ill family member or help in coping with grief and loss.

The hospital's goal for providing care at the end of life considers the settings in which care or service is provided (such as a hospice or palliative care unit), the type of services provided, and the patient population served. The hospital develops processes to manage end-of-life care. These processes

- ensure that symptoms will be assessed and appropriately managed;
- ensure that terminally ill patients will be treated with dignity and respect;
- assess patients as frequently as necessary to identify symptoms;
- plan preventive and therapeutic approaches to manage symptoms; and
- educate patients and staff about managing symptoms.

Standard COP.7

The hospital addresses end-of-life care.

Standard COP.7.1

Care of the dying patient optimizes his or her comfort and dignity.

Hospitals Providing Organ and/or Tissue Transplant Services

Note: Standards COP.8 through COP.9.3 are intended to be used by hospitals providing organ and/or tissue transplant services. Please contact the JCI Accreditation Office with inquiries.

Standard COP.8

The hospital's leadership provides resources to support the organ/tissue transplant program.

Standard COP.8.1

A qualified transplant program leader is responsible for the transplant program.

Standard COP.8.2

The transplant program includes a multidisciplinary team that consists of people with expertise in the relevant organ-specific transplant programs.

Standard COP.8.3

There is a designated coordination mechanism for all transplant activities that involves physicians, nurses, and other health care practitioners.

Standard COP.8.4

The transplant program uses organ-specific transplant clinical eligibility, psychological, and social suitability criteria for transplant candidates.

Standard COP.8.5

The transplant program obtains informed consent specific to organ transplantation from the transplant candidate.

Standard COP.8.6

The transplant program has documented protocols (or procedures) for organ recovery and organ receipt to ensure the compatibility, safety, efficacy, and quality of human cells, tissues, and organs for transplantation.

Standard COP.8.7

Individualized patient care plans guide the care of transplant patients.

Transplant Programs Using Living Donor Organs

Standard COP.9

Transplant programs that perform living donor transplantation protect the rights of prospective or actual donors.

Standard COP.9.1


Transplant programs performing living donor transplants obtain informed consent specific to organ donation from the prospective living donor.

Standard COP.9.2

Transplant programs that perform living donor transplants use clinical and psychological selection criteria to determine the suitability of potential living donors.

Standard COP.9.3

Individualized patient care plans guide the care of living donors.



Anesthesia and Surgical Care (ASC)

Note: The anesthesia and surgery standards are applicable in any setting in which anesthesia and/or procedural sedation are used, and surgical and other invasive procedures that require consent (also see PFR.5.2) are performed. Such settings include hospital operating theatres, day surgery and day hospital units, dental and other outpatient clinics, emergency services, intensive care areas, and others. These standards do not address the use of minimal sedation (anxiolysis). Definitions of the levels of sedation can be found in the Glossary.

Standards

Organization and Management

Standard ASC.1

Sedation and anesthesia services are available to meet patient needs, and all such services meet professional standards and applicable local and national standards, laws, and regulations.

Standard ASC.2

A qualified individual(s) is responsible for managing the sedation and anesthesia services.

Sedation Care

Standard ASC.3

The administration of procedural sedation is standardized throughout the hospital.

Standard ASC.3.1

Practitioners responsible for procedural sedation and individuals responsible for monitoring patients receiving sedation are qualified.

Standard ASC.3.2

Procedural sedation is administered and monitored according to professional practice guidelines.

Standard ASC.3.3

The risks, benefits, and alternatives related to procedural sedation are discussed with the patient, his or her family, or those who make decisions for the patient.

Anesthesia Care

Standard ASC.4

A qualified individual conducts a preanesthesia assessment and preinduction assessment.

Standard ASC.5

Each patient's anesthesia care is planned and documented, and the anesthesia and technique used are documented in the patient's record.

Standard ASC.5.1

The risks, benefits, and alternatives related to anesthesia are discussed with the patient, his or her family, or those who make decisions for the patient.

Standard ASC.6

Each patient's physiological status during anesthesia and surgery is monitored according to professional practice guidelines and documented in the patient's record.

Standard ASC.6.1

Each patient's postanesthesia status is monitored and documented, and the patient is discharged from the recovery area by a qualified individual or by using established criteria.

