Standards Interpretation FAQs

	Standards	Subject	Interpretation Question	Response
International Patient Safety Goal (IPSG)				
1	IPSG.1	Patient Identification During Telephone Consultation	One of our measures to combat COVID 19 transmission in the OPD is telephonic consultation. What is the minimum documentation required regarding the telephonic consultation?	These are extraordinary times, and it is understood that the service you are referencing is solely dedicated to assisting the public in determining whether to seek medical care via a phone conference in order to avoid having patients physically come into the hospital ifnot needed. The standards do not specifically address these circumstances; however, there are several standards that may be referenced in ensuring the quality and safety of patient care services. Standard ACC.3 identifies the need to design and carry out processes to provide continuity of patient care services. While this does not specifically address phone consultations, the principles of this standard apply. When telephone advice is provided it is important to ensure the continuity of care. For example, if a patient calls for advice, basic information about this consultation needs to be documented. As identified, the documentation can be very simple such as a one page form that includes patient identifying information (Name and Birthdate or Name and ID number) as required in IPSG.1; the information the patient provides during the phone consultation, including any response to questions asked by the physician; and the outcome of the phone conference, such as patient referred to outpatient clinic for further assessment and treatment, or patient instructed to remain at home and come into the hospital if symptoms worsen. If possible, the information may be communicated to the service to which the patient is being referred or made available to the referral service, if requested.
2	IPSG.2	Corona Virus Tests as Critical Result	Is the COVID-19 (PCR and antibody test) test considered a critical test?	The intent of Standards IPSG.2 through IPSG.2.2 states that “Safe practices for effective communication includes the development of guidelines for requesting and receiving test results on an emergency or STAT basis, the identification and definitions of critical tests and critical values, to whom and by whom critical test results are reported, and monitoring compliance.” The standards do not specify which diagnostic tests should be identified as a critical test, however; a critical result is defined as a variance from normal range that represents a pathophysiologic state that is high-risk or life-threatening, is considered urgent or emergent in nature, and in which immediate medical action is likely necessary to preserve life or prevent a catastrophic occurrence. As explained in the intent, the organization should identify and define their own critical tests and critical values. Because the list of critical tests for an organization change based on the patient population need and organization’s changing priorities, it is up to the organization to identify which diagnostic tests should be defined as critical to the patient population they serve. Standard IPSG.2.1 is focused on the development and implementation of a process for reporting critical results of diagnostic tests. While there are currently no measurable elements that are tied to the development of a critical test

Standards		Subject	Interpretation Question	Response
				list, Standard IPSG.2.1, ME 1 requires the hospital to develop a formal reporting process that identifies how critical results of diagnostic tests are reported/communicated to health care practitioners.
3	IPSG.2	Critical Results Reporting	If a test result is considered critical, the treating physician is immediately notified. If the test is repeated routinely (maybe every 4 hours) and the result is still critical, the treating physician is not notified immediately with the new critical result, and it's handled as an abnormal result, not a critical result. Is it mandatory to report repeated critical results separately even if it was already reported as critical within the last 4 hours?	The standard does not specify a mandatory requirement for reporting repeated critical results from a series of the same laboratory tests that were ordered to monitor critical ICU patients. The intent of IPSG.2 through IPSG.2.2 defines a critical result as a variance from normal range that represents a pathophysiologic state that is high-risk or life-threatening, is considered urgent or emergent in nature, and in which immediate medical action is necessary to preserve life or prevent a catastrophic occurrence. The intent also defines abnormal result as a result that is outside of the expected range for the test but is not an urgent or emergent life threat. In the case of repeated critical results, subsequent critical results may or may not require an immediate medical action and it is up to the organization to identify which repeated laboratory test results would be considered “critical” and would require continuous provider notification based on the immediate action that may be required by the treating physician. IPSG.2, ME 1 states that “The hospital defines critical results that may represent urgent or emergent life-threatening values for diagnostic tests.” In defining critical results, the organization should address repeated laboratory tests results that may be within the laboratory’s critical range and work with the laboratory department in defining scenarios when these subsequent critical results would not require continuous notification to the ordering physician.
4	IPSG.2.1	Reporting Abnormal and Critical Test Results	Is read-back necessary when the process in place is for a nurse to report the patient details and result to the physician and document the result and responding actions in the EMR?	Standard AOP.5.2, ME 3 states that “The POCT program includes a defined process for reporting abnormal test results, including reporting critical results.” The intent of the standard refers to IPSG.2.1 when establishing a protocol for reporting abnormal test results, including the process for reporting critical results. The measurable elements of IPSG.2.1 outline specific requirements on defining critical results, communicating critical results to healthcare practitioners, and identifying what information should be reported along with the results. IPSG.2 specifies the requirements for read-back policy which are focused on the hospital’s process for improving the effectiveness of verbal and/or telephone communication among caregivers.
5	IPSG.2.1	Critical Results for CTG	The understanding is that the application of critical results for CTGs applies to urgent / emergent situations when a diagnosis ("diagnostic test") is sought. Additionally, most organizations have	Cardiotocography (CTGs) is used to monitor fetal heart rate during pregnancy as a method of assessing fetal well-being, predominantly in pregnancies with increased risk of complications. During this continuous monitoring activity, certain CTG result and interpretations may require urgent and immediate medical action to prevent a catastrophic occurrence such as any CTG reading that indicates fetal distress and may require emergency C-section. For example, inaudible fetal heart beating and/or rare sinusoidal pattern that usually indicates severe fetal hypoxia, severe fetal anemia, or fetal/maternal hemorrhage. (Reference: https://www.aafp.org/afp/1999/0501/p2487.html).

	Standards	Subject	Interpretation Question	Response
			established critical results parameters (beyond the variance of highs and lows) for the CTGs in which immediate medical intervention is required during the continuous monitoring process. Should the organization address CTG as having critical results in both standards IPSG 2.1 (related to critical results) and COP 3.1 (related to alarm settings), in addition, to the AOP 5.2 standard on POCT?	In these specific cases, the results of monitoring (not in a continuous way) is considered a critical result because they represent an urgent or emergent life-threatening value. In this context, requirements of IPSG.2.1 on critical results would apply and the hospital must define what would be considered a “critical result” for CTGs being performed that would require notification to the healthcare provider per IPSG.2.1, MEs 1 and 2. To meet the requirements of IPSG.2.1 in this scenario, the organization may define or at minimum, list CTG results that may require immediate intervention. For example, the organization policy may state that “any inaudible fetal heart rate requires immediate notification and consultation with the obstetrician.” Standard COP.3.1 focuses on clinical alarm management and must be used when scoring noncompliance on the use of clinical alarms. While CTGs are often done at bedside, Standard AOP.5.2 focuses on Point-of-Care “laboratory” testing.
6	IPSG.2.1	Critical Results for CTG	Clarification regarding the IPSG. 2.1 for reporting critical results of diagnostic tests: It is understood that the intent of the standard which states that continuous electronic monitoring such as fetal monitoring (cardiotocography fetal) is not considered a critical result. In situations where patients are admitted to the emergency room in an emergent condition when the physician monitors fetal activity, not in a continuous way, in order to detect fetal distress, such as inaudible fetal heart beating FHB, these limit values are taken into account during the monitoring to refer the patient to an emergency C-section because of the	The intent of IPSG.2.1 defines a critical result as "a variance from normal range that represents a pathophysiologic state that is high-risk or life-threatening, is considered urgent or emergent in nature, and in which immediate medical action is likely necessary to preserve life or prevent a catastrophic occurrence." Further, in the intent it is stated that "Diagnostic tests that produce defined test results that may indicate a threat to life are different from continuous electronic monitoring, such as cardiac telemetry, continuous EEG (electroencephalogram) monitoring, or fetal monitoring. Continuous electronic monitoring is a clinical assessment tool used to detect changes in the patient’s condition that may identify a threat to life but is not designed to produce a defined critical result." Fetal heart monitoring used as a form of continuous electronic monitoring for laboring patients on an L&D ward would not fall under the requirements of IPSG.2.1. However, as described in the question, fetal heart monitoring placed on a patient presenting to the emergency department in an emergent condition is used as a point of care, diagnostic test to determine if further actions are needed to prevent harm to the fetus. In this context, critical results would be defined by the hospital so that staff utilizing fetal heart monitoring in this context would understand when to contact the physician and care team to initiate further care.

	Standards	Subject	Interpretation Question	Response
			imminent threat of fetal death. In situations such as this, could the result of the CTG monitoring (no continuous way) be consider a critical result because it is representing an urgent or emergent life-threatening value?	
7	IPSG.2.2	Handover Between Physicians by End of Shift	For physicians, is it required that handover is documented for every patient by the end of each shift?	Standard IPSG.2.2 states that "The hospital develops and implements a process for handover communication." This standard outlines the requirements for safe communication and handover, noting that breakdown in communication during different types of patient handover can result in adverse events. The hospital must determine the method and process for handover communication, including the development and implementation of standardized forms or tools that are used to ensure that the appropriate information is communicated. It is stated in the intent of IPSG.2.2 that "The handover process may be different for different types of handovers within the hospital. For example, handovers of patient care for the emergency department to a medical ward may require a different process or different content than handovers for the operating theatre to the intensive care unit; however, the handovers are standardized for the type of handover occurring." JCI does not specify that the handover is documented in the medical record, but rather it is recommendation as a best practice that there is some form of documentation that the handover took place. Further, it is mentioned in the intent that "Handover forms or tools, if used by the hospital, are not required to be part of the medical record. The detailed information communicated during the handover is not required to be documented in the medical record; however, the hospital may want to have documentation that the handover occurred." An example of this would be the practitioner documenting in the medical record that the handover was completed and the identity of whom he or she transferred the responsibility of care to.
8	IPSG.2.2	Handover Between Specialties	Is it acceptable that the handover mechanism and tool is different between specialties? Do we have to document the handover?	The hospital must determine the method and process for handover communication, including the development and implementation of standardized forms or tools that are used to ensure that the appropriate information is communicated. It is stated in the intent of IPSG.2.2 that "The handover process may be different for different types of handovers within the hospital. This applies to handover between disciplines (i.e., physician-to-physician will be different than nurse-to-physical therapist) and between units (i.e., ED-to-ICU will be different than X-ray-to-inpatient ward).

Standards		Subject	Interpretation Question	Response
				JCI does not specify that the handover is documented in the medical record, but rather it is recommended in the intent as a best practice that there is some form of documentation that the handover took place. Further, it is mentioned in the intent that "Handover forms or tools, if used by the hospital, are not required to be part of the medical record. In addition, the detailed information communicated during the handover is not required to be documented in the medical record; however, the hospital may want to have documentation that the handover occurred." An example of this would be the practitioner documenting in the medical record that the handover was completed and the identity of whom he or she transferred the responsibility of care to.
9	IPSG.2.2	Pre-Procedure and Post-Procedure Handover	Is it necessary to conduct a preprocedural and post-procedure hand off if the same staff remains with the patient in all three areas (pre-procedure, procedure, and post-procedure)?	When the pre-procedure, the procedure, and the post-procedure (all three) involves the same staff who are responsible for the patient and providing direct care to the patient, a handoff communication may not be necessary. Handoff/handover communication practices are referenced in Standard IPSG.2.2 which states "The hospital develops and implements a process for handover communication." Handoff (also known as handover) is required when there is a transfer of responsibility for a patient and the patient's care such as: • Between health care practitioners (for example, physician to physician, physician to nurse, nurse to nurse, and so on) • Between different levels of care in the same hospital (**for example,** when the patient is moved from an intensive care unit to a medical unit or from an emergency department to the operating theatre) • From inpatient units to diagnostic or other treatment departments, such as radiology or physical therapy; and between staff and patients/families, such as at discharge.
10	IPSG.3.1	High-Alert Medications	How do we distinguish which LASA medications should be included in high-alert medication list?	IPSG.3.1 was updated to focus solely on how the hospital manages look-alike sound-alike (LASA) medications. In the intent of IPSG.3.1 it is described that not all LASA medications meet the definition of high-alert medications, therefore it is required in IPSG.3.1 ME 1 that the hospital must define in writing a list of LASA medications that is separate from the list of high-alert medications. Some medications may actually be on both lists, but many will only be on one or the other. An example of medications that may be on both the look-alike/sound-alike list as well as the high-alert list is glyburide and glipizide – both of which are oral hypoglycemic medications. Hospitals should be looking at their medication utilization patterns as well as data related to near misses, medication errors, and sentinel events to create their own lists of high-alert and look-alike/sound-alike medications.
11	IPSG.3.1	Look-alike Medications for Medications from the Same	How can organizations decrease risk with LASA (look-alike/sound-alike)	Standard IPSG.3.1 states "The hospital develops and implements a process to improve the safety of look-alike/sound-alike medications." The intent for this standard applies to look-alike medicine packaging, such as medicine containers or primary packaging that look

	Standards	Subject	Interpretation Question	Response
		Pharmaceutical Company	medications when the packaging of medications from the same pharmaceutical company all look the same?	like that of other medications, which may lead to potentially harmful medication errors. In addition to risk for error due to look-alike medicine packaging, the intent also mentions that there are many medication names that sound or look like other medication names; for example, dopamine and dobutamine. This is included because confusing names is a common cause of medication errors throughout the world. The intent further clarifies that hospitals need to institute risk management strategies to minimize adverse events with LASA medications and enhance patient safety. This is supported by IPSG.3.1, ME 2 which requires that the hospital develops and implements a process for managing look-alike/sound-alike medications that is uniform throughout the hospital. Standard MMU.6.1 provides further guidance by requiring that medication administration includes a process to verify the medication is correct based on the medication prescription or order. MMU.6.1 ME 1-3 specifies what must be included in the verification process: ME.1 Medications are verified with the prescription or order. ME. 2 The dosage amount of the medication is verified with the prescription or order. ME. 3 The route of administration is verified with the prescription or order. Additionally, if bulk packaging from a single pharmaceutical company is similar for all medications, it is recommended that the following requirements are used as guidance: 1) MMU.6.1, MEs 1-3, and 2) , MMU.5.2, ME 1 "Medications are dispensed in the most ready-to-administer form available."
12	IPSG.3.1	Medication List	In addition to having a LASA (look-alike/sound-alike) medication list, should LASA medications be included in the high-alert medications list as well?	IPSG.3.1 was updated to focus solely on how the hospital manages look-alike/sound-alike (LASA) medications. In the intent of IPSG.3.1 it is described that not all LASA medications meet the definition of high-alert medications, therefore it is required in IPSG.3.1 ME 1 that the hospital must define in writing a list of LASA medications. The requirements in the IPSG.3 through IPSG.3.2 standards thus require that the hospital maintain two separate lists, one for LASA medications and one for high-alert medications.
13	IPSG.3.1	Different Dosages of the Same Medication	Are different dosages of the same medication considered as look-alike/sound-alike (LASA) medications?	The intent of IPSG.3.1 defines look-alike/sound-alike medications as "Look-alike/sound-alike (LASA) names are medicine names that look or sound the same as other medicine names when written or spoken. Look-alike medicine packaging refers to medicine containers or primary packaging that looks like that of another medicine." Different concentrations/dosages of the same medication are not considered LASA medications. MMU.6.1, ME 2 states that "The dosage amount of the medication is verified with the prescription or order." This process should take place prior to medication being administered and will prompt staff to ensure that the correct dosage of the correct medication is being delivered.
14	IPSG.3.2	Concentrated Electrolytes in Patient Care Areas	Can you explain the phrase "as much as is possible given the pharmacy capabilities" from the intent	The intent of IPSG.3 though IPSG.3.3 explains that vials of concentrated electrolytes that require dilution before administration are not to be stored as floor stock in any patient care areas of the hospital except in situations specifically identified in the intent. The intent also identifies the specific exceptions and includes concentrated potassium that may be kept in a cardiac surgery box in the operating theatre when open heart surgeries are performed,

Standards		Subject	Interpretation Question	Response
			of IPSG.3 through IPSG.3.3? For example, CCU is one of the areas where concentrated electrolytes are heavily used and the areas with an extreme emergency. ICU is identified as an exception where concentrated electrolytes in patient care areas are stored. Is it possible to regard CCU as one of the exceptions to the JCI recommendation as the area beyond the pharmacy's maximum capabilities?	magnesium sulfate that is expected to be kept on emergency carts as well as in labor and delivery. The exception identified for the ICU is for concentrated sodium for the treatment of increased intracranial pressure. The ICU is not identified as an exception for concentrated potassium chloride. As such, the CCU would also not qualify as an exception for storing vials of concentrated electrolytes. The intent does provide for situations in which storing all concentrated electrolytes within the pharmacy may not be always possible. Some organizations do not have 24-hour pharmacy support because pharmacists are not as readily available in some countries. In situations such as those, the organization may identify other methods for storing and preparing concentrated electrolytes. However, the expectation is that the organization perform a risk assessment identifying potential risks to patients while also identifying methods for mitigating those risks. In addition, IPSG.3.3. ME 1 states: "Only qualified and trained individuals have access to concentrated electrolytes, and they are clearly labeled with appropriate warnings and segregated from other medications." The expectation of this ME is that anyone handling and preparing concentrated electrolytes must be qualified and trained.
15	IPSG.3.2	Concentrated Electrolytes	In our hospital we have 3% sodium chloride that comes in this formulation from the manufacturer thus no further dilution needed. Is this considered a high-alert medication?	3% and 5% sodium chloride solutions that are already prepared as infusions are not considered concentrated electrolytes. However, they may be labeled as high-alert medications in your organization depending on how it is used in your organization and your own data related to adverse events or near misses. These solutions can cause fluid overload in patients that already have peripheral or pulmonary edema. Other conditions or certain medications can also make patients sensitive to the use of these solutions. You are encouraged to look at your data and use information and identify it as a high-alert solution if your data indicates this. One thing to consider about labeling high-alert medications is that if you label many medications as high-alert without thinking about your own data, staff can become desensitized to the label and can lead to staff not really paying as much attention to these labels.

Standards Interpretation FAQs

	Standards	Subject	Interpretation Question	Response
16	IPSG.3.2	Storage of High-Alert Medications, LASA, and Concentrated Electrolytes	The intent states that vials contained in a cardiac surgery kit, or a cardiac surgery locked storage area are exception to the recommendation to remove concentrated electrolytes from patient care areas. There is a storage area in the surgery area. Is it necessary to lock the storage room/area in the surgery area with a high security?	The intent of IPSG.3, 3.1, and 3.2 requires that hospitals develop and implement a process to improve the safety of high-alert medications, LASA medications, and concentrated electrolytes. The intent of these standards explains the use of a risk management process to prevent the risks related to these medications. Part of the risk management process is the completion of a risk assessment. In reference to the examples given of housing concentrated electrolytes in a cardiac surgery locked storage area, the hospital can complete a risk assessment to understand what the types of staff are who have access to the area and what is the workflow of the area. For instance, if the concentrated electrolytes are stored in an unlocked medication room that is located within the locked cardiac surgery area and environmental services staff have access to the area after hours or in an unsupervised manner, this can pose a risk of unauthorized staff accessing the concentrated electrolytes. The hospital can then use the information gathered from the risk assessment to determine how to best ensure that only trained and qualified staff members have access to concentrated electrolytes.
17	IPSG.3.2	Preparation and Dilution of Concentrated Electrolytes	Is it required that all concentrated electrolytes be mixed and prepared at the pharmacy before sending to the patient care units?	The intent of IPSG.3 through IPSG.3.3 identifies the incorrect or unintentional administration of concentrated electrolytes (for example, potassium chloride, potassium phosphate, sodium chloride, magnesium sulfate) as a frequently cited medication safety issue. The literature has identified several instances of death as a result of the inadvertent administration of a concentrated electrolyte in its concentrated form. The intent further states: Vials of concentrated electrolytes should not be dispensed in their concentrated form to patient care units for individual patients. When vials of concentrated electrolytes are stored on the ward, or a vial is sent from the pharmacy to the ward to be prepared by staff on the ward, there is a significant risk of the medication inadvertently being administered in its concentrated form which could result in death or permanent harm to the patient. The literature recommends, as does the Institute of Safe Medication Practices (ISMP) that concentrated electrolytes should be prepared in the pharmacy by qualified, trained individuals. IPSG.3.2. ME 1 states: "Only qualified and trained individuals have access to concentrated electrolytes, and they are clearly labeled with appropriate warnings and segregated from other medications." The expectation of this ME is that anyone handling and preparing concentrated electrolytes must be qualified and trained. The intent identifies specific exceptions to this practice, such as vials contained in a cardiac surgery kit or in a cardiac surgery locked storage area, magnesium sulfate contained in emergency carts or in areas in which patients with preeclampsia may be treated (labor and delivery, emergency department, or intensive care unit), and concentrated sodium in areas treating patients who may suffer from increased intracranial pressure (intensive care unit, emergency department, and operating room).

Standards		Subject	Interpretation Question	Response
				IPSG.3.3, ME 2 states: "The hospital only stores vials of concentrated electrolytes outside of the pharmacy in situations identified in the intent."
18	IPSG.3 IPSG.3.1 IPSG.3.2	High-Alert Medications	One of the examples of strategies listed in the intent is "Applying redundancies." Could you elaborate on what it means to apply redundancies?	IPSG.3 through IPSG.3.2 address the requirements for improving the safety of high-alert medications, which are defined as “drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients.” Many examples of strategies are given in the intent to improve safety with high-alert medications, such as applying redundancies. While JCI does not require specific strategies to improve the safety of administering high-alert medications, redundancy is a suggested policy. An example of a redundancy would be before a nurse could administer a high-alert medication, they would need to have a second nurse complete the medication verification against the order and then document this double check; therefore, the verification process would be completed twice by two separate individuals permitted to do so.
19	IPSG.3 IPSG.3.1 IPSG.3.2	Safety of High-Alert Medications	Is there a mandate requiring specific medications to be included in the list of High-Alert Medications or is the hospital to determine all High-Alert Medications?	The intent of IPSG.3, 3.1, and 3.2 requires that hospitals develop and implement a process to improve the safety of high-alert medications, LASA medications, and concentrated electrolytes. The intent of these standards explains the use a risk management process to prevent the risk related to these medications. The intent emphasizes that the hospital needs to develop its own list(s) based on its unique utilization patterns of medications and its own internal data about near misses (or close calls), medication errors, and sentinel events, as well as safety issues published in professional literature. For example, published lists of high-alert medications are available from organizations such as ISMP and WHO. The intent of these standards further explains that the list includes medications identified as high risk for adverse outcomes and that information from the literature and/or Ministry of Health may also be used in helping to identify which medications should be included.
20	IPSG.3.2	Non-24-Hour Pharmacy Hours and Concentrated Electrolyte Storage	Please provide guidance regarding compliance with storing concentrated electrolytes on wards due to limited pharmacy service hours.	When vials of concentrated electrolytes are stored on the ward, or a vial is sent from the pharmacy to the ward to be prepared by staff on the ward, there is a significant risk of the medication being inadvertently administered in its concentrated form. The literature has identified several instances of death because of accidentally administering the concentrated form of an electrolyte. The literature recommends, as does the Institute for Safe Medication Practices (ISMP), that concentrated electrolytes should be prepared in the pharmacy by qualified, trained individuals. The intent explains situations in which storing, mixing, and preparing of all concentrated electrolytes within the pharmacy may not be always possible. For example, some organizations do not have 24-hour pharmacy support because pharmacists are not as readily available in some countries. In situations like this,

Standards		Subject	Interpretation Question	Response
				the organization may develop an alternative process for preparing and storing concentrated electrolytes. However, storing concentrated electrolytes on a ward with other medications, particularly the neonatal intensive care unit, is not recommended. Also identified in the intent, several pediatric deaths have occurred as a result of administering concentrated potassium in its concentrated form. When an organization determines the need to store concentrated electrolytes outside of the pharmacy for preparation by individuals other than pharmacists, the following is expected: 1. The organization is expected to conduct a proactive risk assessment. A proactive risk assessment is a process for identifying and systematically analyzing the risks and hazards embedded in the process and structure of care to prevent adverse events from occurring. Knowing where the risks and hazards are helps to inform the design, planning, and development of appropriate interventions that will eliminate or minimize risks and hazards before patient injuries occur. 2. The organization is expected to show evidence that those who prepare concentrated electrolytes are trained and competent to do so. 3. Concentrated electrolytes prepared outside of the pharmacy are expected to be segregated from other medications and clearly labeled with appropriate warning signs. Measurable Element #1 from IPSG.3.2 states: "Only qualified and trained individuals have access to concentrated electrolytes, and they are clearly labeled with appropriate warnings and segregated from other medications."
21	IPSG.3.2	Standard Protocols for Concentrated Electrolytes	Could you provide more information on what is meant by "standard protocols" for IPSG.3.2, ME 3?	Patient safety literature has identified several instances of patient death resulting from the inappropriate administration of concentrated electrolytes. Effective ways to reduce this risk are listed in the intent of Standard IPSG.3.2, such as removing concentrated electrolytes from the patient care units and storing them in the pharmacy and using standardized protocols for managing patients requiring electrolyte replacement. It is for this reason that the use of standard protocols is required in IPSG.3.2 ME 3. Standard protocols are chosen and developed by the clinical experts for each population, are evidence-based, and are standardized for much of a specific patient population. For example, the pediatric department would develop a protocol for potassium replacement based on evidence from the literature. Standardization decreases variation and thus lowers the risk of patient harm.
22	IPSG.4	Surgical Site Marking	When a site marking cannot be placed on the part of the body such as the face during Ophthalmologic or Dermatologic surgical procedures, can a pictogram be used instead	There are instances where alternative site markings are necessary. For example, site marking for removal of an ovary is done on a body drawing or on a digital image rather than the body itself, or with tooth extractions which are often done on diagrams or digital images. It may be necessary to use alternative measures for site marking in selected Ophthalmologic or Dermatologic surgical procedures as well. When alternative measures for site marking are required, the organization is expected to specify in their policy how the site will be marked for these procedures. The organization should also identify these

	Standards	Subject	Interpretation Question	Response
			of marking directly on the face?	differences (that is, how they choose to mark the site--body diagram or digital image, etc.) in their policy. While the standard does not specify how alternative site markings must be done, an "X" is not recommended as the mark because it may be interpreted as "not here" or "wrong side" and could potentially lead to errors in patient care. The hospital must use an instantly recognizable and unambiguous mark for identifying the surgical/invasive site. Additional information on site markings are further outlined in the intent of IPSG.4-IPSG.4.1.
23	IPSG.4 IPSG.4.1	Time-Out	Are IPSG4 & 4.1 applicable to invasive procedures performed outside of operation theater?	The intent statement of IPSG.4 and IPSG.4.1 states that "organizations need to identify all areas within the hospital where surgical and invasive procedures take place; for example, the cardiac catheterization lab, interventional radiology department, gastrointestinal lab, and the like. The approach the hospital takes to ensuring safe surgery applies to all areas of the hospital in which surgical and invasive procedures occur." IPSG.4 and IPSG.4.1 relates to surgical and invasive procedures and, defines invasive procedures as "all procedures involving an incision or puncture, including, but not limited to, open surgical procedures, percutaneous aspiration, selected injections, biopsy, percutaneous cardiac and vascular diagnostic or interventional procedures, laparoscopies, and endoscopies"; these procedures can take place in other areas of the hospital as well such as the emergency department, ICU, or procedure room located on a ward. The hospital must determine all areas where surgical and invasive procedures can be completed, and the requirements of IPSG.4 and IPSG.4.1 apply to all the identified areas as determine by the hospital.
24	IPSG.4 IPSG.4.1	Time-out and Sign-out Processes	Do the time-out and sign-out processes require signatures by the surgical team, or is it okay to just document the components with tick boxes and the time when it was done? At present we are taking signatures of the surgical team for time-out process only.	As identified in the intent of IPSG.4 and IPSG.4.1, The time-out process is held immediately before the start of the procedure with all team members present. Signatures of the team members are not required. The requirements for ISPG.4 and IPSG.4.1 along with the intent provide further details of the required elements. IPSG.4.1, ME2 requires that the sign-out process is expected to be performed in the area where the procedure was done, and before the patient leaves. This provides evidence that the appropriate components of the sign-out were done, and the time it was done would verify that the sign-out was performed. The intent identifies that the four components (as applicable to the procedure performed) are verbally confirmed by a member of the team, typically a nurse. The standard does not specify what type of documentation is needed for the sign-out; but a verbal confirmation of the sign-out must be completed and, at a minimum, include d) through g) of the intent. Signatures of the team members present for the sign-out are not required.

Standards Interpretation FAQs

	Standards	Subject	Interpretation Question	Response
25	IPSG.4	Preoperative Checklist for Procedures Performed Outside the OR Setting	For procedures done outside the OR setting, we do the time-out and sign-out only and the time-out elements contains all elements of the preoperative checklist. Do we still need to do a preoperative checklist for procedures done outside the OR setting?	According to the intent of IPSG.4, preoperative verification is an ongoing process of information gathering and confirmation. Some of the information gathered during the preoperative verification process is similar and purposely duplicative to what is gathered during the time-out, such as the correct patient identity, procedure, and site. There are other elements of the preoperative verification process that are not captured during the time-out and should be verified prior to the procedure, such as ensuring that relevant images, documents, and studies are available, and verifying that all required blood products or medical equipment are available. JCI does not specify how the preoperative verification process or time-out is documented, a checklist is an example of how this can be accomplished. If the hospital determines that a single checklist or document can be used for specific procedures outside of the OR, the document should identify the specific components of each process since they are two separate processes.
26	IPSG.4 IPSG.4.1	Surgery/ Procedural Time-Out Process	1. If two surgeries/ procedures are scheduled back-to-back, are two separate time-outs (sign-ins) required for the two procedures, and if so, when should they occur (at the beginning of each stage of the procedure, or collectively at the beginning of the first procedure)? Which staff should be present at each of the time-outs? What are the required elements for each of the time-outs? 2. If the two timeouts can be combined, which staff must be present? If the two time-outs can be combined, what elements of the second surgery must be	1. Per the JCI requirements, a time-out must be performed before all surgical and invasive procedures as defined in the intent statement of IPSG.4 and IPSG.4.1 and any other procedures as defined by the hospital in policy and procedure. Additionally, the time-out must include all staff that will assist in the procedure and address that the correct patient is receiving the correct procedure at the correct site (i.e., right versus left leg). Two separate time-outs are required for two separate procedures when different surgeons are responsible for the separate procedures. For instance, if a surgical procedure is begun by a thoracic surgeon and completed by a general surgeon, then when the general surgeon enters to complete the second procedure a second time-out would be required prior to beginning the second procedure. If two procedures will be completed in the same surgery by one surgeon, then one time-out can be completed prior to the surgery and must involve all the required time-out elements for each procedure being completed. 2. If the two procedures are being completed by two different surgeons, then a time-out would be required prior to each procedure and if one surgeon is completing both procedures during the surgery, the time-out should take place immediately before the surgery and address both procedures to be performed. Per JCI requirements in IPSG.4.1, the time-out must include all the staff members that will be present during the procedure. The required elements that the team must address during a time-out are: (a) Correct patient identity (b) Correct procedure to be done, and (c) Correct surgical/invasive procedure site.

	Standards	Subject	Interpretation Question	Response
			reviewed separately at the first sign-in?	
27	IPSG.4	Dental Surgery Site Marking	Please provide examples for marking a surgical/invasive site with an instantly recognizable and unambiguous mark for dental surgery.	There are special circumstances in which making an external mark on the surgical site may not be feasible. Examples of this may be tooth extraction, oral surgery, or removal of an ovary. In these cases, the hospital must define how the site marking will take place, for example, a digital mark may be placed on the X-ray or other digital imagery and then confirmed with the patient prior to the procedure. It is stated in the intent of IPSG.4 that the site marking process must be uniform throughout the hospital.
28	IPSG.4	Site Marking in Cath Lab Procedures	Is site marking for Cath lab procedures such as angiography required?	Site marking for certain interventional procedures that do not involve laterality, multiple structures, or multiple levels is not required. Examples include cardiac interventions performed in the cardiac cath lab or interventional radiology where the insertion site may be the "surgical site. For example, balloon angioplasty or embolization of an AVM. However, if the procedure involves a left or right organ, such as a left or right kidney or left or right ovary, a diagnostic image should be available to identify the specific organ involved.
29	IPSG.4	Surgical Site Markings	Can medical students perform the actual site marking on a patient while the surgeon who is performing the procedure is doing direct observation of the student (student is acting as an extension of the hand of the surgeon)?	IPSG.4, ME 3 requires that the site marking is done by the person performing the procedure. The intent further explains specific scenarios on who can do the site marking by stating the following: • Responsible surgeon – The surgical/invasive procedure site marking is done by the person who will perform the procedure. This person will do the entire surgical/invasive procedure and remain with the patient throughout the entire procedure. In cases of surgical procedures, the responsible surgeon typically performs the surgery and therefore would mark the site. There are different titles used for the responsible surgeon, such as attending or consultant surgeon. • Trainee who performs the “entire” procedure with minimal supervision – when the trainee performs the entire procedure, requiring minimal or no supervision from the responsible surgeon or physician. In these circumstances, the trainee marks the surgical site. For a trainee to require minimal or no supervision, a trainee would need to be in his or her advanced surgical training program. A trainee who is still in a medical school and often referred to as a “medical student” would not be allowed to mark the site. Medical students performing the procedure who requires a direct observation by the surgeon does not qualify to mark the site. In this circumstance, the surgeon who is observing the medical student is considered the “responsible surgeon.” When a trainee is in the role of assisting the responsible surgeon or physician, only the responsible surgeon or physician may perform the site marking. An assistant surgeon may also be considered a trainee. As stated in the intent, a trainee who performs the entire procedure with minimal supervision is allowed to mark the site. However, when the trainee or assistant surgeon requires a higher level of supervision, the

	Standards	Subject	Interpretation Question	Response
				responsible surgeon or physician is required to perform the site marking even if the trainee performs the entire procedure.
30	IPSG.5.1	Use of Bundles	Are organizations required to use bundles?	IPSG.5.1 sets forth the requirement that hospitals use evidence-based interventions to decrease the most common hospital-associated infections (HAI), such as catheter-associated urinary tract infections (CAUTI) and ventilator-associated pneumonia (VAP). The intent of IPSG.5.1 uses the Institute for Healthcare Improvement (IHI) definition of bundles as "A small set of evidence-based interventions for a defined patient segment/population and care setting that, when implemented together, will result in significantly better outcomes than when implemented individually." While JCI does not require that the hospital use a specific bundle, it is required that the hospital uses evidence-based interventions to address the priority HAIs. Based on the IHI definition of a bundle that is utilized for this standard, the combination of certain evidence-based interventions can be referred to as bundles. The wording in IPSG.5.1 ME 2 addresses this when it states that bundles are an example of evidence-based interventions that can be used to prevent HAIs.
31	IPSG.6	Fall Assessment	Is there any minimum policy we can implement for our Telephone Consultations? Can education and fall risk be included in this?	The policy for consultation is addressed in the Standard GLD.6.2, ME 1 which states that…" All diagnostic, consultative, and treatment services provided by independent practitioners outside the hospital, such as telemedicine, teleradiology, and interpretations of other diagnostics, such as electrocardiogram (ECG), electroencephalogram (EEG), pathology, and the like, are credentialed and privileged by the hospital to provide such services." Regarding the assessment of fall risk for inpatient and outpatient, the hospital determines the process for fall risk assessment and screening. There are different components of the fall risk assessment process that will be very challenging to perform through telephone consultation. Fall risk screening often involves a tool, which may include a minimal number of questions and/or observations. If the results of screening indicate patient populations that are at risk for falls, interventions and/or measures are implemented to reduce risk. In the outpatient setting, screening generally provides the information needed to identify appropriate fall-risk interventions/measures. The organization may wish to perform an in-depth assessment following screening for specific outpatients or situations; however, it is up to the organization to make this determination. Unlike fall-risk screening that can be performed by trained administrative staff, fall-risk assessments must be performed by competent and trained clinicians.

	Standards	Subject	Interpretation Question	Response
				There are examples of fall-risk screening tools as well as fall-risk assessment tools for different patient populations that can be found in the literature. Keep in mind, as required by IPSG.6.1, ME 1 (outpatients), the screening/assessment tools need to be appropriate to the patients being served—for example, the tool used for screening pediatric patients would not be the same as that used with geriatric patients.
32	IPSG.6.1	Fall Assessment	My question is about international patient safety goal 6.1: regarding preventing harm from falls in the outpatient unit. I would like to ask about fall assessment, documentation, and measure such as put bracelet for the patient with high risk for fall in some situations such as a patient who comes to submit the pathology sample or to blood withdraw, for a patient who comes to perform some imagining such as XR knowing that there are no nurses in the unit	IPSG.6.1 requires that outpatients are screened for fall risk. However, not all outpatients have to be screened given the general nature of outpatient visits. The intent identifies that, "Only those patients whose condition, diagnosis, situation, and/or location identifies them as at risk for falls are screened." It is up to the hospital to identify the types of outpatients who are screened, and this will be based on various factors, including patient population, the services that are provided, environmental factors, individual patients' physiological factors, and other issues. The hospital determines the process for fall risk screening of outpatients, including the staff who will perform screening. If a hospital chooses to have staff at the registration desk screen patients for fall risk when the patient arrives, the staff must be trained to screen outpatients accurately, educated in the falls management program, and understand their role and responsibilities. Fall risk screening often involves a tool, which may include a minimal number of questions and/or observations. If the results of screening indicate the outpatient is at risk for falls, interventions and/or measures are implemented to reduce risk. In the outpatient setting, screening generally provides the information needed to identify appropriate fall-risk interventions/measures. The organization may wish to perform an in-depth assessment following screening for specific outpatients or situations; however, it is up to the organization to make this determination. Unlike fall-risk screening that can be performed by trained administrative staff, fall-risk assessments must be performed by competent and trained clinicians. There are examples of fall-risk screening tools as well as fall-risk assessment tools for different patient populations that can be found in the literature. Keep in mind, as required by IPSG.6.1, ME 1 (outpatients), the screening/assessment tools need to be appropriate to the patients being served—for example, the tool used for screening pediatric patients would not be the same as that used with geriatric patients.
Access to Care (ACC)				

	Standards	Subject	Interpretation Question	Response
1	ACC.4.1 ACC.4.2	Discharge Summary	Do outpatients and ER patients receive discharge summaries?	ACC.4.2 states that a complete discharge summary is prepared for all inpatients, including content such as admission diagnosis, significant physical and other findings, diagnostic or therapeutic procedures performed, medications administered and prescribed, status at time of discharge, and follow up instructions. Patients cared for and discharged from the Emergency Department, or an outpatient clinic of the hospital are not considered inpatients, however; ACC.4 and ACC.4.1 require that the hospital has a discharge planning and referral process that addresses the patient and family education related to the patient's ongoing need for continuing care and services. In the intent of ACC.4 and ACC.4.1, discharge planning is defined as a process that helps determine what types of continuing care and services a patient may need after leaving the hospital. Based on this definition and the continuity of care that is covered between inpatients, those cared for in the ED, and outpatient clinics, the hospital should have a process to determine what instructions the patient and family needs after discharge from the ED and outpatient encounters. The hospital must then have a process for communicating this information with patients and families in order to ensure that they understand how to continue caring for themselves and maintain their necessary follow up care.
Patient-Centered Care (PCC)				
1	PCC.3	Patient Experience	For the PCC standard on patient experience measurement, is it sufficient to use a Net Promoter Score (NPS) as the framework for us to measure patient experience as we complement the NPS survey with free text comments?	PCC.3, ME 2 states that "Data from the patient experience are aggregated, analyzed, and transformed into information to identify strategies for improving the patient experience." Net Promoter Scores can be used with additional free text although the standard does not specify how organizations measure, aggregate, and analyze patient experience data. However, it is important that the organization identifies the patient experience that needs to be measured and analyzed based on the organizational needs and settings. The intent of PCC.3 further explains that "Measuring patient satisfaction is one way to capture patient experience information". However, hospital leaders need to be aware that patient satisfaction is a subjective measure, while patient experience is an objective measure. For example, asking patients if they were pleased with the room layout would be a patient satisfaction measure because preference on a room layout is subjective. Asking patients if they have access to their health care records is a measure of patient experience because patient data access is an objective measure. As an integral component of health care quality, patient experience includes several aspects of health care delivery that patients value highly when they seek and receive care, such as timely appointments, easy access to information, and good communication with health care providers."
2	PCC.4.1	Uniform Recording of Informed Consent	The organization has a process for recording the informed consent for	The intent of PCC.4.1 states that informed consent may be obtained at several points in the care process, such as upon admission or immediately prior to an invasive procedure.