Surgical Care

Standard ASC.7

Each patient's surgical care is planned and documented based on the results of the assessment.

Standard ASC.7.1

The risks, benefits, and alternatives are discussed with the patient and his or her family or those who make decisions for the patient.

Standard ASC.7.2

Information about the surgical procedure is documented in the patient's record to facilitate continuing care.

Standard ASC.7.3

Patient care after surgery is planned and documented.

Standard ASC.7.4

Surgical care that includes the implanting of a medical device is planned with special consideration of how standard processes and procedures must be modified.



Medication Management and Use (MMU)

Standards

Organization and Management

Standard MMU.1

Medication use in the hospital is organized to meet patient needs, complies with applicable laws and regulations, and is under the direction and supervision of a licensed pharmacist or other qualified professional.

Selection and Procurement

Standard MMU.2

Medications for prescribing or ordering are stocked, and there is a process for medications not stocked or normally available to the hospital or for times when the pharmacy is closed.

Standard MMU.2.1

There is a method for overseeing the hospital's medication list and medication use.

Storage

Standard MMU.3

Medications are properly and safely stored.

Standard MMU.3.1

There is a process for storage of medications and nutrition products that require special consideration.

Standard MMU.3.2

Emergency medications are available, monitored, and safe when stored out of the pharmacy.

Standard MMU.3.3

The hospital has a medication recall system.

Ordering and Transcribing

Standard MMU.4

Prescribing, ordering, and transcribing are guided by policies and procedures.

Standard MMU.4.1

The hospital defines the elements of a complete order or prescription.

Standard MMU.4.2

The hospital identifies those qualified individuals permitted to prescribe or to order medications.

Standard MMU.4.3

Medications prescribed and administered are written in the patient's record.

Preparing and Dispensing

Standard MMU.5

Medications are prepared and dispensed in a safe and clean environment.

Standard MMU.5.1

Medication prescriptions or orders are reviewed for appropriateness.

Standard MMU.5.2

A system is used to dispense medications in the right dose to the right patient at the right time.

Administration

Standard MMU.6

The hospital identifies those qualified individuals permitted to administer medications.

Standard MMU.6.1

Medication administration includes a process to verify the medication is correct based on the medication prescription or order.

Standard MMU.6.2

Policies and procedures govern medications brought into the hospital for patient self-administration or as samples.


Monitoring

Standard MMU.7

Medication effects on patients are monitored.

Standard MMU.7.1

The hospital establishes and implements a process for reporting and acting on medication errors and near misses.



Patient and Family Education (PFE)

Standards

Standard PFE.1

The hospital provides education that supports patient and family participation in care decisions and care processes.

Standard PFE.2

Each patient's educational needs are assessed and recorded in his or her record.

Standard PFE.2.1

The patient's and family's ability to learn and willingness to learn are assessed.

Standard PFE.3

Education methods include the patient's and family's values and preferences and allow sufficient interaction among the patient, family, and staff for learning to occur.

Standard PFE.4

Health professionals caring for the patient collaborate to provide education.

Section III: Health Care Organization Management Standards



Quality Improvement and Patient Safety (QPS)

Standards

Note: In all QPS standards, leaders are individuals and leadership is the collective group. Accountabilities are described at the individual or collective level. (Also see the “Governance, Leadership, and Direction” [GLD] chapter for other related requirements.)

Management of Quality and Patient Safety Activities

The overall program for quality and patient safety in a hospital is approved by governance (see GLD.2), with the hospital’s leadership defining the structure and allocating resources required to implement the program (see GLD.4). Leadership also identifies the hospital’s overall priorities for measurement and improvement (see GLD.5), with the department/service leaders identifying the priorities for measurement and improvement within their department/service (see GLD.11 and GLD.11.1).

The standards in this QPS chapter identify the structure, leadership, and activities to support the data collection, data analysis, and quality improvement for the identified priorities—hospitalwide, as well as department- and service-specific. This includes the collection and analysis on, and the response to, hospitalwide sentinel events, adverse events, and near-miss events. The standards also describe the central role of coordinating all the quality improvement and patient safety initiatives in the hospital and providing guidance and direction for staff training and communication of quality and patient safety information. The standards do not identify an organizational structure, such as a department, as this is up to each hospital to determine.