	Standards	Subject	Interpretation Question	Response
			elective surgeries by signing a consent and scanning it into the patient medical record. However, this process is not followed during emergency cases and verbal consent is obtained from the patient and noted in the patient record. Can this compromise the uniform recording of patient consent?	For example, informed consent can be obtained when the patient is admitted for inpatient care in the hospital and before certain procedures or treatments for which the risk is high. The standard does not specify the point in the patient care process when informed consent must be obtained as long as the consent process is obtained before the start of the procedure or treatment and is clearly defined in the hospital's policies and procedures. When there are different informed consent processes for different circumstances, such as in an emergency when the usual consent process cannot be followed, these process differences must also be defined in the policies and procedures. Relevant laws and regulations should also be incorporated into the policies and procedures.
3	PCC.4.3	Informed Consent Process	The intent lists different elements in the informed consent process that must be explained to the patient prior to obtaining consent. Are these elements required to be documented in the patient consent forms?	Informed consent is a process. The process needs to include a discussion with the patient. The elements of informed consent listed in PCC.4.3 do not need to be listed on the consent forms unless required by hospital policy. However, the requirement is that these elements are explained to the patient when informed consent(s) is required for the treatment and procedure. When the patient consents to a surgical procedure, the patient must be informed of all the elements identified in the intent of PCC.4.3, that is: patient condition, proposed treatment, potential benefits and drawbacks, possible alternatives, the likelihood of success, possible problems related to recovery, and possible results of non-treatment. This information needs to come from the surgeon performing the procedure. The standard does not specifically require that this information is provided through written documentation. Measurable element #1 states: "Patients are informed of elements a) through h) in the intent as part of the informed consent process…" The standard and MEs do not specify how the information must be presented to the patient. It could be provided through a pamphlet that the patient reviews followed by a discussion with the physician, it could be provided via an audio/visual presentation (such as on CCTV), or through a one-on-one discussion by the physician. The hospital may choose the format in which the information is presented. The hospital may choose to document this by making a note in the chart of what information was provided to the patient and how it was presented. The consent can then say that information presented to the patient has been documented in the clinical record. The patient also has the right to be informed about the anesthesia being used. The anesthesiologist is responsible for informing the patient about the risks, benefits, and alternatives of the anesthesia selected. Again, this information can be documented in the patient record.

	Standards	Subject	Interpretation Question	Response
				The process must follow the requirements identified in obtaining informed consent, however it is up to the organization to decide whether it is in one consent form or separate forms. If the organization chooses to use one form, the form needs to clearly identify who informed the patient about each of those areas (i.e., surgery, anesthesia, administration of blood products), what information the patient was given, and that the patient understood the information.
4	PCC.5.2	Patient Education	Are written educational materials for patient education reinforcement required for theater procedures, anesthesia and sedation?	The intent of PCC.5.2 states that the hospital decides when and how verbal education is reinforced with written materials to enhance understanding and to provide a future educational reference. Best practices in education show that for learning to take place, the content being taught must be reinforced multiple times, both in verbal and non-verbal interactions. In addition to this, many factors that relate to the patient experience in the hospital such as medication use, chronic medical conditions, and stress further increase the need for reinforcing education with written materials. It is recommended that verbal education be reinforced for surgical procedures and other procedures that require the use of anesthesia or sedation. For instance, patients admitted as an inpatient post-surgery can be provided written materials upon discharge to reinforce education about topics such as wound care, follow up appointments, and when to call for signs of infection. For patients undergoing an outpatient procedure, the hospital can provide written materials that reinforce education about the procedure, follow up appointments, and the possible side effects that may be experienced after anesthesia or sedation.
Assessment of Patients (AOP)				
1	AOP.1	Minimum Content of Assessments for Each Clinical Discipline	The standards require hospitals to define minimum content of assessment for each clinical discipline. Is it also required to define the minimum content of assessments to be performed in each clinical department?	The intent of Standard AOP.1 states that “the hospital defines, in policies, the minimum content of assessments to be performed by physicians, nurses, and other clinical disciplines” With regard to defining the minimum content of assessments performed at each clinical department, the hospital must consider situations where the content varies from other departments. For example, the minimum content for patient assessments in the dermatology clinic may be very different from the minimum content of assessments in the cardiology clinic. In these instances, the hospital’s policies must define how these variations are addressed. Additionally, the intent of Standard AOP.4 states that “a patient may undergo many kinds of assessments outside and inside the hospital by many different departments and services.” As such, Standard AOP.4, ME 1 requires that patient assessment data and information be analyzed and integrated.

	Standards	Subject	Interpretation Question	Response
2	AOP.1.5	Pain Assessment	Could you please explain the required process for providing a referral for a patient in pain who is seen in an outpatient department?	The intent of AOP.1.5 states that "When pain is identified in the outpatient setting, the patient may be more thoroughly assessed and treated in the hospital or provided with a referral for further assessment and treatment." The intent also provides examples of questions that may be used in screening patients for pain. These include asking if the patient is currently experiencing pain, if the level of pain is keeping the patient from sleeping at night and from participating in any activities, and if the patient is experiencing pain daily. In an outpatient setting, it is important to establish a pain screening process to determine the need for patient referral. An outpatient who provided positive answers to the organization's pain assessment questions could indicate the need for a more in-depth assessment of the patient's pain. This in-depth follow-up assessment may lead to providing the patient additional guidance to manage his or her pain, or it may also lead to the patient being treated in the hospital. For example, an outpatient at a Physical Therapy clinic whose pain assessment results indicated the need for further assessment may be referred to the hospital's pain clinic for treatment. AOP.1.5, ME.4 also states that "The assessment is recorded in a way that facilitates regular reassessment and follow-up according to criteria developed by the hospital and the patient's needs." As such, the organization must establish specific criteria that will determine the appropriate follow up procedures based on the initial pain assessment results.
3	AOP.1.5	Pain Assessment	If pain assessment is done for all patients as part of checking vital signs, do we still need to perform pain screening for OPD patients?	AOP.1.5, ME 2 states that "Outpatients whose condition, diagnosis, or situation may indicate they are at risk for pain are screened for pain." Based on this, the hospital must determine which outpatient populations will require screening for pain. As defined in the intent of AOP.1.5, a screening is a very high-level process that can be performed by clinicians, support staff (such as a registration clerk), or even the patient. A screening for pain may consist of one or more simple questions that can be asked during the registration process, on an intake form completed by the patient, or may be asked and documented by the physician referring the patient to the hospital or outpatient setting. Additionally, AOP.1.5, ME 5 states that "when the need for additional specialized assessments is identified, patients are referred within the hospital or outside the hospital."
4	AOP.6.2	Maximum Radiation Dose	Is the meaning of "maximum dose of a study" that radiation exposure cannot exceed that limit, and does it apply to patient dose monitoring, X-ray machine QC and calibration, and Diagnostic Reference Level (DRL)?	AOP.6.2, ME 4 states that "Radiation safety includes education about dosing and implementation of protocols that identify the maximum dose of radiation for each type of study." JCI does not specify the maximum doses for each type of study; Instead, organizations must follow applicable professional standards, laws, and regulations which often identify the recommended maximum doses of radiation for healthcare settings. If regional or local laws and regulations do not provide guidance, organizations may refer to industry standards and other published resources. Regarding the application of maximum doses for real patient monitoring, QC, and calibration, and the use of Diagnostic Reference Level, organizations must follow manufacturer requirements of the corresponding diagnostic imaging instruments.

	Standards	Subject	Interpretation Question	Response
5	AOP.6.5	Use of PACS (Picture Archive and Communication System)	Is the use of Picture Archive and Communication System (PACS) required to prevent critical patient information from being swapped in the archive system?	While JCI does not endorse or recommend a specific practice to manage the organization's PACS system, AOP.6.5 does require that the hospital uses a quality control process to manage the radiology and diagnostic imaging service. AOP.6.5 ME 3 states that "quality control includes regular surveillance and documentation of imaging results." In relation to the question about imaging results or patient information being easily swapped in the system, putting together a process where qualified staff complete regular surveillance of imaging results can potentially identify this possible swapping of patient information. While JCI does not endorse any specific practice to manage a PACS system, the following is a link to an executive summary and guidance document on the technical and quality management requirements for PACS systems: https://www.nccoe.nist.gov/sites/default/files/library/sp1800/hit-pacs-nist-sp1800-24-draft.pdf.
6	AOP.6.5	Quality Control Procedures	• ME 1 - are "quality control procedures" limited to equipment only, or are they dedicated to quality of services/imaging results? • Does ME.3 require conducting a surveillance of image interpretation /findings reported by radiologist in the form of a Known Performance Indicator (KPI), for example, a KPI for monitoring incidents where there's a difference between the preliminary and final report? • Does ME.5 require maintaining a KPI for monitoring identified deficiency of the quality of the image (i.e., a KPI for monitoring incidents	AOP.6.5, ME 1 – The intent of Standard AOP.6.5 contains a bullet point list that describes what should be included in the hospital's quality control procedures for diagnostic imaging. Examples given in this list include validation of the test method, regular surveillance of imaging results, and testing of any reagents or solutions when used. Based upon the items in this list, the quality control procedures listed in AOP.6.5, ME 1 relate to both equipment and the quality of services/imaging results. AOP.6.5, ME 3 – JCI does not specify how the regular surveillance of imaging results must be completed. It is described in the intent of AOP.6.5 that qualified radiology staff should complete this regular surveillance, for example, specific radiologists qualified to read radiology results may randomly review a representative sample of both low frequency, high-risk imaging results/reports and high-frequency, low risk imaging results and reports to ensure consistency in the reported results and imaging modality. The hospital does not necessarily need to make this data into a KPI to the hospital leadership but may choose to make it a Known Performance Indicator (KPI) for the radiology department. AOP.6.5, ME 5 – JCI does not specify whether the correction and documentation of deficiencies needs to be made a KPI. The hospital may choose to develop a KPI regarding this if review of the documentation shows that a specific exam is repeatedly being corrected or re-run, for example, repeat head CT angiography (CTA) exams. Making this into a KPI can help the radiology department to understand what is leading to the need for repeat CTA such as the issue being due to improper contrast administration technique.

	Standards	Subject	Interpretation Question	Response
			where a radiologist asks to repeat a CT scan test to obtain a better image)?	
Care of Patients (COP)				
1	COP.3.1	Clinical Alarm Management	What is the expectation of the data from medical devices on which alarms are causing false alarms?	The amount of data required and the timeframe for the data will depend on the specific medical devices that are being reviewed. The intent of COP.3.1 states that the hospital coordinates with the medical leadership of each area to understand which alarms pose risks if ignored. The hospital can then gather data from those devices to determine which alarms happen most often. For instance, medical devices more commonly used, such as cardiac monitoring will have much more data related to alarms than something less frequently used; therefore, the hospital wouldn't have to gather as long a timeframe worth of data to have enough information to guide the team.
2	COP.3.1	Clinical Alarm Management	For clinical alarms, is the presence of a central monitor technician mandatory for units with both central monitoring and decentralized monitoring?	For units that utilize centralized monitoring, for example, monitoring patient's heart rate in an ICU and then having a centralized set of monitors in the nursing station, JCI does not require that a central monitoring technician be hired. COP.3.1, MEs 4 and 5 state that staff utilizing monitoring technologies are trained and competent to do so; therefore, if centralized monitoring is used, the staff on the unit must be trained to operate and respond to the presence of clinical alarms.
3	COP.3.1	Clinical Alarm Management	Is an alarm management technician mandatory for hospitals that have both centralized and decentralized alarm management systems?	JCI does not require that hospitals hire a specific person to act as an alarm management technician to be compliant with the measurable elements of COP.3.1. It is recommended that staff working in the decentralized monitoring area (such as central telemetry technicians) be included in the team that manages the clinical alarms management program because they are responsible for responding to many clinical alarms throughout the hospital.
4	COP.3.1	Clinical Alarm Management	Does this include the Nurse call bells?	Nurse call bells could be included in the alarm management program. While nurse call bells are not alarms for physiologic monitoring, they are a way for patients to call for help; thus, alarm fatigue in relation to nurse call bells may also lead to patient harm.
5	COP.3.1	Data for Clinical Alarm Management	What types of data needs to be collected in establishing our clinical alarm management program?	The intent of COP.3.1 outlines considerations that can be helpful in determining alarm signals that may pose a risk to patient safety. These considerations include input from the medical staff and clinical departments, data from medical devices on which alarms are causing false or nonactionable alarms, and potential for patient harm based on internal incident history. For example, when medical devices cause a high incidence of false or nonactionable alarms, staff may assume that the alarms are unlikely to represent any

	Standards	Subject	Interpretation Question	Response
				actionable clinical event and potentially silence the alarms or modify the parameters inappropriately. This data and information would be important for an organization to understand to identify strategies to reduce the risk of harm. Incident reports related to clinical alarms and data from alarm manufacturers should provide useful starting points in gathering data for establishing an alarm system management program. In establishing the program, the organization may identify additional data that would be helpful in specific clinical units. These additional data may be discussed during the survey even if they are still under progress for integration in the organization's clinical alarm system management program.
6	COP.3.1	Clinical Alarm Management	Do the standards cover equipment with alarms in the laboratory, or only medical equipment/devices used for direct patient care?	Standard COP.3.1 focuses on managing clinical alarm systems used for patient care. These clinical alarms include all patient physiologic monitoring and patient care equipment alarms such as cardiac monitor alarms, fetal monitors, apnea alarms, cell-salvaging devices, elopement alarms, infusion pump alarms, ventilator alarms, pulse oximeters and emergency assistance alarms. Most alarms used in the laboratory are used for laboratory equipment and performing laboratory procedures. These alarms may be considered part of the laboratory equipment and should be maintained according to manufacturer's instruction and laboratory policies. In maintaining alarms used in the laboratory, standard AOP.5.5 states that "All equipment used for laboratory testing is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities."
7	COP.3.5	Self-Harm Risk Assessment	Please elaborate on what areas other than Psych unit, ED and Ob-gyn would need attention for suicidal or self- harm risk assessment	JCI does not specify which areas of the hospital require patients to be screened for suicide risk; the Psychiatric ward, the Emergency Department, and the Labor &Delivery/Post-Partum units are given as an example in the intent. The hospital determines, based on its patient population and services offered, which areas should use screening for suicide risk.
8	COP.3.5	Suicide Risk Assessment	Do you have any recommendation for screening tools to assess suicide risk in patients?	COP.3.5, ME 2 states that "The hospital uses evidence-based tools to assess patients for suicidal ideation based on established criteria. Patients who screen positive, are identified as "at risk" for suicide and/or self-harm based on the established criteria." JCI does not endorse a specific tool. The hospital must determine which tool best suits the patient population that it intends on screening. Examples of evidence-based, validated screening tools include, the Ask Suicide-Screening Questions (ASQ) toolkit developed by the National Institute of Mental Health, the Patient Health Questionnaire-9 (PHQ-9) Depression Scale, and the Columbia Suicide Risk Scare C-SSRS assessment tool.

	Standards	Subject	Interpretation Question	Response
9	COP.4	Use of Protective Equipment for Lasers	In our hospital a laser is used for vascular surgery. The laser is switched on in the vein and switched off before leaving the vein. Are goggles necessary in this situation?	Standard COP.4, ME 5 states that "Personal protective equipment appropriate to the type of lasers and optical radiation devices and type of procedures is available for staff and patients, and staff use it correctly and ensure that patients are protected during procedures." The standard does not specify the type of laser procedures that would make the use of goggles necessary. However, best practices and literature always recommend the use of personal protective equipment (including goggles) when lasers are being used. For example, using personal protective equipment at all times when using lasers could prevent potential harm in situations where lasers were accidentally switched on while not in use, or left on after completion of the procedure.
10	COP.4	Management of Lasers	In the case of Laser Soldering Machine, which runs a laser in a controlled environment inside the machine, with built-in coolant controls, do we still need to meet the general room and interlocking requirements of laser standards?	The intent of COP.4 provides examples of administrative and engineering controls that promote safety and prevent injury with the use of laser technologies. The standards do not specify these engineering controls and room requirements because of various laser technologies that are available and use in different organizational settings. It is up to the organization to identify these safety measures to ensure that the hospital's program for the safe use of lasers and optical radiation devices is based on manufacturers' recommendations, industry standards and professional guidelines, and complies with applicable laws and regulations per COP.4, ME 1.
11	COP.4	Management of Lasers	Which equipment and technologies are included in the scope of the laser management programs? The intent describes lasers as a source of optical radiation, which includes ultraviolet radiation, high-intensity visible light, and infrared radiation. Are Ionizing Radiation, commonly used in Brachytherapy, included in the program's scope and are biophotomodulation equipment (LEDS)	Standard COP.4 states that "The hospital establishes and implements a program for the safe use of lasers and other optical radiation devices used for performing procedures and treatments." The intent of the COP.4 standard also states that "The use of lasers is becoming more common in health care as laser technology evolves and the clinical applications broaden." For this reason, the standard does not specify which equipment and technologies should be part of the program. While the intent of COP.4 provides examples of procedures and treatments that may use laser technology and optical radiation, it is up to the organization to identify their own equipment and technologies where standard COP.4 would apply. For other radiation equipment and technologies where COP.4 may not be applicable, such as for ionizing radiation used in brachytherapy, Magnetic Resonance Imaging, and nuclear medicine scans for example, standard AOP.6.2 states that "A radiation and/or diagnostic imaging safety program for patients, staff, and visitors is in place, is followed, and is compliant with applicable professional standards, laws, and regulations." Healthcare organizations should always determine potential risks to patients, staff, and visitors when developing programs, policies, and procedures to meet the standard. As such, the intent of AOP.6.2 also states that "The safety program reflects the risks and

	Standards	Subject	Interpretation Question	Response
			considered as optical radiation?	hazards encountered and addresses safety practices and prevention measures for radiology and diagnostic imaging staff, patients, and visitors."
12	COP.8.5	Informed Consent from Transplant Candidates	Please clarify the informed consent process for transplant candidates, and the intent for MEs 2-6. Additionally, does this information need to be documented in the medical record, or just be verbalized to the patient?	Standard COP.8.5, ME 1 requires that the transplant program follows the hospital's policy when obtaining informed consent from transplant candidates. The requirements for informed consent for the hospital are found in PCC.4.1. Standard PCC.4.1 states that the hospital must develop a uniform process for obtaining informed consent that is carried out by staff who are trained to do it in a manner and language that the patient understands. The standard does not require a written process; however, the standard does require that there is uniform documentation of the process for obtaining informed consent in the patient medical record. Many hospitals choose to use a written process which clearly demonstrates the information provided to patients, the patient's permission as evidenced by a signature, and a uniform recording of the process. MEs 2- 6 of Standard COP.8.5 are the required additional processes and information that are specific to the transplant program. For example, COP.8.5, ME 3 requires additional information to be provided that is specifically related to the transplant factors which are identified in the intent. Like the hospital's requirements for informed consent, there is nothing in the standard that requires this information to be written into a formal document. However, the surveyors will look for evidence that this process occurs. For example, they may interview patients and/or families to determine what information they received; they may question staff about the process, including what information is provided; and/or they may review the medical record to determine how the informed consent process was recorded.
13	COP.8 COP.9	Bone Marrow Transplant	If a hospital only performs bone marrow transplants, how would COP.8 and COP.9 standards apply?	The Organ and Tissue Transplant standards are meant to address both solid organ as well as relevant tissue transplants. Some tissue transplants present very little risk to the patient. For example, a corneal transplant does not involve living donors, and is at very low risk of rejection and has a very high success rate. On the other hand, bone marrow transplant involves living donors and presents potential risks to the donor as well as the recipient. As an example, the literature identifies that the one-year survival rate is an important factor because the first year is the period when complications of a stem cell transplant are most likely to happen. Therefore, as identified in COP.8.5, ME 4, it would be important to include the expected one-year survival rate in the informed consent. The literature also identifies that a complication of bone marrow transplant is "graft-versus-host disease." As identified in COP.8.5, ME 5, providing the potential transplant recipient with potential rejection rates, along with other relevant information is an important aspect of the informed consent process. While stem cells are not considered "organs", there are expectations related to the suitability of the donor and the match to the recipient. The literature identifies criteria for being a donor and excludes, for example, people with diseases defined as autoimmune disorders, such as multiple sclerosis, systemic lupus, chronic fatigue

	Standards	Subject	Interpretation Question	Response
				syndrome and fibromyalgia. Therefore, there are some general requirements from standard COP.8.6, that would apply - such as ME 1 that requires CPGs related to donor data and recipient data to ensure compatibility before retrieval of stem cells; ME 2 that requires ensuring the medical suitability of the donor; and ME 4 that requires confirming the donor was tested and is free from infectious diseases and malignancies. There are potential risks to the stem cell/bone marrow donor. When bone marrow is harvested via a surgical procedure – generally aspiration of marrow from the donor's hip – there are risks to the donor. Risks are related to undergoing a surgical procedure such as, the risk of anesthesia, the risk of surgical site infection, etc. In addition, the donor may experience pain for days following the procedure and may have interruptions in their daily activities. The donor has a right to understand all these risks, as well as have an advocate that supports them, should they decide not to donate. In addition, as mentioned above, the literature identifies criteria for accepting bone marrow from a donor, therefore standard COP.9.2 applies. Finally, a bone marrow donor who has undergone a surgical procedure for collection of bone marrow should have a care plan that guides their care and treatment following their procedure requirements. With respect to stem cell donation (which is a form of bone marrow donation) – generally, the stem cells are collected via a process that is similar to donating blood. In this type of donation, the rigor of the COP.9 standards may not be necessary; however, the donor should still be provided with information about the process and provide consent. These are examples only and are not all-inclusive of the standards and MEs that would pertain to bone marrow donor and transplantation.
Anesthesia and Surgical Care (ASC)				
1	ASC.3	Definition of Procedural Sedation	Are minimal sedation/anxiolysis included in the definition of procedural sedation and therefore subject to the same standards as moderate sedation?	There are multiple references in the ASC chapter that discuss the continuum of sedation that begin with mild sedation. The overview of the ASC chapter states: "Anesthesia and procedural sedation are commonly viewed as a continuum from minimal sedation to full anesthesia along which the patient gradually loses their reflexes to protect their airway, such as coughing and gagging." The overview goes on to state: "This chapter does not address the use of sedation for the purposes of anxiolysis or sedation required in the ICU for ventilator tolerance." In addition, the intent of ASC.1 states that "Sedation and anesthesia are commonly viewed as a continuum from minimal sedation to full anesthesia. A patient's response may move along that continuum during which the patient's protective airway reflexes are at risk." The intent of ASC.3.2 supports this by stating again: "The degrees of sedation occur on a continuum from mild to deep sedation, and a patient may progress from one to another." Lastly, ASC.3 goes on to say, after the definition, that "Regardless of the medication, dose, or route of administration, when a medication is used for the purposes of altering the patient's cognitive state in order to facilitate a specific procedure, it is considered procedural sedation." The requirements identified in the ASC standards related to

	Standards	Subject	Interpretation Question	Response
				procedural sedation are expected to be applied to what health care practitioners identify as "mild sedation" when used for the purposes of allowing a patient to tolerate a painful or unpleasant procedure. Small doses of Chloral Hydrate intended for use as an anxiolytic prior to anesthesia and surgery do not fall under procedural sedation. However, when Chloral Hydrate is administered, particularly in children, with the intent to allow the patient to tolerate an unpleasant procedure (commonly used to sedate the child for a CT or MRI), it is considered procedural sedation and all standards/expectations for procedural sedation apply.
2	ASC.3	Administration of Procedural Sedation	Can minimal monitoring for sedation requirements be different in a section of the hospital if it is supported by a credible internationally accepted guideline?	The intent of ASC.3 states that the administration of procedural sedation must be uniform throughout the hospital and those hospitals must develop specific guidelines for how and where procedural sedation may be used. Hospital policies and procedures must describe the standardization of procedural sedation. Regarding monitoring for sedation, ASC.3.2 requires that "procedural sedation is administered and monitored according to professional practice guidelines." Policies and procedures must describe the monitoring process for wherever procedural sedation is provided throughout the hospital based on the professional practice guidelines. In addition, the individual responsible for providing the monitoring must be competent in monitoring requirements, response to complications, use of reversal agents, and recovery criteria per ASC.3.2, ME 2. 2.
3	ASC.3	Immediate Availability of Medical Equipment During Procedural Sedation	When a sedated patient is being transported to another service, the "immediately available equipment" during the transport may not be immediately available. Can it be considered "available" within the reach of code team (below 5 minutes)?	The intent of ASC.3 states that "standardization of procedural sedation is supported by policies and procedures that are understood by all practitioners permitted to administer procedural sedation and identifies the immediate availability and use of specialized medical equipment, appropriate to the age and history of the patient." In addition, ASC.3 ME 3 states that "emergency medical equipment and supplies are immediately available and customized to the type of sedation being performed and the age and medical condition of the patient." Patients who have recently undergone procedural sedation are at a heightened risk for respiratory compromise, even during transport, and therefore the emergency medical equipment needed to resuscitate the patient must be immediately present. For instance, the team transporting the patient should have a staff member trained in advanced resuscitation and have a bag or other means of bringing this emergency equipment with them during transport.
4	ASC.3	Advanced Life Support Training for	Is the Pediatric Emergency Assessment, Recognition and Stabilization (PEARS)	ASC.3, ME 4 states that "an individual with advanced life-support training appropriate for the age and history of the patient, is immediately available when procedural sedation is being performed."

	Standards	Subject	Interpretation Question	Response
		Administration of Procedural Sedation	course offered by AHA acceptable as advanced life support training?	The intent of ASC.3 requires that those staff members permitted to administer procedural sedation must have special qualifications and skills; therefore, they must have sufficient experience with the patient population that they care for, such as pediatric patients. In relation to the PEARS course provided by the American Heart Association, the course is intended for physicians and nurses that do not specialize in the care of pediatric patients. PEARS training ensures an individual understands how to recognize and manage pediatric emergencies. A PEARS class teaches the trainee how to provide support during the treatment of sick or injured pediatric patients. However, PEARS training does not prepare an individual to lead advanced life-support resuscitation as a course such as PALS would provide and as is required by ASC.3, ME 4. There are many courses in pediatric life support provided through the American Heart Association and other professional associations that are designed for physicians and nurses who specialize in the care of pediatric patients and provide the required advanced-life support training.
5	ASC.3	Procedural Sedation	Is the administration of IV valium for “anxiolysis” by non- anesthesiologists in an outpatient setting considered “minimal sedation”? If so, do the standards of “procedural sedation” not apply?	Procedural sedation is defined as “A technique of administering sedatives or dissociative agents with or without analgesics to induce a state that allows the patient to tolerate unpleasant procedures while maintaining cardiorespiratory function.” The situation described is considered procedural sedation and all related standards to procedural sedation applies. As stated in the Intent of Standard ASC.3, “Regardless of the medication, dose, or route of administration, when a medication is used for the purposes of altering the patient’s cognitive state in order to facilitate a specific procedure, it is considered procedural sedation.” Standard ASC.3.2 also describes the levels of sedations not in terms of the medications used but in terms of the patient’s ability to protect and maintain a patent airway. The Intent of Standard ASC.3.2 also states that “Patients undergoing procedural sedation require monitoring of their level of consciousness, ventilator and oxygenation status, and hemodynamic variables at a frequency based on the type and amount of medication administered, the length of the procedure, and the type and condition of the patient. Important considerations during the sedation procedure include the patient/s ability to maintain protective reflexes; an independent, continuous patent airway; and the capability to respond to physical stimulation or verbal commands.”
6	ASC.7.2	Operative Report	For ASC.7.2, ME 3 ,3, what is considered the “next level of care” in relation to “The surgical report, template, or operative progress note is	ASC.7.2, ME 3 states that “The surgical report, template, or operative progress note is available immediately after surgery before the patient is transferred to the next level of care.” When discussing the next level of care in the intent, it is stated that “To support a continuum of postsurgical supportive care, the information about the surgery is recorded in the patient’s medical record immediately after surgery, prior to the patient being transferred

	Standards	Subject	Interpretation Question	Response
			available immediately after surgery before the patient is transferred to the next level of care."	from the surgical or the post-anesthesia recovery area." The use of the word "or" denotes that for the purposes of this standard and ME, the PACU is considered an extension of the OR.
Medication Management and Use (MMU)				
1	MMU.1	Uniform Medication Dispensing	Please explain expectations for "uniform medication dispensing and distribution systems"?	The hospital must have a process for distributing medication from the main pharmacy to the wards and other patient care areas that is uniform. Using a uniform process for all areas will help to reduce errors and ensure that the correct medication is delivered to the correct area for the correct patient. Likewise, there should be a uniform or standardized process for dispensing medications on each ward or unit to patients. Using a standardized process can help to reduce error and ensure that the correct dose of the correct medication is given to the correct patient through the correct route and the correct time. For example, the hospital may choose to use an automated medication dispensing system on the wards and units that interfaces with the electronic medical record in order to decrease medication error. Or, if using a manual system, a standardized process should be followed to ensure that staff trained to administer medications complete the appropriate checks prior to administration. To support this, the use of pre-packaged and pre-labeled medications has been shown to reduce the risk of medication administration errors. For instances where medications are prepared and not immediately used (such as preparing medications from multi-use vials into syringes and sterile basins in the operating theater or procedural areas) these medications must be labeled with the required elements defined in the hospital policy and MMU.4.2.
2	MMU.3	Medication Labeling in Pharmacy	Do we need to place the label of "Name of the Medication" in the bottom or beside for each medication cupboard in the pharmacy?	MMU.3 provides guidance for organizations on how medications should be stored. As mentioned in the intent of MMU.3, medications must be stored in places determined by the organization that are suitable to product stability and labeled in such a manner that facilitate the staff's ability to ensure that the correct medication, dose, and route, are given to the correct patient at the correct time as required in MMU.4.1 ME 4. It is not required that medication drawers be labeled in any specific manner; therefore, the organization must determine how to best label medication drawers in the areas where medications are stored. MMU.4.1 ME 3 requires that the organization has a uniform process for dispensing and distributing medications in the most ready-to-administer form as possible. It is important that all individual vials, packages, and other dosages of medications are labeled in such a way that the staff administering medications can easily identify the medication, dose, route, and any other special considerations such as whether the medication is a high-alert or look-alike sound-alike medication.
3	MMU.3.1	Access to Emergency Medication Cart	How can organizations properly secure emergency medications	The standard MMU.3.1 requires that hospitals provide quick access to appropriate emergency medications based upon the location and services provided.

	Standards	Subject	Interpretation Question	Response
			and be available for quick access during emergencies?	MMU.3.1 ME 3 further states that "access to emergency medications does not require a specific individual or keys to unlock the emergency cart." In the case of an emergency, if the specific individual or the keys to unlock the cart are not immediately available, there may be a significant delay in accessing the necessary resuscitation medications that could result in a poor outcome. An example of how the hospital might store the medications in a ready to access manner would be in a designated drawer in the unit's emergency cart or in an emergency box with a breakaway lock rather than a key lock.
4	MMU.3.1	Emergency Medication for Pediatric Patient	What do you mean by Emergency medication for pediatric patients?	Standard MMU.3.1 addresses the accessibility of emergency medications, including emergency pediatric medications. While common emergency medications used in pediatric resuscitation are not different than those used in adult resuscitation, the dosage is often different, and weight based. Pediatric medications may also require a different concentration whereas adult medications are generally given by dose. JCI does not require that hospitals have a designated pediatric emergency cart; however, if the hospital does care for pediatric patients, emergency medications for pediatric patients should be readily available. If the hospital does not have specific pediatric emergency carts, the intent of MMU.3.1 gives the example of designating a specific drawer in the adult emergency cart. This designated drawer allows for the storage of medications and other emergency equipment needed for care and dosing in a standardized manner to prevent errors in emergency situations.
5	MMU.3	Disposal of Narcotics	What are the recommended methods for proper disposal of narcotics?	JCI does not specify how hospitals must dispose of narcotics. Standard MMU.3, ME 2 addresses the security, storage, and accountability of controlled substances and identifies that an organization must follow the country's applicable laws and regulations. The intent of standards FMS.7 through FMS.7.2 identifies pharmaceuticals as a category of hazardous materials and addresses the requirement for the organization to have a process for the proper disposal of hazardous waste in a safe and legal manner. The organization may consider including narcotics and controlled substances as part of the hazardous waste plan. The most common and least costly method cited in the literature is to flush or expel partial excess narcotic doses down a drain (sewerage). Some organizations have wasted the excess into a needle box; however, this method is not considered to be tamper-proof. Professional organizations such as Institute for Safe Medication Practice (ISMP), the WHO, and other regional professional organizations may identify acceptable practices for disposal of narcotics.
6	MMU.4	Medication List	Should we provide a list of medications that includes new medications and	Standard MMU.4, ME.2 states that "the patient's medical record contains a list of current medications taken prior to admission or registration as an outpatient, and this

Standards		Subject	Interpretation Question	Response
			previously prescribed medications a patient should continue to take, or is it sufficient to keep this information only in the patient's electronic medical record where medical providers can check them easily?	information is made available to the patient's health care practitioners and the pharmacy as needed." Standard MMU.4, ME 3 also states that "Initial medication orders are compared to the list of medications taken prior to admission, according to the hospital's established process." When patients are taking medications prior to admission, proposed new medication orders should be compared against the list of medications the patient is currently taking. After this process of medication reconciliation, the patient's medical record should be updated to list all medications taken prior to admission and the list of all medications that the patient should continue to take including those that were newly prescribed while inpatient. The goal of this review process is to improve the quality and safety of adding a new medication to the patient's treatment plan and reduce the risk of an adverse medication event. A listing of all current medications is recorded and should be made available to the pharmacy, nurses, and physicians. While a patient is an inpatient, they should also be informed of the medications that are being administered to them but there is not a requirement to provide a written list to the patient while they are in the hospital. However, as identified in ACC.4.1, MEs 2 and 3, upon discharge from the hospital, patients are provided with a complete list of medications to be taken at home and they are educated about the safe and effective use of all medications.
7	MMU.4	Medication Reconciliation	please clarify definition of sample medications.	Medication samples are prescription medications packaged as one or more dosage units by a manufacturer or distributor in accordance with local laws and regulations. A medication sample is not intended to be sold and is intended to promote the eventual sale of the medication.
8	MMU.4	Medication Reconciliation	We have CPOE in our institution but only for inpatient units and some daycare units, but outpatient areas are manual prescription. What is the best way in a busy outpatient clinic to perform the medication reconciliation?	Standard MMU.4, ME.2 states that "the patient's medical record contains a list of current medications taken prior to admission or registration as an outpatient, and this information is made available to the patient's health care practitioners and the pharmacy as needed." Standard MMU.4, ME 3 also states that "Initial medication orders are compared to the list of medications taken prior to admission, according to the hospital's established process." Inpatient and outpatient settings that use manual prescription processes may pose an added challenge for medication reconciliation. As such, it is critical that the organization establish a process to keep patient profiles updated. Proposed new medication orders should be immediately compared against the list of medications the patient is currently taking. After this process of medication reconciliation, the patient's medical record should be updated to list all newly prescribed medications and the list of all medications that the patient should continue to take. The goal of this review

Standards		Subject	Interpretation Question	Response
				process is to improve the quality and safety of adding a new medication to the patient's treatment plan and reduce the risk of an adverse medication event. As described in the intent, Joint Commission International recognizes that it can be difficult to obtain a complete medication list from every patient in an encounter, and accuracy is dependent on the patient's ability and willingness to provide this information. The intent further explains that a credible effort to collect this information is recognized as meeting the intent of the requirement. Examples of a credible effort may include contacting the patient's pharmacy and/or family members or consulting with the patient's primary physician.
9	MMU.4	Medication Reconciliation	Currently we have manual prescriptions, can you give some examples for how to achieve medication reconciliation in outpatient/ ambulatory care setting? Home meds recorded by physician are not in the information of pharmacist	The intent of Standard MMU.4 highlights medication reconciliation as a critical safe medication management process for reducing risks for adverse events. The standard does not specify areas where medication reconciliation between physician and other healthcare providers are required. However, medications are prescribed in many areas of the hospital. As such, medication reconciliation between physicians and other healthcare providers should be conducted in all areas where medication prescription occurs which includes outpatient clinics and the emergency department. There are specific situations in which a targeted medication review can be completed. For example, when contrast media is being administered in a diagnostic imaging organization, there is the potential for interactions with drugs the patient may be taking, such as drugs that may enhance the renal effects of contrast media, drugs that may enhance allergic-type reactions to contrast media, or drugs that may interfere with the hematological effects of contrast media. The pharmacist is not specifically identified as the person that needs to complete all medication reconciliation. In the example listed of the outpatient/ambulatory setting, the reconciliation process can be completed by a physician, nurse, or other trained staff member. Standard MMU.5.1 describes the appropriateness review process, which is more detailed and is completed by the pharmacist. MMU.5.1, ME 4 states that the full appropriateness review process must be completed within 24 hours when a designated professional is not immediately available to complete the review. Additionally, Standard ACC.4.3 describes the information that is required to be in the outpatient profile, part of this information is documentation of the medication reconciliation process.
10	MMU.4	Medication Reconciliation	On MMU, what information/ details should be documented to prove that a "credible" effort was done?	As described in the intent of MMU.4, Joint Commission International recognizes that it can be difficult to obtain a complete medication list from every patient in an encounter, and accuracy is dependent on the patient's ability and willingness to provide this information. The intent further explains that a credible effort to collect this information is recognized as meeting the intent of the requirement. Examples of a credible effort may include contacting the patient's pharmacy and/or family members or consulting with the patient's primary physician.