Standard QPS.1

A qualified individual guides the implementation of the hospital’s program for quality improvement and patient safety and manages the activities needed to carry out an effective program of continuous quality improvement and patient safety within the hospital.

Measure Selection and Data Collection

Standard QPS.2

Quality and patient safety program staff support the measure selection process throughout the hospital and provide coordination and integration of measurement activities throughout the hospital.

Standard QPS.3

The quality and patient safety program uses current scientific and other information to support patient care, health professional education, clinical research, and management.

Analysis and Validation of Measurement Data

Standard QPS.4

The quality and patient safety program includes the aggregation and analysis of data to support patient care, hospital management, and the quality management program and participation in external databases.

Standard QPS.4.1

Individuals with appropriate experience, knowledge, and skills systematically aggregate and analyze data in the hospital.

Standard QPS.5

The data analysis process includes at least one determination per year of the impact of hospitalwide priority improvements on cost and efficiency.

Standard QPS.6

The hospital uses an internal process to validate data.

Standard QPS.7

The hospital uses a defined process for identifying and managing sentinel events.

Standard QPS.8

Data are always analyzed when undesirable trends and variation are evident from the data.

Standard QPS.9

The organization uses a defined process for the identification and analysis of near-miss events.


Gaining and Sustaining Improvement

Standard QPS.10

Improvement in quality and safety is achieved and sustained.

Standard QPS.11

An ongoing program of risk management is used to identify and to proactively reduce unanticipated adverse events and other safety risks to patients and staff.



Prevention and Control of Infections (PCI)

Standards

Standard PCI.1

One or more individuals oversee all infection prevention and control activities. This individual(s) is qualified in infection prevention and control practices through education, training, experience, or certification.

Standard PCI.2

There is a designated coordination mechanism for all infection prevention and control activities that involves physicians, nurses, and others based on the size and complexity of the hospital.

Standard PCI.3

The infection prevention and control program is based on current scientific knowledge, accepted practice guidelines, applicable laws and regulations, and standards for sanitation and cleanliness.

Standard PCI.4

Hospital leadership provides resources to support the infection prevention and control program.

Standard PCI.5

The hospital designs and implements a comprehensive program to reduce the risks of health care–associated infections in patients and health care workers.

Standard PCI.5.1

All patient, staff, and visitor areas of the hospital are included in the infection prevention and control program.

Standard PCI.6

The hospital uses a risk-based approach in establishing the focus of the health care–associated infection prevention and reduction program.

Standard PCI.6.1

The hospital tracks infection risks, infection rates, and trends in health care–associated infections to reduce the risks of those infections.

Standard PCI.7

The hospital identifies the procedures and processes associated with the risk of infection and implements strategies to reduce infection risk.

Standard PCI.7.1

The hospital reduces the risk of infections by ensuring adequate medical technology cleaning and sterilization and the proper management of laundry and linen.

Standard PCI.7.1.1

The hospital identifies and implements a process for managing expired supplies and the reuse of single-use devices when laws and regulations permit.

Standard PCI.7.2

The hospital reduces the risk of infections through proper disposal of waste.

Standard PCI.7.3

The hospital implements practices for safe handling and disposal of sharps and needles.

Standard PCI.7.4

The hospital reduces the risk of infections associated with the operations of food services.

Standard PCI.7.5

The hospital reduces the risk of infection in the facility associated with mechanical and engineering controls and during demolition, construction, and renovation.

Standard PCI.8

The hospital provides barrier precautions and isolation procedures that protect patients, visitors, and staff from communicable diseases and protects immunosuppressed patients from acquiring infections to which they are uniquely prone.

Standard PCI.8.1

The hospital develops and implements a process to manage a sudden influx of patients with airborne infections and when negative-pressure rooms are not available.

Standard PCI.9


Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly when required.

Standard PCI.10

The infection prevention and control process is integrated with the hospital's overall program for quality improvement and patient safety, using measures that are epidemiologically important to the hospital.

Standard PCI.11

The hospital provides education on infection prevention and control practices to staff, physicians, patients, families, and other caregivers when indicated by their involvement in care.



Governance, Leadership, and Direction (GLD)

Standards

Governance of the Hospital

Standard GLD.1

Governance structure and authority are described in bylaws, policies and procedures, or similar documents.

Standard GLD.1.1

The operational responsibilities and accountabilities of the governing entity are described in a written document(s).

Standard GLD.1.2

Those responsible for governance approve the hospital's program for quality and patient safety and regularly receive and act on reports of the quality and patient safety program.

Chief Executive(s) Accountabilities

Standard GLD.2

A chief executive(s) is responsible for operating the hospital and complying with applicable laws and regulations.

Hospital Leadership Accountabilities

Standard GLD.3

Hospital leadership is identified and is collectively responsible for defining the hospital's mission and creating the programs and policies needed to fulfill the mission.

Standard GLD.3.1

Hospital leadership identifies and plans for the type of clinical services required to meet the needs of the patients served by the hospital.

Standard GLD.3.2

Hospital leadership ensures effective communication throughout the hospital.

Standard GLD.3.3

Hospital leadership ensures that there are uniform programs for the recruitment, retention, development, and continuing education of all staff.

Hospital Leadership for Quality and Patient Safety

Standard GLD.4

Hospital leadership plans, develops, and implements a quality improvement and patient safety program.

Standard GLD.4.1

Hospital leadership communicates quality improvement and patient safety information to governance and hospital staff on a regular basis.

Standard GLD.5

Hospital leadership prioritizes which hospitalwide processes will be measured, which hospitalwide improvement and patient safety activities will be implemented, and how success of these hospitalwide efforts will be measured.

Hospital Leadership for Contracts

Standard GLD.6

Hospital leadership is accountable for the review, selection, and monitoring of clinical or nonclinical contracts.

Standard GLD.6.1

Hospital leadership ensures that contracts and other arrangements are included as part of the hospital's quality improvement and patient safety program.

Standard GLD.6.2

Hospital leadership ensures that independent practitioners not employed by the hospital have the right credentials for the services provided to the hospital's patients.

Hospital Leadership for Resource Decisions

Standard GLD.7

Hospital leadership makes decisions related to the purchase or use of resources—human and technical—with an understanding of the quality and safety implications of those decisions.

Standard GLD.7.1

Hospital leadership seeks and uses data and information on the safety of the supply chain for drugs, medical technology, and supplies to protect patients and staff from contaminated, fake, and diverted products.

Clinical Staff Organization and Accountabilities

Standard GLD.8

Medical, nursing, and other leaders of departments and clinical services plan and implement a professional staff structure to support their responsibilities and authority.

Direction of Hospital Departments and Services

Standard GLD.9

One or more qualified individuals provide direction for each department or service in the hospital.

Standard GLD.10

Each department/service leader identifies, in writing, the services to be provided by the department, and integrates or coordinates those services with the services of other departments.

Standard GLD.11

Department/service leaders improve quality and patient safety by participating in hospitalwide improvement priorities and in monitoring and improving patient care specific to the department/service.

Standard GLD.11.1

Department/service leaders of clinical departments or services select and implement quality and patient safety measures specific to the scope of services provided by the department or service and useful in the evaluation of the physicians, nurses, and other professional staff participating in the clinical care processes.

Standard GLD.11.2

Department/service leaders select and implement clinical practice guidelines, and related clinical pathways, and/or clinical protocols, to guide clinical care.

Organizational and Clinical Ethics

Standard GLD.12

Hospital leadership establishes a framework for ethical management that promotes a culture of ethical practices and decision making to ensure that patient care is provided within business, financial, ethical, and legal norms and protects patients and their rights.

Standard GLD.12.1

The hospital's framework for ethical management addresses operational and business issues, including marketing, admissions, transfer, discharge, and disclosure of ownership and any business and professional conflicts that may not be in patients' best interests.

Standard GLD.12.2

The hospital's framework for ethical management addresses ethical issues and decision making in clinical care.

Standard GLD.13

Hospital leadership creates and supports a culture of safety program throughout the hospital.

Standard GLD.13.1

Hospital leadership implements, monitors, and takes action to improve the program for a culture of safety throughout the hospital.