Standards		Subject	Interpretation Question	Response
				The hospital can document this credible effort in situations where all the required information cannot be gathered. The hospital can then decide about the safety of administering the medications based on the information that has been obtained.
11	MMU.4	Medication Reconciliation in Outpatient Departments	Does the medication reconciliation between Physician and other healthcare provider only apply to Inpatient Admission or does it also apply to the emergency departments and outpatient clinics?	The intent of Standard MMU.4 highlights medication reconciliation as a critical, safe medication management process for reducing risks for adverse events. The standard does not specify areas where medication reconciliation between physician and other healthcare providers are required. However, medications are prescribed in many areas of the hospital. As such, medication reconciliation between physician and other healthcare providers should be conducted in all areas where medication prescription occurs which include outpatient clinics and the emergency department.
12	MMU.4	Medication Reconciliation Prior to Administration	When physician and pharmacist are reconciling medications upon initial orders, is it required for nurses to also reconcile before administration?	The standard does not require an additional medication reconciliation by nurses prior to administration. However, standard MMU.6.1 includes specific measurable elements that require the hospital to establish a medication administration process to verify that the medication is correct based on the medication prescription or order. The intent of MMU.6.1 also outlines items to verify for safe administration of medications. These include verifying the medication with the prescription or order, time and frequency of administration with the prescription or order, dosage amount with the prescription or order, route of administration with the prescription or order, and identity of the patient.
13	MMU.4	Information Needed to Reconcile Current and Newly Ordered Medications	The intent of the MMU 4 states that “The types of information that clinicians use to reconcile medications include, but are not limited to, medication name, dose, frequency, route, and purpose.” What does purpose mean?	Standard MMU.4, ME 1 states that “The hospital identifies the information needed to reconcile current and newly ordered medications.” The intent of Standard MMU.4 also states that “The types of information that clinicians use to reconcile medications include, but are not limited to, medication name, dose, frequency, route, and purpose.” The term “purpose” is actually meant as the “indication” for the medication. For example, when ordering paracetamol, it would be important to identify if the intent is to reduce fever or to control pain. This also becomes important during the appropriateness review when an additional medication is ordered that may have the same indication. For example, ordering morphine sulfate for pain when the patient currently has an order for paracetamol. The intent further states that “Organizations should identify the information that needs to be collected to reconcile current and newly ordered medications and to safely prescribe medications in the future.” Identifying the purpose (or indication) against each current medication is not required. Instead, it is up to the organization to identify all information to be collected to ensure a safe and accurate medication reconciliation process as per Standard MMU.4, ME 1. The organization’s process should include a review of a proposed new medication against the

Standards		Subject	Interpretation Question	Response
				list of medications the patient is currently taking in a manner that will identify and reduce the risk of an adverse medication event.
14	MMU.4	Electronic and Manual Reconciliation Forms	Can we use a manual document attached to the electronic medical records, or must there be one standardized electronic process for medication reconciliation?	Standard MMU.4 outlines requirements for medication reconciliation as an important process of safe medication management. The measurable elements of MMU.4 address specific required steps in which organizations must comply for a safe medication reconciliation process. The process can be utilized with electronic or non-electronic systems or both. Often, as organizations begin their conversion from paper records to electronic records, they may need to use a combination of both. The JCI standards do not limit organizations to using only one or the other if the documentation provides a safe patient care process for meeting the requirements of the standards.
15	MMU.4	Medication Reconciliation	The intent of MMU.4 suggests that this standard is to be applied during "initial" encounters (admission, outpatient visits). Since managing medication during inpatient transitions and discharge are addressed in other standards, can medications during transition be addressed in ACC 3, ME 1 and ME 3, and discharge meds in ACC 4.1?	MMU.4 focuses on the medication reconciliation process for initial orders prior to admission as an inpatient or registration as an outpatient. The standard does not specifically require a full medication reconciliation during transfers of care within the hospital. Medication reconciliation can be addressed in standard ACC.3 MEs 1,3, & 5. Specifically, ACC.3, ME 5mentions that a summary of information transferred with the patient should contain items f) through l) of the intent. Item j) in the intent is medications. This concept can also be addressed via IPSG.2.2, which describes handover communications being: 1. Between health care practitioners 2. Between different levels of care within the hospital (such as ICU to med surg, OT to recovery, emergency department to ward, etc.) 3. From wards to diagnostic or treatment areas within the hospital 4. Between staff and patients/families
16	MMU.4.2	Required Elements of a Complete Order or Prescription	Are “indication” and “maximum dose” required in every prescription?	There is a difference between letter c) of the intent of MMU.4.2, which requires additional information for use to be included in orders for PRN medications that is different from Measurable Element 2 of MMU.4.2 which states that the maximum dose is required in all medication orders. Additionally, the wording in the intent statement “all orders and prescriptions contain the name of the drug, the dose, and the frequency and route of administration” does not match the requirements in MMU.4.2 ME 2. The expectation for PRN medications represents a special set of medication orders and therefore, adding the additional information about maximum dose is necessary to help staff safely administer these medications. For example, if the patient has multiple PRN medications for pain such as acetaminophen and Norco (or other narcotic/acetaminophen combinations) listing the maximum dose of acetaminophen is important.

Standards		Subject	Interpretation Question	Response
				Joint Commission International has issued an errata and updated the 7th Edition of the *Accreditation Standards for Hospitals* to address this clarification. The errata are available on The Joint Commission website and can also be accessed through the following link: **Errata to *JCI Accreditation Standards for Hospitals*, 7th Edition**
17	MMU.4.2	Complete Medication Order	We have some medicines that include tablets, and the concentration of the tablet is 200 mg, and the doctor wants a dose of 600 mg. What is the safest way to write the medicine? Is it to write 3 pills (200 X3) or just write the dose 600 mg and the nursing gives 3 pills?	JCI states in the intent of MMU.4.2 that errors in medication orders account for approximately 50% of medication errors. In response to the example listed in your question, the order should be written in a way that clearly defines the dose, which is one of the key medication order elements that are listed in MMU.4.2 ME 2. For instance, with orders that are written referencing pills or vials, the specific dose of the pills or vials should be listed as well in order to prevent an error. There could be a situation where a specific medication is stocked in both 200 mg and 400 mg pills and if the total dose ordered is 600 mg, the order should be written in such a way as to indicate that 3 of the 200 mg pills are needed to deliver the full dose of 600 mg. It should be noted however, that the standard and ME do not require that an order specify the number of pills or vials, only that it specifically state the dose of the medication. Organizations are encouraged to develop policies/procedures that specify the safest way in which to write medication orders.
18	MMU.4.2	IV Medication Order	Should all IV medication orders include rates?	The intent for Standard MMU.4.2 identifies the elements of a complete order or prescription and letter f) of the intent states that when intravenous infusions are ordered, the rate of administration needs to be specified. How the rate of administration is stated in an order can vary depending on the route or type of medication, and the writing style of the prescriber. Examples of how the rate of administration can be stated in an order: • IV push medication, in place of a rate for administration, the order might indicate that the medication be given over a certain amount of time, such as "Labetalol, 50 mg, IV push over 2 minutes." • IV bolus medications - the physician specifies the amount of the bolus and over a specific period of time, such as “500ml 0.9% normal saline bolus to be administered over one hour." • Certain medications, such as Vancomycin, where the rate of administration is determined when calculating dosages during preparation according to patient information such as lab values and patient weight, as stated in letters d and e. The intent further explains that standard MMU.4.2 “sets hospitalwide expectations for medication orders. The processes are reflected in complete orders entered in the medical record, the pharmacy or dispensing unit receiving the information needed for dispensing, and the administration of the medication based on a complete order.” Therefore, missing

	Standards	Subject	Interpretation Question	Response
				elements of a medication order, such as the IV medication rate, will not meet the requirements for standard MMU.4.2, and MMU.4.2, ME 3.
19	MMU.5.1	Appropriateness Review	If the procedure requires procedural sedation and the physician ordering sedation medication is available during ordering, administration, and monitoring, does the sedation medication need to go through appropriateness review?	The intent of MMU.5.1 states that "there may be circumstances in which the full appropriateness review is not practical, such as in an emergency or when the ordering physician is present for ordering, administering, and monitoring of the patient (for example, in the operating theatre or the emergency department), or with oral, rectal, or injectable contrast in interventional radiology or diagnostic imaging where the medication is part of the procedure." Another example of a situation analogous to those listed above in which the physician is continually present is during procedural sedation. However, the requirements identified in the ASC standards related to procedural sedation are expected to be applied. For example, Standards ASC.3 and ASC.3.3 on Sedation Care outline very specific requirements on standardized practice, practitioner's responsibility and patient monitoring, use of professional guidelines, and risk-benefit analysis.
20	MMU.5.2	Medication Labeling	For the MMU it says label the container upon transferring from original container. If we are using Ziplock, are we going to label the Ziplock or the medication cup?	MMU.5.2 states that "a system is used to safely dispense medications in the right dose to the right patient at the right time." The intent of MMU.5.2 further explains that "when a medication is removed from its original packaging or prepared and dispensed in a different form/container—and not immediately administered—the medication must be labeled with the name of the medication, the dosage/concentration of the medication, the date of preparation, the date of expiration, and two patient identifiers." Based on these statements, when medications are being transferred to a Ziplock or medication cup and are not meant to be immediately administered to the patient, these medications must be labeled. Additionally, organizations must recognize that multiple medications in a Ziplock bag or medication cup may be misidentified due to the color or size of specific pills looking similar and therefore present an increased risk for medication administration error.
21	MMU.6.2	Patients Own Medications	It is often difficult to obtain the information on "resource" of medications from the patients. How can a hospital perform risk assessment for medications brought in by the patient/family?	Standard MMU.6.2 states that "policies and procedures govern medications brought into the hospital by the patient or family and medication prescribed for patient self-administration." In developing these policies and procedures, the intent of MMU.6.2 explains that the hospital is required to perform a risk assessment on all medications that the patient or patient's family brings to the hospital. As stated in the intent, elements of the risk assessment are listed as: "where the patient obtained the medication, when the medication was obtained, and how the medication was stored at home."

	Standards	Subject	Interpretation Question	Response
				The intent of MMU.6.2 also states that based on the results of the risk assessment, the hospital determines whether the medications are safe for administration to the patient. JCI recognizes that given certain situations, it may be difficult to gather all the necessary information about medication from patients and their family. MMU.4 describes the overall process for medication reconciliation and requires that hospitals put forth a credible effort to obtain this information. For example, a credible effort may include contacting the patient's pharmacy and/or family members or consulting with the patient's primary physician. The hospital can document this credible effort in situations where all the required information cannot be gathered and then make a decision about the safety of administering the medications based on the information that has been obtained.
Quality Improvement and Patient Safety (QPS)				
1	QPS.6	Data Validation	What is the expectation for data validation and data collected from IT systems? Can you share examples of data validation methodologies that will be acceptable during the survey?	The JCI standards don't specifically address data validation for data that is collected from IT systems; however, the same concepts related to data validation can be applied to data that is collected both electronically and manually. For data that is gathered electronically, the hospital must perform data validation when any of the items a) through f) in the intent of QPS.6 are met. In addition to this, it is recommended that manual data validation be performed upon the adoption of any new data system and on a periodic basis. While the use of electronic systems to gather data may help improve workflow and resource use, a system that is incorrectly gathering data that is not validated could lead to a large amount of incorrect data and can therefore lead to an overall decrease in quality.
2	QPS.6	Evidence-Based Data Validation Methodology	Could you share examples of Evidence-based data validation methodologies?	Standard QPS.6 states that "The hospital uses an internal process to validate data." JCI does not specify which evidence-based process for data validation should be used to meet the requirements of this standard. One example of a data validation process is described as follows: 1. Re-collecting the data by a second person not involved in the original data collection 2. Using a statistically valid sample of records, cases, and other data. A 100% sample would only be needed when the number of records, cases, or other data is very small. 3. Comparing the original data with the re-collected data 4. Calculating the accuracy by dividing the number of data elements found to be the same by the total number of data elements and multiplying that total by 100. A 90% accuracy level is a good benchmark. 5. When data elements are found not to be the same, noting the reasons (for example, unclear data definitions) and taking corrective actions

	Standards	Subject	Interpretation Question	Response
				6. Collecting a new sample after all corrective actions have been implemented to ensure the actions resulted in the desired accuracy level. 7. Other areas for data validation include ensuring the accuracy of data entry and data extraction, particularly when using information technology and software programs for data collection and analysis.
3	QPS.6	Data Validation Process	Regarding the internal data validation process: when considering a sample analysis methodology by a second individual to seek 95% accuracy, are there expectations for the individuals participating in data aggregation and validation to ensure interrater reliability?	Standard QPS.6 describes the requirements for data validation and describes six specific situations in the lettered list of the intent when data validation would be required. An important part of completing an unbiased and valid data validation process would be to ensure interrater reliability. JCI does not require that the individuals completing the data validation and assessing for interrater reliability be from different departments, but rather that two different individuals take part in the process. Additionally, the individuals participating in data aggregation and validation should be trained to do so, as is stated in QPS.3, ME 2 "Individuals with appropriate clinical or managerial experience, knowledge, and skills participate in the process."
4	QPS.7	Definition of Sentinel Event	The standard requires the hospital to include the definition of sentinel event in its policy that includes the elements a) through r) in the intent. Are we required to include all these elements in our sentinel event definition even if the event may not be encountered due to the service not being offered in our facility? For example, severe neonatal hyperbilirubinemia for those who do not have maternity and newborn services.	The Scope of the Survey is explained in The Summary of Key Accreditation Policies where it states that "All standards contained in the current edition of the Joint Commission International Accreditation Standards for Hospitals are applicable unless the hospital does not provide that service (for example, does not provide laboratory services on-site)." The intent of Standards QPS.7 and QPS.7.1 carefully outline different patient safety events that healthcare organizations should include in their definition of a sentinel event. The hospital must define in their policy which events outlined in the Intent of Standards QPS.7 and QPS.7.1 would not be encountered due to the hospital not offering a specific service. For example, organizations that do not provide blood transfusion services may state in their policy that "Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups) is not applicable." Following the indication of such an event being "not applicable," the policy should clearly state the rationale as services not being offered. However, the organization must be aware that the service not being offered may not be the sole reason for a patient safety event to not occur. The expectation is that organizations carefully review all system issues that can lead to patient, staff, or visitor harm and that the hospital must have a process for identifying and managing all patient safety events that are applicable to their situation by starting with the events outlined in the intent.

	Standards	Subject	Interpretation Question	Response
5	QPS.7	Sentinel Event – Severe Neonatal Hyperbilirubinemia	We would like to understand whether we should consider the total bilirubin value or indirect bilirubin value to identify sentinel events in item n) severe neonatal hyperbilirubinemia (bilirubin> 30 milligrams / deciliter)?	Bilirubin test results may be expressed as direct, indirect, or total bilirubin. While total bilirubin is a combination of direct and indirect bilirubin, laboratory results for bilirubin in some countries only include direct and total bilirubin. As with most laboratory tests, reporting may vary based on applicable local and national standards, laws, and regulations. Additionally, results reporting may vary from laboratory to laboratory. In determining bilirubin value for severe neonatal hyperbilirubinemia, the hospital should consult the laboratory on how they report test results for bilirubin. The hospital's definition of severe neonatal hyperbilirubinemia should be based on the laboratory's test reporting for bilirubin. The hospital should also refer to Standard AOP.5.8 which states that "Established norms and ranges are used to interpret and to report clinical laboratory results." The measurable elements of Standard AOP.5.8 further outline requirements on reference ranges for each test performed and establishing ranges based on the hospital's geography and demographics.
6	QPS.7	Sentinel Event	Question about no harm incidents: is the process of investigation for a no harm incident similar to near miss? Also, what shall we call incidents that do not include patients? Do we call non- patient events an incident? For example, facility maintenance, smoking, cleaning issues. etc.	The definition of no harm events and near miss events are included in the intent of Standard QPS.7.1 and are as follows: • A *no-harm event* is a patient safety event that reaches the patient but does not cause harm. • A *near miss* (or close call) is a patient safety event that did not reach the patient. QPS.7.1, ME 4 states that "Hospital leadership defines a process for managing near miss events and no-harm events that includes an analysis of the events to identify corrective actions." After the hospital defines the process, it should be uniformly applied to both no-harm and near miss events. In the intent of QPS.7, the definition of sentinel event is centered around events that may affect the patient; however, letter k) in the list on page 181 relates to rape or assault of staff, independent practitioners, visitors, or vendors while on site at the hospital. The FMS chapter contains standards to stipulate how the hospital is required to manage the facility to promote safety and security for staff and patients, many of the examples such as facility maintenance, smoking, cleaning issues (hazardous materials), are addressed in this chapter.
7	QPS.7.1 QPS.8	Data for Adverse Events	What is the difference between QPS.7.1 and QPS.8 and how are these two standards handled?	QPS.7.1 relates to how the hospital manages adverse, no-harm, and near miss events. Based upon the definition of these events, they can happen anywhere in the hospital and the response that is outlined in QPS.7.1 is a reactive response. For example, a patient can have a fall with injury while waiting in a registration area for the outpatient diagnostic imaging area, but this may be rare. While the specific events in the lettered list a) through

Standards		Subject	Interpretation Question	Response
				h) in the intent of QPS.8 can meet the definition of adverse, no-harm, or near miss events in QPS.7.1, the requirements of this standard are more focused on proactive monitoring. These are high-risk events that can happen in specific areas of the patient care process and the hospital is expected to proactively monitor for and respond to these events.
8	QPS.8	Preop/Postop Discrepancies	What is expected for the data gathering of all major discrepancies between preoperative and postoperative diagnoses?	Standard QPS.8 is a standard that requires organizations to monitor patient care outcomes in order to identify the quality of the services and determine if quality improvement initiatives are needed. Letters a) through h) of the intent identify the minimum services that are to be monitored. Letter d) requires organizations to monitor undesirable trends that occur in surgical procedures. One of the undesirable trends in surgery is associated with a post-operative diagnosis being very different from the pre-operative diagnosis. Choosing the surgical procedure is dependent on the surgeon having a pre-operative diagnosis, for example, appendicitis, abdominal aortic aneurysm, intestinal tumor, ovarian growths, etc. Obtaining the correct informed consent, preparing the patient for the correct surgery, preparing the operating theatre, setting out the correct instruments/equipment, and having a properly trained surgical team are all dependent on the patient's pre-op diagnosis. When the pre-op diagnosis is significantly different from the post-op diagnosis, there is the potential for increased risk of poor outcomes as there may be changes in the surgical procedure required because of a different diagnosis. Changes in the procedure may result in changes to the team, the equipment, the instruments, and the like. For example, the surgical equipment, instruments, and team needed to perform a colon resection for an intestinal obstruction is likely very different from the instruments, equipment, and surgical team needed for repair of an abdominal aortic aneurysm. It is also possible that the surgery cannot be completed, resulting in the added risk of the patient having to have a second surgery. Reviewing and analyzing all the major discrepancies can help identify areas for improvement, thereby reducing the incidence of risks to patients and ultimately improving patient outcomes.
Prevention and Control of Infections (PCI)				
1	PCI.6.1	Expired Supplies	In the 7th edition, what measurable element is applicable for the management of expired supplies?	Standard PCI.6.1 and its intent both address having a process and policy for managing expired supplies. Therefore, the expectation remains that the organization have a process for managing expired supplies. The requirement for managing expired supplies was inadvertently left out of the measurable elements of PCI.6.1. Joint Commission International has issued an errata and updated the 7th Edition of the *Accreditation Standards for Hospitals* to address this clarification. The following has been added to PCI.6.1, ME 1:

	Standards	Subject	Interpretation Question	Response
				The hospital identifies single-use devices and materials that may be reused in accordance with local and national laws and regulations and implements a process for managing expired supplies The errata are available on The Joint Commission website and can also be accessed through the following link: **Errata to *JCI Accreditation Standards for Hospitals*, 7th Edition**
2	PCI.9	Food Service and Storage	How should the refrigerator used by patients and their families be managed? Do I need to open the refrigerator for inspection?	The intent of PCI.9 states that "The hospital conducts a risk assessment when food is stored or prepared outside of central kitchen areas, including patient refrigerators, and implements protocols to mitigate risk related to this practice." Part of conducting the risk assessment may include regular inspection although the standard does not specify how to conduct risk assessments for refrigerators used by patients. The expectation is that the hospital stores food and nutrition products in a manner that reduces the risk of infection as per PCI.9, ME1.
3	PCI.9	Food Storage	Would validation of a process meet the requirements of PCI.9, to ensure food is safe during transportation and distribution.	Standard PCI.9 states that "The hospital reduces the risk of infections associated with the operations of food services." Regarding the validation process, this would depend on what is included in the validation process. An example of one method for ensuring food safety during transportation and distribution may be for the organization to randomly check the temperature during transportation to ensure the temperature is within the correct range. The measurable elements of PCI.9 have specific requirements on food storage, temperature checks, and following professional guidelines to ensure food safety. All requirements of the measurable elements of PCI.9 must be met to ensure food safety during transportation and distribution.
Governance, Leadership, and Direction (GLD)				
1	GLD.4.1	Hospital Leadership Communication	What does "regular basis" mean?	In the context of the JCI standards, "regular basis" means a structured or systematic occurrence of an event. For example, GLD.4.1 states that "Hospital leadership communicates quality improvement and patient safety information to the governing entity and hospital staff on a regular basis." Because it is not always possible to specify time intervals to comply to all JCI standards (i.e., monthly, annually), the term "regular basis" is used so that organizations can determine how to establish their process of review at an interval that is most optimal to the organization.
2	GLD.5	Reporting IPSG Compliance to Leadership	Do you require reporting IPSG compliance to governance?	Standard GLD.5 ME 3 states: "The chief executive and hospital leadership set priorities for compliance with the International Patient Safety Goals." Standard GLD.4.1, ME 1 states:

	Standards	Subject	Interpretation Question	Response
				"Hospital leadership reports on the quality and patient safety program at least quarterly to the governing entity." While there is no standard that specifically states that IPSGs must be reported to leadership, the requirement for leadership to set priorities for compliance with IPSGs as part of the QPS program and the requirement to report on the QPS program indicates that the reporting includes the IPSGs.
3	GLD.6	Contracted Services	GLD.6 requires monitoring the quality of clinical and nonclinical contracts. How do we draw the line for the "scope" of contractors?	GLD.6 outlines requirements on hospital leadership's responsibilities for management of contract services. It is stated in the intent of Standard GLD.6 that "Hospital leadership describes, in writing, the nature and scope of services provided through contractual agreements." Thus, the hospital must determine the scope of each contract. GLD.6 addresses all contracts for any services provided to the hospital by an external party. In monitoring these contracts, GLD.6, ME3 states that "Department/service leaders share accountability for the review, selection, and monitoring of clinical and nonclinical contracts." Therefore, contract monitoring also includes contractors for services that have always been provided by contractors. For example, if a hospital has always contracted maintenance of certain medical equipment since its purchase, these contracts with equipment maintenance service providers must be monitored to ensure that medical equipment continue to function correctly and appropriately. JCI recognizes that an organization may have several clinical and nonclinical contract services to meet patient and management needs of the hospital. However, leadership oversight of these contract services are critical to ensure that all aspects of patient care remains optimal and safe.
4	GLD.6.2	Credentialing, Privileging, and Evaluation of Contracted Medical Staff	Please clarify what is meant by GLD.6.2, ME 2 being applicable to "independent practitioners outside the hospital," and GLD.6.2, ME 3 being applicable to "independent practitioners providing services on the premises of the hospital."	Standard GLD.6.2 describes the responsibilities of hospital leadership in ensuring the credentials and competence of both contracted services that utilize practitioners, such as teleradiology, and independent practitioners that provide direct or indirect care within the hospital. Throughout the intent and the following MEs the standard delineates the difference between how the hospital interacts with contracted services that utilize health care practitioners and independent practitioners that practice within the hospital. GLD.6.2, ME 2 refers to how the hospital interacts with contract services that utilize health practitioners, such as teleradiology. In this example, the hospital must ensure that the individuals working in the teleradiology service are credentialed and privileged to provide their services; however, the hospital does not have the authority to evaluate the practitioners, that is the responsibility of the service itself. The hospital can put quality metrics for the service into its contract and complete quality assurance on its services but cannot evaluate the practitioners individually. GLD.6.2, ME 3 relates to independent practitioners contracted to provide services on the premises of the hospital; therefore, the hospital has more authority over these individuals and in addition to credentialing and privileging, are also evaluated in the same manner as other practitioners in accordance with SQE.9 through SQE.12.

Standards Interpretation FAQs

	Standards	Subject	Interpretation Question	Response
5	GLD.7.1	Supply Chain	We have identified supplies at most risk, such as medications, medical equipment, medical consumables, implants, blood and blood products, and nutritional products. Do we have to perform an annual supply chain analysis on each of these supplies or 1 analysis on 1 supply per year?	The standard does not require any specific number of supply chain analyses to be done annually. The requirement is for organizations to identify the supplies that are at most risk and determine what, if any, risks points there are in the chain. It is not expected that organizations would have the resources to analyze the supply chain for all supplies at risk at once, but it is expected that organizations begin by analyzing the supplies that have been prioritized as having the highest risk. The priority may be based on different factors. For example, a supply that is suddenly not performing in the manner that has been expected, may be a criterion to identify this supply as a high priority. A sudden change in the performance of a supply, such as a medication that is no longer as effective as it once was; or a change in the packaging of a supply or medication may also trigger an organization to analyze the chain or contact the manufacturer. Each organization may identify different supplies at risk and may prioritize the at risk supplies differently depending on their own data and experiences.
6	GLD.10	Department Planning	GLD.10 talks about department planning documents, does this mean a department manual for each department outlining scope of services, staffing requirements, qualifications, competencies, department processes, etc.?	The intent of GLD.10 states that…" Department policies and procedures reflect the department's goals and services as well as the knowledge, skills, and availability of staff required to assess and to meet patient care needs." Each department will have a different scope of services, staffing requirements, and processes. As such, a manual for each department may be necessary depending on the size of the hospital. However, it is also critical to coordinate and/or integrate services within and with other departments and services as per GLD.10, ME 5. Integration and coordination avoid unnecessary duplication of services and help conserve resources. For smaller healthcare organizations who chose to develop one manual for all department services, the integrated manual must also be coordinated to ensure that the manual clearly describe the current and planned services provided by each department or service.
7	GLD.11.2	Clinical Practice Guidelines	In regard to the five CPG/ protocols/ pathways annually: 1. How actively do we need to monitor it? 2. Of all CPGs established; can the hospital decide what subset to monitor? 3. Can a hospital carry forward/continue some	GLD.11.2, ME 4 states that "Department/service leaders demonstrate how the use of clinical practice guidelines, clinical pathways, and/or clinical protocols has reduced variation in processes and outcomes." 1. JCI does not specify how active the hospital must be in monitoring the implementation and outcomes of the CPGs that were chosen. • It is recommended that when a new process, such as the implementation of a new CPG is implemented, that it is frequently monitored to help educate staff and intervene while the CPG is new in practice. • Once the staff responsible for monitoring the newly implemented CPGs determine that compliance with the CPG is sufficient and being followed appropriately, they may decide to monitor the CPG less actively, for example, completing chart audits monthly as opposed to weekly. Before determining this,

Standards		Subject	Interpretation Question	Response
			of the previous year's clinical practice guidelines/pathways to the next year to complete the annual requirement of at least five, if the process and outcome measures still show need for improvement, or is it expected that hospital has to select five new guidelines/pathways irrespective of the fact where the previous ones stand?	the staff involved in the monitoring must determine what the goals are, such as percent compliance, how to monitor, such as random chart audits, and then what level of non-compliance or deviation would indicate the need to increased monitoring. 2. The intent of Standard GLD.11.2 describes the process that leadership must take to determine which Clinical Practice Guidelines (CPG) or protocols are evidence-based and appropriate for the services that the hospital provides. • GLD.11.2, ME 1 states that the hospital determines at least five CPGs to focus on • The hospital may utilize many CPGs depending on the scope of services provided; however, data may show that they do not need to monitor all as intensely ○ i.e., monitoring for maintenance vs. active monitoring that is covered in GLD.11.2, ME 4 3. GLD.11.2, ME 1, states that "On an annual basis, department/service leaders collectively determine at least five hospital-wide priority areas on which to focus the use of clinical practice guidelines." In meeting the required five CPG/pathways that are identified annually, organizations may carry forward a CPGs from the previous year if the outcome measures continue to show the need for improvement. In addition, organization may choose to select the same CPGs if the organization still will want to increase the goal for compliance. Please also note that GLD.11.2, ME 2 require that CPGs, pathways, and protocols are selected, evaluated, implemented, and monitored following the items a) through h) of the intent.
8	GLD.14	Eligibility for Academic Medical Centers	If research is not allowed and not available in our institution but our hospital is the principal training site for an integrated medical school, will we be surveyed as an academic medical center and should follow MPE and HRP chapters or will we only be surveyed with GLD.14 for oversight of our medical education program?	JCI states in the Introduction of the Accreditation Standards for Hospitals that "JCI will consider an applicant hospital an eligible academic medical center if it meets the following three criteria: 1. It is integrated (by organization or administration) with a medical school. 2. It is the principal site for the education of both (a) medical students (that is, undergraduates) and (b) postgraduate medical specialty trainees (for example, residents or interns) from such medical school. 3. At the time of application, it conducts medical research with approval and oversight by an Institutional Review Board (IRB) or research ethics committee. Hospitals that do not conduct medical research as outlined in numbered 3 above will not be surveyed against the MPE and HRP chapters. The requirements of GLD.14 will be considered when reviewing the oversight of medical education.
Facilities Management and Safety (FMS)				

Standards Interpretation FAQs

	Standards	Subject	Interpretation Question	Response
1	FMS.2	Qualified Individual for Facility Management and Safety Program	What are the qualifications/ certifications needed for a Safety Officer?	The intent of FMS.2 states that "training and experience may include, but is not limited to, risk management, facility management, and hospital operations." The hospital determines what additional experience or education may be required to manage the overall Facility Management and Safety (FMS) Program based upon the size, services, and needs of the hospital. For example, the individual may have previous experience leading an FMS program at a smaller organization or have experience leading or co-leading a program that covers risk or facility management. Additionally, the intent states that the individual chosen to lead the FMS program may be a member of the hospital leadership team or a leader of one of the FMS programs mentioned in the FMS chapter.
2	FMS.2	Annual Review of FMS Plans and Programs	FMS.2, letter "f" of the intent states that "the programs are reviewed and revised at least annually, or more frequently as needed." If the programs are reviewed annually, but the policies only reflect when they are revised, would that meet the requirement?	FMS.2, ME 2 directs the organization to letter "f" in the intent which requires programs to be reviewed and revised annually, or more frequently if needed. If a review finds that a revision is not needed at that time, the review still needs to happen and proof of the review is expected. For example, most program policies have a space to document the date of the review, and name and signature of the individual who completed the review. If no revisions are needed, the document would just require a date change and a signature reflecting that it was reviewed. This would be an acceptable form of proof that the review was completed. Verbal confirmation of a review is not acceptable because it is not providing a "record" of the review. Review and revision of programs every two years does not meet the requirement. Additionally, FMS.2, ME 2 (element f) also states that the facility management and safety structure must be managed effectively and in a consistent and continuous manner. The individual who oversees the facility management and safety structure is responsible for elements a) through f) of the intent, such as ensuring the programs are reviewed and revised at least annually, or more frequently if needed (for example, when there are changes to requirements in the country's laws and regulations; changes to the hospital's facilities, systems, or equipment; and so on).
3	FMS.3	Risk Assessment	I would like to ask about the risk assessment process. When we are evaluating the risks in the hospital, a "5x5 matrix" is used by scoring the likelihood (probability of the hazard causing harm) and impact (a consequence of the	The Joint Commission International's SAFER Matrix is designed to help organizations prioritize the findings from their accreditation survey - SAFER is an acronym for the following: "Survey Analysis for Evaluating Risk™". The SAFER Matrix is JCI's transformative approach for identifying and communicating risk levels of findings cited during surveys. It provides one, comprehensive visual representation of survey findings to help organizations prioritize and focus corrective actions by measuring the likelihood to harm and scope for each measurable element cited. Organizations are not expected to adopt JCI's SAFER Matrix as their framework for conducting risk assessments. Generally, organizations choose from well-established and

	Standards	Subject	Interpretation Question	Response
			harm occurring) of the risk. The likelihood is scored from 1 to 5 (Rare, Unlikely, Possible, Likely, and Extreme). The impact is scored from 1 to 5 (Insignificant, Minor, Moderate, Major, and Extreme). But, according to the SAFER Matrix, the likelihood and scope of the risks are assessed by three levels. Therefore, how can we adapt the risk evaluation process in the Hospital Risk Evaluation System? Do we need to change the scoring of the risk evaluation /or risk evaluation levels according to the SAFER Matrix?	published proactive risk assessments, such as a Hazard Vulnerability Analysis (HVA) or a Failure Modes and Effects Analysis (FMEA). The SAFER Matrix is more of a reactive analysis to non-compliance issues found by surveyors during the survey process. QPS.10 is asking organizations to use a proactive approach to identifying risks in their organization.
4	FMS.3.1	Risk Assessment Plan	I understand that for each of the FMS plans we need a separate risk assessment which is very specific to each plan. However, for the integrated risk assessment plan required for FMS.3, do we combine all the areas for improvement identified in each plan's risk assessment along with corrective actions and monitor its progress, or are we expected to identify key or critical processes from	A risk assessment is a thorough look at your workplace to identify those things, situations, processes, and the like, that may cause harm. After identification is made, the hospital analyzes and evaluates how likely and severe the risks are. When this determination is made, the hospital can next, decide what measures should be in place to effectively eliminate or control the harm from happening. Standard FMS.3, ME 1 states that "The risk assessments from all eight FMS programs are integrated to develop and document a comprehensive, facility-wide risk assessment at least annually." The rationale for integrating the risk assessments is to determine which risks from each program are most serious and need to be addressed/controlled first. It is likely that the risk assessments can identify multiple risks for each program, but the seriousness of each risk may be very different. For example, it may be that the risks from the security program risk assessment identify 4 risks, but the probability and severity of each risk has been identified as low.

	Standards	Subject	Interpretation Question	Response
			each of the plans and put them together to conduct a risk assessment for FMS.3?	On the other hand, the risk assessment for the fire safety program has identified three risks, but the probability and severity of each risk has been identified as moderate to high. Through integration of the eight risk assessment programs, the hospital can create a ranking or an action list that allows leadership to determine the risks that need to be addressed first. JCI does not specify any particular method for identifying, combining, and ranking risks; however, leadership needs to be able to review the integrated risk assessment plan and determine which risks from the overall combined risk assessments have the greatest priority.
5	FMS.4	FMS Monitoring Data	Are the monitoring data collected and analyzed under FMS.4, ME 1, and the monitoring data collected under FMS.5, ME 4, FMS.6, ME 5, FMS.7, ME 3, FMS.8, ME 4, FMS.9, ME 3, FMS.10, ME 3. all the same, or ae they different? What is the expectation?	FMS.4, ME 1 state's that "Monitoring data are collected and analyzed for each of the facility management and safety programs and used to reduce risks in the environment and support planning for replacing or upgrading facilities, systems, and equipment." The monitoring data addressed in this ME is the same as the monitoring data for each program that are referenced in the following MEs: FMS.5, ME 4; FMS.6, ME 5; FMS.7, ME 3; FMS.8, ME 4; FMS.9, ME 3; FMS.10, ME 3. Each of the above MEs applies to the specific monitoring data for each program and FMS.4 applies to how the FMS program utilizes the monitoring data, including aggregation, analysis, incorporation into the QPS program, and reporting to leadership.
6	FMS.8	Goals for Reducing Fire Safety Risk	Please provide details on how the hospital can identify goals, implement improvements, and monitor data to ensure that fire safety risks are reduced or eliminated?	FMS.8, ME 4 states that "The hospital identifies goals, implements improvements, and monitors data to ensure that fire safety risks are reduced or eliminated." The goals that are discussed in this ME are related to the data that is generated from the completion of the fire safety risk assessment that is discussed in the intent of Standard FMS.8. The intent provides a list of items a) through k) that must be a part of this risk assessment. Depending on the condition of the hospital facility, the services provided, and other factors incorporated into the assessment, the hospital will need to decide what goals are to be tracked, for example, the hospital may determine that the medical gas system in the operating theatre is damaged and thus must be repaired. A goal derived from this may be to utilize interim safety measures, repair the system as soon as possible to protect patient safety, and then to proactively assess the function of the system to ensure that it remains free from damage. JCI does not specify a certain document that must be used to assess or track the goals identified, but an example of a tool that can be used to complete the risk assessment addressed in the intent of FMS.8 is the Failure Mode & Effects Analysis (FMEA) tool that is referenced throughout the standards manual and the Survey Process Guide.
7	FMS.8.1	Containment of Fire and Smoke	FMS.8.1, ME 3 states that "When required by local laws and regulations, the	FMS.8.1, ME 3 would depend on local laws and regulations. However, organizations must still meet the requirements on FMS.8.1, ME 1 and ME 2:

	Standards	Subject	Interpretation Question	Response
			fire safety program includes containment of fire and smoke, and these features are maintained to ensure effectiveness and safety." Is this required only when "required by local laws and regulations"?	ME 1: The fire safety program includes equipment/systems for the early detection and alarm notification of fire and smoke. ME 2: The fire safety program includes equipment/systems for the suppression of fire. FMS.8.1, ME 3 is an example of when the organization is responsible for adhering to our standards OR following local laws and regs, whichever is "more stringent." Making this mandatory without including the local laws and regs clause could be very costly for organizations. As such, ME 1 and ME 2 are those we require while ME 3 would depend on the local laws and regulation requirement. During the survey/engagement, it would be helpful for JCI field staff to ask the organization to provide a copy of the local laws related to this requirement and/or ask them to explain the local regulations.
8	FMS.8.4	Fire Safety Education	If an organization's doctors are not staff members, would you expect them to also participate in fire safety education?	Fire safety education is part of the facility management and safety programs. FMS.13, ME 2 states "Training on the facility management and safety programs includes vendors, contract workers, volunteers, students, trainees, and others, as applicable to the individuals' roles and responsibilities, and as determined by the hospital." Some independent practitioners may only work for the organization at very limited time frames based on their contract agreement. In these cases, the organization must determine and specify in their policy the appropriate safety education and training required to ensure that these vendors, contract workers, and others are knowledgeable of the fire safety program and can describe how to bring patients to safety per FMS.8.4, ME 2 .
9	FMS.8.4	Staff Evaluation for Fire Safety Measures	Does the hospital need to literally "evaluate" (meaning an "exam" or a "test") the staff? If not, then what does "staff who do not pass are reeducated" mean?	The standard does not specify how the organization establishes the evaluation of exercises. While the intent provides several examples of exercises that organizations may use, it is up to the organization to establish their own evaluation process. A computer-based teaching and a written exam are some of these examples that the organization may use. Some exercises may also depend on what their national, local, or regional laws and regulations require. The critical component of this standard is to make sure that whatever the exercise chosen to evaluate the fire safety program, staff should be knowledgeable of the program and be able to describe how to bring patients to safety. When a staff member does not demonstrate the ability to bring patients to safety or follow established protocols based on the organization's evaluation, staff must be re-educated and retested. Reeducation and retesting do not necessarily mean a written exam; however, the organization should establish this reeducation and retesting in their policy. For example, if the staff is not able to point to the safety exits or demonstrate the proper use of fire extinguishers during an exercise, those staff will require reeducation and training and the organization's policy must include the requirement for follow up training and reeducation of these staff members.