Health Professional Education and Human Subjects Research

Note: This standard applies to hospitals that provide health professional education but do not meet the eligibility criteria for Academic Medical Center Hospital accreditation.

Standard GLD.14

Health professional education, when provided within the hospital, is guided by the educational parameters defined by the sponsoring academic program and the hospital's leadership.

Human Subjects Research

Note: This standard applies to hospitals that conduct human subjects research but do not meet the eligibility criteria for Academic Medical Center Hospital accreditation.

Standard GLD.15

Human subjects research, when provided within the hospital, is guided by laws, regulations, and hospital leadership.

Standard GLD.16

Patients and families are informed about how to gain access to clinical research, clinical investigation, or clinical trials involving human subjects.

Standard GLD.17

Patients and families are informed about how patients who choose to participate in clinical research, clinical investigations, or clinical trials are protected.

Standard GLD.18

Informed consent is obtained before a patient participates in clinical research, clinical investigations, or clinical trials.

Standard GLD.19

The hospital has a committee or another way to oversee all research in the hospital involving human subjects.



Facility Management and Safety (FMS)

Standards

Leadership and Planning

Standard FMS.1

The hospital complies with relevant laws, regulations, and facility inspection requirements.

Standard FMS.2

The hospital develops and maintains a written program(s) describing the processes to manage risks to patients, families, visitors, and staff.

Standard FMS.3

One or more qualified individuals oversee the planning and implementation of the facility management program to reduce and control risks in the care environment.

Safety and Security

Standard FMS.4

The hospital plans and implements a program to provide a safe physical facility through inspection and planning to reduce risks.

Standard FMS.4.1

The hospital plans and implements a program to provide a secure environment for patients, families, staff, and visitors.

Standard FMS.4.2

The hospital plans and budgets for upgrading or replacing key systems, buildings, or components based on the facility inspection and in keeping with laws and regulations.

Hazardous Materials

Standard FMS.5

The hospital has a program for the inventory, handling, storage, and use of hazardous materials.

Standard FMS.5.1

The hospital has a program for the control and disposal of hazardous materials and waste.

Disaster Preparedness

Standard FMS.6

The hospital develops, maintains, and tests an emergency management program to respond to emergencies, epidemics, and natural or other disasters that have the potential of occurring within their community.

Fire Safety

Standard FMS.7

The hospital establishes and implements a program for the prevention, early detection, suppression, abatement, and safe exit from the facility in response to fires and nonfire emergencies.

Standard FMS.7.1

The hospital regularly tests its fire and smoke safety program, including any devices related to early detection and suppression, and documents the results.

Standard FMS.7.2

The fire safety program includes limiting smoking by staff and patients to designated non-patient care areas of the facility.

Medical Technology

Standard FMS.8

The hospital establishes and implements a program for inspecting, testing, and maintaining medical technology and documenting the results.

Standard FMS.8.1

The hospital has a system in place for monitoring and acting on medical technology hazard notices, recalls, reportable incidents, problems, and failures.

Utility Systems

Standard FMS.9

The hospital establishes and implements a program to ensure that all utility systems operate effectively and efficiently.

Standard FMS.9.1

Utility systems are inspected, maintained, and improved.

Standard FMS.9.2

The hospital utility systems program ensures that potable water and electrical power are available at all times and establishes and implements alternative sources of water and power during system disruption, contamination, or failure.

Standard FMS.9.2.1

The hospital tests its emergency water and electrical systems and documents the results.

Standard FMS.9.3

Designated individuals or authorities monitor water quality regularly.

Facility Management Program Monitoring

Standard FMS.10

The hospital collects and analyzes data from each of the facility management programs to support planning for replacing or upgrading medical technology, equipment, and systems, and reducing risks in the environment.

Staff Education

Standard FMS.11

The hospital educates, trains, and tests all staff about their roles in providing a safe and effective patient care facility.

Standard FMS.11.1

Staff members are trained and knowledgeable about their roles in the hospital's programs for fire safety, security, hazardous materials, and emergencies.

Standard FMS.11.2

Staff are trained to operate and to maintain medical technology and utility systems.

Staff Qualifications and Education (SQE)

Standards

Planning

Standard SQE.1

Leaders of hospital departments and services define the desired education, skills, knowledge, and other requirements of all staff members.