	Standards	Subject	Interpretation Question	Response
10	FMS.8.4	Fire Safety Evaluation of Staff from All Shifts	Do "all" staff need to take part in the fire safety evaluation and testing?	FMS.8.4, ME 1 states "staff from all shifts including the night shift and weekends, annually participate in an exercise to evaluate the fire safety program." As such, participation of all staff members in at least one fire safety exercise per year is required. The 7th edition clarifies that staff includes those working on different shifts and on weekends. As the intent of the standard explains, organizations can choose how to evaluate their staff in their fire safety programs. Some examples of these exercises are also provided in the intent. Whatever the exercise chosen to evaluate the fire safety program, staff should be knowledgeable of the program and be able to describe how to bring patients to safety. Another related standard is FMS.13, ME 2which states that… "Training on the facility management and safety programs includes vendors, contract workers, volunteers, students, trainees, and others, as applicable to the individuals' roles and responsibilities, and as determined by the hospital." Because some independent practitioners may only work for the organization at very limited time frames based on their contract agreement, organizations must determine and specify in their policy the appropriate safety education and training required to ensure that these vendors, contract workers, and others are knowledgeable of the fire safety program and can describe how to bring patients to safety per FMS.8.4, ME 2.
11	FMS.9.1	Frequency of Inspection/Testing of Medical Equipment	According to the manufacturer's recommendations, periodic inspections are recommended once every six months for some equipment. With the number of units requiring inspection, it is not always possible to inspect all the equipment as recommended. Is it necessary to inspect all the equipment during the recommended period?	FMS.9.1, ME 3 requires the organization to inspect and test new medical equipment and according to age, use, and manufacturers' recommendations thereafter. JCI recognizes that following manufacturer's recommendations may not always be optimal depending on the frequency, and the numbers of equipment in an organization. When the hospital deviates from manufacturer recommendations, it is critical to a conduct risk assessment and ensure that the equipment functions appropriately and that the deviation does not negatively impact patient care. Any deviations from manufacturer recommendations must be justified based on the results of the organization's risk assessment. Accordingly, FMS.9, ME 2 states that "A medical equipment risk assessment is conducted and documented annually throughout the hospital, and medical equipment risks are identified and prioritized from the risk assessment."
12	FMS.9.1	Medical Equipment	What is the standard monthly percentage, or goal for the periodic preventive maintenance (PPM) for medical equipment? For example, if the hospital has 100 pieces medical	JCI does not specify the minimum percent of periodic preventative maintenance per month, but states in the intent of FMS.9.1 that: "As part of the medical equipment program, the hospital conducts and documents a risk assessment, at least annually, to identify areas in which medical equipment risks exist." Based upon the results of the risk assessment and the equipment's age, use, and manufacturer's instructions, the hospital determines how often periodic preventive maintenance (PPM) should be completed for different types of equipment and develops a program to accomplish this as defined in FMS.9.1, ME 1.

	Standards	Subject	Interpretation Question	Response
			equipment due for periodic preventive maintenance for the month of August, what is the minimum percentage of medical equipment that should be maintained as per JCI standards?	FMS.9.1, ME 3 states that "The hospital identifies goals, implements improvements, and monitors data to ensure that medical equipment risks are reduced or eliminated." One of the goals of JCI and accreditation compliance is to improve quality and patient safety, and progress to a high reliability environment; therefore, it is not recommended that if a specific standard is being met (such as a goal of 95% compliance) the hospital would decrease the rigor of the goal.
13	FMS.10.3	Potable Water Testing	Can an organization carry out water testing in house such as the hospital's laboratory or must the tests be outsourced? Should the laboratory doing the testing be accredited?	The intent of FMS.10.3 and FMS.10.3.1 states that testing of potable water can be carried out by individuals designated by the hospital, such as staff from the clinical laboratory, or by public health or water control authorities outside the hospital, or others judged competent to perform such tests. When testing is done in-house, the hospital must follow industry standards and professional guidelines for maintaining water quality and comply with local laws and regulations for ensuring safe drinking water. The standard does not require that water testing laboratories be accredited. However, it is the responsibility of the hospital to ensure that the testing laboratory is reputable and follows applicable laws and regulations for water testing.
14	FMS.10.3.1	Water Testing in Renal Dialysis	Why is JCI prescriptive about renal dialysis and not in other areas where water is being used such as blood bank, lab, CSSD, etc.?	Patients undergoing hemodialysis are directly and internally exposed to water, primarily in the form of dialysate. Patient adverse events have resulted from water and dialysis solutions that contain contaminants and chemicals because patients are directly exposed to the water used in this process; therefore, the quality of the water used for dialysis is critical. The literature identifies standards and recommended practices that address limits on specific contaminants within water used for dialysis, dialysate, and substitution fluids. Because the quality of the water is so critical in the safety of hemodialysis, the JCI 7th edition standard FMS.10.3.1 includes the specific, evidence-based requirements for testing the water used in the hemodialysis process. Standard FMS.10.3 addresses the testing requirements for potable water which includes water that is used in processes in the dental clinic, laboratory, blood bank, and CSSD. In addition, standard PCI.6, MEs 1 and 2 require that the hospital follow professional practice guidelines for sterilization techniques and for low- and high-level disinfection.
15	FMS.10.3.1	Sensitivity Testing of Dialysis Water	If the available laboratories in a country do not provide testing of dialysis water as per the JCI suggested standards,	Water testing can be carried out by available testing options in the country, by public health, by water control authorities outside the hospital, or by others judged competent to perform such tests. The standard does not specify limitations on the sensitivity for testing and concentration of chemicals. However, FMS.10.3.1, ME 1 requires the hospital to

Standards		Subject	Interpretation Question	Response
			and as there are limitations with regards to sensitivity for testing very low concentration of certain chemicals, can an organization go with the available testing options in the country for chemical analysis of dialysis water, such as testing for Mercury, Beryllium & Thallium?	identify and follow industry standards and professional guidelines for maintaining water quality and implementing infection prevention and control measures. The standard also does not specify which chemical contaminants must be tested because this may vary per local regulations and updated industry standards that hospitals follow. However, the organization must ensure that water used in hemodialysis is tested monthly for bacterial growth and endotoxins and tested annually for chemical contaminants per FMS.10.3.1, ME 2.
16	FMS.10.3	Water Testing	Regarding water testing: FMS.10 requires that potable water be tested at least quarterly. For organizations that do not have centralized potable water supply, but use water drums mounted on portable water dispensers, how is this standard applied?	FMS.10.3, ME 1, states "Quality of potable water is tested at least quarterly or more frequently based on local laws and regulations, conditions of the sources for water, and previous experience with water quality problems. The testing results are documented." This ME applies to potable water that enters the facility through the local utility systems or water that may be stored in large containers at the facility. For water that is prepackaged in water drums and delivered in a sealed manner from a contracted company, the organization should understand what testing process is used by the company which fills and supplies the prepackaged water drums. This testing and quality management completed by the company would fall under GLD.6 and should be written into the contract with the water company. For the cooler that the drums are placed onto, the maintenance and cleaning of these would need to be in accordance with manufacturer recommendations and would fall under the purview of the FMS program and applicable PCI standards such as PCI.7.
17	FMS.11	Testing Disaster Preparedness Plan	Due to COVID-19, we are not able to conduct disaster preparedness training. Are there alternative measures to meet the requirements for testing the entire emergency management program and all critical elements in the intent?	FMS.11, ME 4 requires hospitals to test their disaster preparedness program annually and states that this can be done with the community or internally, JCI recognizes that given the current situation with COVID-19, completing annual testing with the larger community may not be feasible or safe. An alternative temporary measure could include participation in a tabletop drill, or simulating a disaster with trained professionals, during which staff discuss their response to both these events, and documentation of a plan The organization may also review Standard PCI.12.2 on the evaluation of an emergency preparedness program for global communicable diseases. The intent of PCI.12.2 states that "If the hospital experiences an actual event, activates its program, and debriefs properly afterward, this represents the equivalent to an annual evaluation. Debriefing following an annual evaluation, or an actual event can identify vulnerable processes that may need to be reevaluated."

Standards		Subject	Interpretation Question	Response
Staff Qualifications and Education (SQE)				
1	SQE.6	Weekly Day Off and Working Hours	What is the JCI requirement for number of days off per week and weekly total working hours?	JCI Hospital Standards do not specify or require that an organization define the number of hours staff work or the number of patients each health care professional cares for at one time. However, there are requirements in the Hospital Standards that address human resources as well as identifying safety risks in the organization. The issue of long work hours and risks to patient safety may be linked, and there are examples in the literature related to working excessively long hours and the impact this may have on patient safety. The Staff Qualifications and Education (SQE) chapter addresses human resource issues. Standard SQE.6 requires organizations to use a recognized staffing plan and to assign and reassign staff according to the plan. SQE.6.1 requires organizations to evaluate the effectiveness of the staffing plan. It is here that the risk of tired staff and number of staff in relation to patient safety might be identified. Standard SQE.8.2 addresses the requirement for a staff health and safety program, and ME 6 requires: "The hospital promotes staff well-being by creating a culture of wellness that supports physical well-being and emotional health." The Governance, Leadership, and Direction (GLD) chapter also has relevance to this inquiry. Standard GLD.1.2, ME 2 requires that the hospital's governing entity to receive and act on reports from the quality and patient safety program. If long working hours have resulted in incidents such as adverse events or near miss events related to patient safety, they should be reported to the quality and patient safety structure. In turn, these should be reported to the governing entity for consideration and action. GLD.2 requires organizations to operate within applicable laws and regulations. Some countries have laws and regulations that address length of a working day and/or number of patients per physician, and organizations are expected to be compliant with those laws and regulations.
2	SQE.8.1	Resuscitative Technique for Anesthesiologists and Other Staff	SQE 8.1, ME1 requires that all staff members that provide patient care are trained in at least BLS. SQE 8.1, ME 2 requires that the hospital identifies the appropriate level of training (advanced or basic) appropriate to their role. We have required that all anesthesiologists are trained in ACLS. Is ACLS sufficient to meet SQE 8.1, ME1?	Per the wording of SQE.8.1, ME 1, all staff that care for patients are required to be trained in at least BLS and per SQE.8.1, ME 2 the hospital must then identify staff whose role necessitates additional training such as ACLS. Based on these requirements, the anesthesiologists in question would need to be trained in both BLS and ACLS. Additionally, while the American Heart Association (AHA) does not require BLS as a prerequisite for taking ACLS, many training centers require BLS prior to taking an ACLS course and strong BLS skills are the foundation of effective ACLS implementation.

	Standards	Subject	Interpretation Question	Response
3	SQE.8.1.1	Resuscitation Training for Non- Clinical Staff	Do "the other staff specified by a hospital" include the cleaning staff, supplier staff, and others who may not be involved with patient care?	Standard SQE.8.1 identifies the requirements regarding resuscitation training for staff who provide patient care. These staff include for example, doctors, nurses, nursing assistants, physician assistants, and others who care for patients. This standard requires that these staff have at minimum, training in basic life-support. The standard also requires the organization to identify the staff who need to have advanced life-support. Staff requiring advanced life-support include for example, staff who are responsible for providing procedural sedation and staff who are part of a resuscitation team. The hospital may also identify that staff who work in intensive care units, the emergency department, or the operating theatre may also need advanced life-support. Standard SQE.8.1.1 addresses the requirements if a hospital should choose to train other staff in resuscitation. However, it is not required for a hospital to train other staff. Other staff would be those who do not provide patient care and examples of other staff could include registration clerks, housekeeping staff, and some that you also identified, such as IT staff, telephone staff, suppliers, and the like. Just to reinforce, staff who do not provide patient care are NOT required to be trained in resuscitation, however if hospitals choose to train other staff, they must meet the requirements of SQE.8.1.1. Standard SQE.8.1.1 could be considered not applicable if hospitals choose not to train other staff.
4	SQE.9 SQE.9.1 SQE.9.2	Primary Source Verification (PSV)	It is stated in the intent that a hospital is not required to conduct PSV if another JCI accredited hospital has already conducted it for the concerned physician. For this to apply, do we have to be affiliated with this hospital or can it apply without affiliation?	The intent of Standard SQE.9 through SQE.9.2 states that “an affiliated hospital that has already conducted primary source verification of the medical staff applicant is acceptable as long as the affiliated hospital has current Joint Commission International accreditation with full compliance on its verification process found in SQE.9.1, MEs 1 and 2.” Full compliance means the hospital’s Official Survey Findings Report indicates that all measurable elements are fully met, or any not met or partially met measurable element required to be addressed by Strategic Improvement Plan (SIP) actions have been addressed and are now in full compliance. As such, hospitals who are not affiliated with another JCI- accredited organization must conduct their own verification process per measurable elements of SQE.9.1. If a hospitals is affiliated with another JCI-accredited healthcare organization that has conducted primary source verification, it is important to remember that the affiliated hospital must provide a copy of the Official Survey Findings Report indicating that all measurable elements of SQE.9.1 are fully met from its most recent survey.
5	SQE.9 SQE.13 SQE.15	Primary Source Verification	In some countries, primary source verification is completed by state boards,	SQE.9.1, ME 1, SQE.13, ME 2 and SQE.15, ME 2 state that "Education, training, and certifications are verified from the original source according to parameters found in the intent of SQE.9 and are documented." Also, SQE.9, ME 1, SQE.13, and SQE.15 require an ongoing, uniform process to manage and verify credentials, with documentation.

	Standards	Subject	Interpretation Question	Response
			councils, or other government entities. Because of this, hospitals are not conducting their own primary source verifications for their nurses and allied health professionals, excluding physicians. Is this an acceptable practice, and if so, what evidence is expected?	If the hospital is following their established process, and documentation is provided according to said process, and in compliance with the JCI requirements, the practice is acceptable. Standards SQE.9-SQE.9.2 describe the process for assessing the credentials of staff and completing primary source verification. Additionally, the intent outlines the process by which a governmental or nongovernmental third party can complete the PSV and if the hospital has confidence in this agency, and can provide evidence that PSV was completed, this is acceptable.
6	SQE.9 SQE.13 SQE.15	Primary Source Verification	For countries that offer online verification of licensure for nurses and other licensed allied health professionals, is it acceptable practice for the nurses and others licensed allied health professionals to submit a copy of the verification to the hospital and then HR staff can use this to verify the license online indicating the verification was completed.	The requirements for primary source verification in SQE.13 and SQE.15 are described in the intent of SQE.9. The intent of SQE.9 states that "Verification is the process of checking the validity and completeness of a credential from the source that issued the credential. This process can be accomplished by an inquiry to a secure online database of, for example, those individuals licensed in the hospital's city or country." Per this explanation, the hospital can verify the licensure of nurses and other license allied health professionals via the secure online database of the appropriate board. To satisfy SQE.13, ME 13 and SQE. 15 ME 3, the hospital will need a uniform process for documentation of verification.
7	SQE.9 SQE.10 SQE.11 SQE.12	Contracted and Hospital Employed Providers	Are all providers required to be contracted or employed by the organization?	There are two main sets of standards that relate to the hospital's responsibilities with medical staff and health care providers. For providers that are employed by the hospital, Standards SQE.9-12 describe the initial credentialing and primary source verification process, privileging, ongoing professional practice evaluation, and reappointment and renewal of clinical privileges. For licensed health care professionals and independent health care practitioners not employed by the hospital, Standard GLD.6.2 describes the requirements that the hospital must follow.
8	SQE.11	Ongoing Professional Practice Evaluation (OPPE)	Is there guidance related to physician weekly work hours, and physician-to-patient ratios?	The standards do not specify the number of hours that doctors are allowed to work consecutively or weekly. If there are specific governmental regulations on doctor's hours or regulations from the Ministry of Health, then those would be considered more rigorous than

	Standards	Subject	Interpretation Question	Response
				the JCI Standards in this regard and the expectation would be that the hospital follows and complies with these regulations. The SQE chapter lists several standards that relate to how the hospital must determine what privileges doctors hold and how the hospital monitors the safety and quality of care delivered by doctors. Specifically, SQE.11 states that the hospital must have a standardized and ongoing process to evaluate the quality and safety of care provided by each medical staff member. It is further discussed in the intent of this standard that the person responsible for evaluating the quality and safety of care uses a standardized and evidence-based process to gather data that is necessary to evaluate quality and safety and compare against other medical staff members in the same department. The hospital determines what data is gathered to evaluate safety and quality of care delivered. Additionally, SQE.8.2 addresses the concept of staff burnout, stating in the intent that "Best-practice research related to compassion fatigue and staff burnout recommends that hospitals create programs to support staff involved in sentinel and adverse events and to proactively develop skills to promote staff resiliency and promote staff health and well-being." As mentioned in this statement and SQE.8.2, ME 6, the hospital should have a program to address staff well-being, part of this would include determining an appropriate amount of work hours and patient ratios that are safe for both patients and staff.
9	SQE.11	Ongoing Professional Practice Evaluation of Medical Staff Members	Requesting additional guidance regarding the ongoing professional practice evaluation of medical staff members requirement that states, "physician behaviors and professional growth comparison to other departments/service medical staff member."	SQE.11, ME 2 states that "The ongoing professional practice evaluation process identifies areas of achievement and potential improvement related to the behaviors, professional growth, and clinical results of the medical staff member, and the results are reviewed with objective and evidence-based information as available. These results are compared to other department/service medical staff members." Identification of areas of achievements and improvement opportunities related to medical staff behaviors vary in each organization and each medical staff. The intent of SQE.11 provides examples of evaluating behaviors which can include the following: (1) evaluation of whether a medical staff member understands and supports the hospital's code of behavior and the identification of acceptable and unacceptable behaviors; (2) an absence of reported behaviors by the medical staff member that are identified as unacceptable; (3) and gathering, analysis, and use of information and data from staff surveys and other sources regarding the culture of safety in the hospital. The intent also explains how each medical staff member may have varying degrees, and ways on how they can identify growth and improvement in different important dimensions of health care and professional practice. Some of the acceptable professional growth examples outlined in the intent include improving provision of care, medical/clinical knowledge, and interpersonal and communication skills.