Standard SQE.1.1

Each staff member's responsibilities are defined in a current job description.

Standard SQE.2

Leaders of hospital departments and services develop and implement processes for recruiting, evaluating, and appointing staff as well as other related procedures identified by the hospital.

Standard SQE.3

The hospital uses a defined process to ensure that clinical staff knowledge and skills are consistent with patient needs.

Standard SQE.4

The hospital uses a defined process to ensure that nonclinical staff knowledge and skills are consistent with hospital needs and the requirements of the position.

Standard SQE.5

There is documented personnel information for each staff member.

Standard SQE.6

A staffing strategy for the hospital, developed by the leaders of hospital departments and services, identifies the number, types, and desired qualifications of staff.

Standard SQE.6.1

The staffing strategy is reviewed on an ongoing basis and updated as necessary.

Standard SQE.7

All clinical and nonclinical staff members are oriented to the hospital, the department or unit to which they are assigned, and to their specific job responsibilities at appointment to the staff.

Standard SQE.8

Each staff member receives ongoing in-service and other education and training to maintain or to advance his or her skills and knowledge.

Standard SQE.8.1

Staff members who provide patient care and other staff identified by the hospital are trained and can demonstrate appropriate competence in resuscitative techniques.

Standard SQE.8.2

The hospital provides a staff health and safety program.

Determining Medical Staff Membership

Standard SQE.9

The hospital has a uniform process for gathering the credentials of those medical staff members permitted to provide patient care without supervision.

Standard SQE.9.1

Medical staff members' education, licensure/registration, and other credentials required by law or regulation and the hospital are verified and kept current.

Standard SQE.9.2

There is a uniform, transparent decision process for the initial appointment of medical staff members.

The Assignment of Medical Staff Clinical Privileges

Standard SQE.10

The hospital has a standardized, objective, evidence-based procedure to authorize medical staff members to admit and to treat patients and/or to provide other clinical services consistent with their qualifications.

Ongoing Monitoring and Evaluation of Medical Staff Members

Standard SQE.11

The hospital uses an ongoing standardized process to evaluate the quality and safety of the patient care provided by each medical staff member.

Medical Staff Reappointment and Renewal of Clinical Privileges

Standard SQE.12

At least every three years, the hospital determines, from the ongoing monitoring and evaluation of each medical staff member, if medical staff membership and clinical privileges are to continue with or without modification.

Nursing Staff

Standard SQE.13

The hospital has a uniform process to gather, to verify, and to evaluate the nursing staff's credentials (license, education, training, and experience).

Standard SQE.14

The hospital has a standardized process to identify job responsibilities and to make clinical work assignments based on the nursing staff member's credentials and any regulatory requirements.

Standard SQE.14.1

The hospital has a standardized process for nursing staff participation in the hospital's quality improvement activities, including evaluating individual performance when indicated.

Other Health Care Practitioners

Standard SQE.15

The hospital has a uniform process to gather, to verify, and to evaluate other health professional staff members' credentials (license, education, training, and experience).

Standard SQE.16

The hospital has a uniform process to identify job responsibilities and to make clinical work assignments based on other health professional staff members' credentials and any regulatory requirements.

Standard SQE.16.1

The hospital has a uniform process for other health professional staff members' participation in the hospital's quality improvement activities.



Management of Information (MOI)

Standards

Information Management

Standard MOI.1

The hospital plans and designs information management processes to meet internal and external information needs.

Standard MOI.2

Information privacy, confidentiality, and security—including data integrity—are maintained.

Standard MOI.3

The hospital determines the retention time of records, data, and information.

Standard MOI.4

The hospital uses standardized diagnosis codes, procedure codes, symbols, abbreviations, and definitions.

Standard MOI.5

The data and information needs of those in and outside the hospital are met on a timely basis in a format that meets user expectations and with the desired frequency.

Standard MOI.6

Health information technology systems are assessed and tested prior to implementation within the hospital and evaluated for quality and patient safety following implementation.

Standard MOI.7

Records and information are protected from loss, destruction, tampering, and unauthorized access or use.

Standard MOI.8

Decision makers and other staff members are educated and trained in the principles of information use and management.

Management and Implementation of Documents

Standard MOI.9

Written documents, including policies, procedures, and programs, are managed in a consistent and uniform manner.

Standard MOI.9.1

The policies, procedures, plans, and other documents that guide consistent and uniform clinical and nonclinical processes and practices are fully implemented.

Patient Clinical Record

Standard MOI.10

The hospital initiates and maintains a standardized clinical record for every patient assessed or treated and determines the record's content, format, and location of entries.

Standard MOI.10.1

The clinical record contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment, and to document the course and results of treatment.

Standard MOI.10.1.1

The clinical records of patients receiving emergency care include the time of arrival and departure, the conclusions at termination of treatment, the patient's condition at discharge, and follow-up care instructions.

Standard MOI.11

The hospital identifies those authorized to make entries in the patient clinical record.

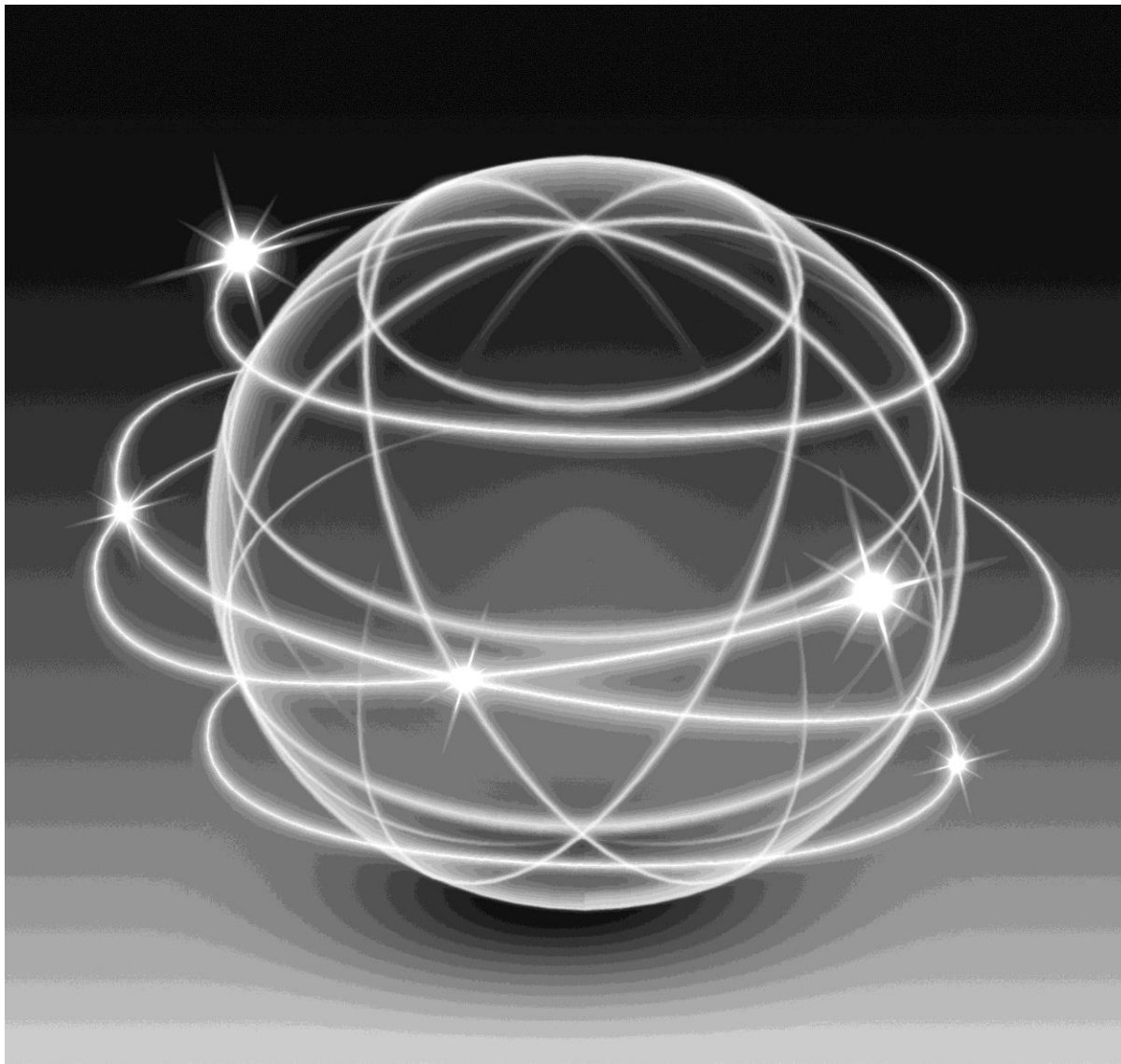
Standard MOI.11.1

Every patient clinical record entry identifies its author and when the entry was made in the record.

Standard MOI.12

As part of its monitoring and performance improvement activities, the hospital regularly assesses patient clinical record content and the completeness of patient clinical records.

Section IV: Academic Medical Center Hospital Standards



The Medical Professional Education (MPE) and Human Subjects Research Programs (HRP) standards for Academic Medical Center Hospitals were developed and first published in 2012 to recognize the unique resource such centers represent for health professional education and human subjects research in their community and country. These standards also present a framework for including medical education and human subjects research into the quality and patient safety activities of academic medical center hospitals. Unless deliberately included in the quality framework, education and research activities often are the unnoticed partners in patient care quality monitoring and improvement.

The standards are divided into two chapters, as medical education and clinical research are most frequently organized and administered separately within academic medical centers. For all hospitals meeting the eligibility criteria in the “Summary of Key Accreditation Policies” section of this publication, compliance with the requirements in these two chapters, in addition to the other requirements detailed in this fifth edition manual, will result in an organization being deemed accredited under the Joint Commission International Standards for Academic Medical Center Hospitals.

Organizations with questions about their eligibility for Academic Medical Center Hospital accreditation should contact JCI Accreditation’s Central Office at jciaccreditation@jcrinc.com.



Medical Professional Education (MPE)

Standards

Standard MPE.1

Those responsible for governance and leadership of the hospital approve and monitor the participation of the hospital in providing medical education.

Standard MPE.2

The hospital's clinical staff, patient population, technology, and facility are consistent with the goals and objectives of the education program.

Standard MPE.3

Clinical teaching staff are identified, and each staff member's role and relationship to the academic institution is defined.

Standard MPE.4

The hospital understands and provides the required frequency and intensity of medical supervision for each type and level of medical student and trainee.

Standard MPE.5

Medical education provided in the hospital is coordinated and managed through a defined operational mechanism and management structure.

Standard MPE.6

Medical students and trainees comply with all hospital policies and procedures, and all care is provided within the quality and patient safety parameters of the hospital.

Standard MPE.7

Medical trainees who provide care or services within the hospital—outside of the parameters of their academic program—are granted permission to provide those services through the hospital's established credentialing, privileging, job specification, or other relevant processes.



Human Subjects Research Programs (HRP)

Note: This chapter was previously entitled “Human Subject Research Programs.” The title was changed to reflect the most common usage of the terminology in the field.

Standards

Standard HRP.1

Hospital leadership is accountable for the protection of human research subjects.

Standard HRP.1.1

Hospital leadership complies with all regulatory and professional requirements and provides adequate resources for effective operation of the research program.

Standard HRP.2

Hospital leadership establishes the scope of research activities.

Standard HRP.3

Hospital leadership establishes requirements for sponsors of research to ensure their commitment to the conduct of ethical research.

Standard HRP.3.1

When one or more of the research-related duties and functions of the sponsor are provided through an outside commercial or academic contract research organization, the accountabilities of the outside contract research organization are clearly defined.

Standard HRP.4

Hospital leadership creates or contracts for a process to provide the initial and ongoing review of all human subjects research.

Standard HRP.5

The hospital identifies and manages conflicts of interest with research conducted at the hospital.

Standard HRP.6

The hospital integrates the human subjects research program into the quality and patient safety program of the hospital.

Standard HRP.7

The hospital establishes and implements an informed consent process that enables patients to make informed and voluntary decisions about participating in clinical research, clinical investigations, or clinical trials.

Standard HRP.7.1

The hospital informs patients and families about how to gain access to clinical research, clinical investigations, or clinical trials and includes protections for vulnerable populations to minimize potential coercion or undue influence.