	Standards	Subject	Interpretation Question	Response
				Furthermore, the intent provides examples of measures for the different dimensions of health care and professional practice that organizations may use. Areas of achievement and improvement opportunities must be applicable to the roles and responsibilities of each medical staff member who is being evaluated. For example, professional growth opportunities for pathologists may include expanding his or her clinical knowledge in the application of newest technologies in laboratory medicine. As part of SQE.11, ME2, results of ongoing professional practice evaluation must be compared with other department/service staff members to reduce variation in behaviors, professional growth, and clinical results. Because medical/clinical knowledge vary in each specialty, comparison of clinical results related to specific clinical expertise may be focused within relevant department staff in the same clinical setting. However, comparison of professional growth opportunities may be conducted between different departments to reduce variations on patient care practices within the organizations. When available, the organization may also use objective, evidence- based best practice or benchmark sources of clinical result data and information from external organizations within their region.
10	SQE.11	External Benchmarking	During our JCI survey visit this past year, the following measurable element was cited: SQE 11, ME 3 Unavailability of externally benchmarked Physicians' clinical Indicators It worth mentioning that the above-mentioned citation was one of the top 25 most commonly citated findings. We have difficulty finding external benchmarks for clinical indicators. Can you identify sources of external benchmarks to help us meet the standard?	It is correct in that this is one of the more frequently scored standards/MEs in many parts of the world. During the development of the 7th Edition standards, we conducted focus groups with some of our accredited organizations via phone conference and many of these groups identified difficulty in participating in external benchmarking, particularly for individual physicians. We see more and more hospitals and physician practices moving towards "group practice" as opposed to individual practice. In such circumstances, the patient outcomes can not necessarily be attributed to a single physician, but rather to the group. JCI believes that there is still value in performing external benchmarking for individual physicians in areas of practice where benchmarks are available such as, surgery, pathology, emergency medical practice, and interventional cardiology. However, after much discussion and additional exploration, it was determined that having a requirement for external benchmarking was burdensome for many international organizations. Therefore, for the 7th Edition of the hospital standards, SQE.11, ME 3 has been revised and combined with SQE.11, ME 2. The new requirement (ME 2) is as follows: SQE.11, ME 2 – "*The ongoing professional practice evaluation process identifies areas of achievement and potential improvement related to the behaviors, professional growth, and clinical results of the medical staff member, and the results are reviewed with objective and evidence-based information as available. These results are compared to other department/service medical staff members.*"
Management of Information (MOI)				

Standards Interpretation FAQs

	Standards	Subject	Interpretation Question	Response
1	MOI.4	Medical Record Abbreviation	Is there a list of criteria regarding abbreviations used in medical records that JCI uses for accreditation purposes?	The Joint Commission International recognizes that nonuniform or non-standardized use of abbreviation is a contributing factor to patient safety incidents due to potentially inconsistent interpretation or misunderstanding of medical records. The intent of Standard MOI.4 states that "abbreviations can be problematic and at times even dangerous, particularly in the context of prescribing medications. For this reason, some hospitals do not allow the use of abbreviations in their organizations at all. When abbreviations are allowed in the hospital, processes are implemented to prevent or reduce risks to patient safety." In regard to a list of criteria regarding abbreviations used in medical records for JCI accreditation purposes, the intent of Standard MOI.4 also specifies the following: • Abbreviations are not used on informed consent documents, patient rights documents, discharge instructions, and discharge summaries. • When a hospital uses abbreviations, the hospital develops and implements a process for the uniform use of approved abbreviations, such as through the use of a list. This uniform use includes each abbreviation having only one meaning. • When a hospital uses abbreviations, the hospital develops and/or adopts a do-not- use list of abbreviations and symbols. For example, the Institute for Safe Medication Practices (ISMP) maintains a list of abbreviations, symbols, and dose designations that should never be used when communicating medical information. Each measurable element of Standard MOI.4 also outlines critical requirements with which JCI-accredited organizations must comply related to the uniform use of approved symbols and abbreviations across the hospital.
2	MOI.7.1	Implementation of Policies, Procedures and Plans - Monitoring	How should organization monitor the implementation of policies, procedures and plans?	The intent of Standard MOI.7.1 requires that policies and procedures are implemented throughout the hospital because they standardize care processes and help to improve care quality and ensure patient and staff safety. JCI does not require that all the hospital's policies and procedures be monitored. Resources must be utilized to assess those policies and procedures that are high-risk, new, recently updated/modified, low-volume, or those that govern care processes related to sentinel/adverse events. MOI.7.1 ME 4 states that "the implementation of policies, procedures, and plans is monitored, and the information supports full implementation." Monitoring full implementation of policies can be done in a variety of ways and it is up to the organization to establish this monitoring process. For example, standard IPSG.1 requires the use of at least two patient identifiers to identify patients and label elements associated with the patient's care and treatment plan. In order to monitor compliance, the hospital may

	Standards	Subject	Interpretation Question	Response
				randomly audit specimens, intravenous medications, special dietary trays, and other elements associated with the patient's care for proper labeling. Similarly, if the hospital has recently implemented a procedural sedation policy that describes a protocol for monitoring of vital signs and the use of capnography throughout the procedure, a random sample of charts can be reviewed to assess that vital signs were monitored and documented at the correct intervals and that capnography was used during the procedure. When the hospital is reviewing charts or using other methods to audit care in order to assess compliance with policies, a representative sample must be used. A representative sample is based on the volume of the procedure or process that is being assessed, therefore; if a certain procedure is completed only 10 times per year, then all 10 instances would be reviewed; but if 1000 procedures are completed a sample would be sufficient.
3	MOI.10	Review of Medical Records	Does a physician or nurse have to check the sample of charts? Can the assessment of the medical record be done by any trained and competent person?	Standard MOI.10, ME 2 requires that "the medical record review is conducted by physicians, nurses, and others authorized to make entries in patient medical records or to manage patient medical records." Authorized personnel are other clinicians who are also authorized to make entries in the patient medical record. These may include pharmacists, social workers, nutritionists, and the like. During the patient medical record review, each professional group authorized to make entries must be represented to ensure accuracy and completeness of the record and clinical information. The review of collated medical record data by authorized personnel will allow the team to assess identified gaps in the accuracy and completeness of documentation and address these gaps. The staff that gather the data from the medical records and collate this data into a usable format for review do not need to be the same as the authorized personnel that complete the review, for example, staff trained in quality that support the quality department can gather and collate this data. Additionally, a representative sample of medical records from all services must be reviewed at least quarterly or more frequently as determined by laws and regulations per MOI.10, ME 1. The sample of medical records must also include active and discharged medical records and inpatient and outpatient medical records.
4	MOI.10	Legibility of Information	MOI.10 ME 3 what type of legibility are you looking	MOI.10, ME 3 states that "The review focuses on the timeliness, accuracy, completeness, and legibility of the medical record."

	Standards	Subject	Interpretation Question	Response
			for in the electronic medical record?	The increasing use of electronic health records helps address the issue of illegible medical records. However, there are still instances where organizations must pay attention to ensure legibility of information in electronic medical records. For example, areas in electronic medical record where providers can enter free text information. Information that has been typed by the provider must be legible and understandable by other authorized personnel who may need to access these records.
5	MOI.10	Legibility and Accuracy of Information	Is use of abbreviation part of legibility or accuracy?	The use of abbreviation focuses on accuracy and consistent use across the organization. As stated in Standard MOI.4, "The hospital uses standardized diagnosis and procedure codes and ensures the uniform use of approved symbols and abbreviations across the hospital." For example, when the organization is using the abbreviation "MS," it must be clear across the organization if this abbreviation stands for multiple sclerosis or magnesium sulfate. MOI.10, ME 3 states that "The review focuses on the timeliness, accuracy, completeness, and legibility of the medical record." Regarding MOI.10, accuracy in the use of abbreviation could apply to ensure that all information in the medical records is understood in the same manner across the organization.
6	MOI.10	Accuracy of Information	What are the components of accuracy of documentation?	Ensuring accuracy of information in the medical records means ensuring that there are no discrepancies, such as comparing the lab results against the lab reporting system or ensuring that when abbreviations are used, they refer to the terms that they are intended to abbreviate according to the hospital's list of approved abbreviations. Another example that is often seen with electronic medical records is misuse of copy and paste (this is described in the intent of MOI.8 and assessed at MOI.8 ME 3). For example, when reviewing the daily progress notes on an intubated patient in the ICU, staff reviewing the medical record could compare the notes stating whether the patient is or isn't extubated against other documentation of the patient's airway status.
7	MOI.10	Accuracy of Information	What is an appropriate sample size for MOI.10, especially for a large hospital and the number or outpatient and inpatient records required?	The intent of MOI.10 explains that patient medical record review is based on a sample representing the practitioners providing care in outpatient, inpatient, and other services provided. The intent also states that" a representative sample means medical records from all services and not a specific sample size; however, it should make sense for the organization. For example, random sampling and selecting approximately 5% of medical records may achieve a representative sample." While the standard does not specify the sample size requirement, organizations may use the 5% representative sample size that was provided as an example in the intent and expand this number based on organization's own assessment. Please also note that the sample of medical records must also include active and discharged medical records and

	Standards	Subject	Interpretation Question	Response
				inpatient and outpatient medical records. For example, if there are 100 patient medical records in labor and delivery, the organization may randomly select 5 records for review from labor and delivery. This would be in addition to the other 5% of patient medical records from different departments including outpatients.
8	MOI.11	Qualifications for the Individual Overseeing Information Technology Systems	How can you judge "qualified" for the personal that oversees the health information technology systems?	The intent of MOI.11 states "leadership identifies a qualified individual to oversee health information technology systems in the organization. The individual is qualified by education, training, and/ or experience relevant to the role and responsibilities." The job description should match the individual's qualification through his or her training records, education, and/or experience.
9	MOI.12	Criteria for a Secure Mobile Device Platform	How do you judge what is a secure platform?	Secure platforms can be described as platforms that can only be accessed by authorized users. The intent of MOI.12 states that in addition to implementing a secure mobile platform, the hospital system can remotely disable or remove patient data and information from the mobile devices if they are lost or stolen. Other forms of security controls are also identified in the intent in letters a) through e).
10	MOI.12	Quality Assurance in Mobile Patient Communication	How to ensure the quality of patient care, specifically in texts?	When mobile devices and text messaging are used for patient care, the organization ensures that all information is accurate, delivered in a timely manner, and clearly understood by the receiver of the information. MOI.12, ME 3 requires "that text messages and e-mails on mobile devices that have data and information relating to a patient's care are documented in the patient's medical record." One way to assess the quality of patient care when using text messages is verifying that the information on the patient's medical record accurately reflects the information that was communicated about the patient through a text messaging platform.
11	MOI.12	ISO27001 and MOI.12	If the hospital uses texting through a service provider that has ISO27001 (international Standard that describes the requirements for an information security management system), will this meet the requirement for a secure platform? Or are there any further specific questions we need to ask the org?	ISO/IEC 27001 is a comprehensive document that examine the organization's information security risks, taking account of the threats, vulnerabilities, and impacts. There are organizations who are certified under this ISO standard document. Because ISO 27001 is recognized as an international standard that provides a framework for Information Security Management Systems that provides continued confidentiality, integrity, and availability of information within an organization, having an up-to-date, non-expired ISO 27001 certification indicates that the organization has established a secure platform. During a survey, it is important to determine the scope of ISO 27001 certification and make sure that they cover all aspects of the health information technology that the organization is using for patient care. For example, if the organization allows the use of mobile devices, the surveyor will discuss with the organization if the use of mobile devices is part of their ISO 27001 certification.

	Standards	Subject	Interpretation Question	Response
12	MOI.12	Security of Patient Information Via Text Messaging	How does hospital ensure that a secure messaging platform is implemented to meet the elements a) through e) in the intent of MOI.12 and are there any specific applications we should use?	Text messaging is becoming more popular in many hospitals with clinical staff using third-party messaging apps on smartphones and tablets to contact other doctors and nurses. Several concerns arise with the use of text messaging in hospitals including security and timely receipt of information. As identified in MOI.12, when organizations choose to communicate via a text messaging platform, the organization must ensure the confidentiality and security of information, as well as the timely receipt and verification of that information. Most apps don't contain strong enough protections for protected health information and any breaches could put these details into the wrong hands. In addition, when a text message about a patient's condition is sent through a personal mobile device, there is no assurance that the message will be viewed. JCI does not recommend or endorse any particular platform or app for text messaging in hospitals. There are several secure text messaging apps designed specifically for healthcare professionals. These specially designed text messaging apps can provide the following: • integrate messages with a hospital's electronic health records (EHR) system and alarm systems • use different alert sounds for texts based on priority • pull information about scheduling directly from the hospital's internal network • transmit messages using encryption • create PINs so the app isn't always accessible when the device is in use, and • track when messages were sent, delivered and answered for a clear audit trail. The availability of specialized apps may be dependent on a particular region or country. JCI does not maintain a list of organizations that utilize texting and therefore would not be able to provide contact information. You may want to contact the provider of your electronic medical record (EMR) to see if they have worked with apps that integrate with the EMR. You may also consider contacting mobile device carrier companies to determine if there are specific apps/platforms available for healthcare institutions.
Medical Professional Education (MPE)				
1	MPE.6	Monitoring of Data Collection for Medical Students	Should the hospital quality and patient safety monitoring include medical student and trainees for their compliance on program elements like IPSGs and medical record documentation?	The intent of Standard MPE.6 states that "although it would be desirable for each medical student and trainee to have basic education on quality and patient safety in his or her respective academic program." Thus, the hospital must have a planned and deliberate program to introduce such concepts, support the medical students and trainees in complying with relevant policies and guidelines, and include medical students and trainees in all quality and safety monitoring programs." For the Standard MPE.6, ME 2 where it states that "medical students and trainees are included in the data collection for the hospital's quality monitoring programs," the expectation is that the hospital would include medical students and trainees in all of the organization's quality and safety monitoring programs. Medical students or trainees are not

	Standards	Subject	Interpretation Question	Response
				expected to complete the data gathering, but rather that the care delivered by medical students and trainees is included in the data gathered. For example, catheter-associated urinary tract infection (CAUTI) data from patients where the medical students or trainees inserted the catheters would be included along with data from hospital staff who may have much more experience inserting the catheters.
2	MPE.6	Residents and Physician Performance Evaluations	We have developed a matrix of objective physician performance evaluations. Should we include residents? Does it fall under MPE, or is it not required at all?	Medical staff are required to provide patient care as indicated by their licensure and clinical privileges, as reflected in standards SQE.10 and SQE.11. Residents would not fall under this category because they may not have privileges to independently provide patient care. In addition, residents typically provide patient care as "medical students" or "trainees" under the supervision of licensed and privileged medical staff, which aligns with Standard MPE.6. If the hospital considers a resident a "trainee" as defined in 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," then his or her work is evaluated as required by the SQE standards, as defined in the intent: "In these circumstances, the individual trainee must be evaluated and given permission to provide those services through the normal established processes for such professionals as described in the Staff Qualifications and Education (SQE) standards."
Survey Process Guide Questions				
1	N/A – SPG related	Look-Back Period	Can you clarify the expectations for the look back period?	We recognize that due to the COVID-19 pandemic, hospitals are focused on ensuring safe, quality patient care and may have altered the services normally provided to patients within their community. As such, JCI has decided to postpone the implementation of the 36-month look back indefinitely. This pertains only to the new extended look-back process that was first announced in July 2018 and was scheduled for implementation on 1 January 2021. The original look-back process remains effective for all hospitals and academic medical centers and will remain in effect for surveys conducted in 2021. The original look-back process for all hospital and academic medical centers is as follows: • A 12-month look-back period of compliance for triennial surveys • A 6-month look-back period of compliance for initial surveys • No look-back period for a follow up survey; sustainability of improvement is used to evaluate compliance. The Joint Commission International Hospital Standards are intended to promote continuous, systematic and organization-wide improvement in daily performance and in the outcomes of patient care. It is JCI's expectation that all hospitals will maintain

	Standards	Subject	Interpretation Question	Response
				compliance with the JCI standards in such a way as to provide safe, quality patient care during the pandemic and develop a plan of action to address the return to continuous compliance with the JCI standards in the near future. Joint Commission International has issued an errata and updated the 7th Edition of the *JCI Survey Process Guide for Hospitals* to address this clarification. The errata are available on the Joint Commission International website and can also be accessed through the following link: **Errata to *JCI Survey Process Guide for Hospitals*, 7th Edition**
2	N/A- SPG Related	Scoring Rules	Is value weighted for each result of fully met, partially met, and not met equating to 1, 0.5, and 0 when the score is calculated?	Compliance with the requirements of the Measurable Elements is documented as the rate (percentage) of compliance demonstrated by the hospital. The scoring guidelines are written in the positive, which is the percentage of compliance required to achieve a score of: • fully met (compliance rate of 90% or greater), • partially met (compliance rate of 50% to 89%), or • not met (compliance rate of 49% or fewer). Whenever possible, the demonstrated compliance is reported as "compliance rate" (%). For example, 10 of 15 (67% compliance rate) initial nursing assessments were completed within 24 hours of inpatient admission to the medical/surgical inpatient units (3W, 2E, 4S, and 4N), as required by the hospital's policy. The score for this finding is "partially met," because the compliance rate percentage for the finding is between 50% and 89%. The actual percentages are not used in calculating scores used in the Decision Rules. The percentages are converted as follows: • fully met (compliance rate of 90% or greater) is identified as "10" • partially met (compliance rate of 50% to 89%) is identified as "5" • not met (compliance rate of 49% or fewer) is identified as "0" Decision Rule 1 states: The organization demonstrates acceptable compliance with each standard. Acceptable compliance is a score of at least "5" on each standard. (See page 17 from the Survey Process Guide). As an example of how this is calculated, a standard with 3 measurable elements could be scored as: • ME 1 is scored as "fully met" which equals "10"

	Standards	Subject	Interpretation Question	Response
				• ME 2 is scored as “partially met” which equals “5” • ME 3 is scored as “not met” which equals “0” Calculation: 10+5+0=15. The total score of 15 is divided by 3 MEs and equals “5”. Therefore, Decision Rule #1 is Met because the total score of the standard is “5” In regard to weight of each result when the score is calculated, the Survey Process Guide also explains the Accreditation Decision Rules and how each organization meets various criteria for being accredited.
3	Survey Process	Virtual Survey Document Submission	How are we expected to submit live documents such as patient records during the virtual survey?	Organizations may contact the Joint Commission International Account Executive for instructions on how to upload documents prior to and/or during the virtual survey. In addition, information about video surveys and directions are also posted on Direct Connect.
COVID-Related Questions				
1	N/A -COVID testing	COVID-19 Impact Assessment and Survey Process	After we receive the impact assessment for our next survey, are we expected to continuously update the impact assessment even after the survey?	The COVID-19 Impact Assessment process is currently applicable to all hospitals undergoing a survey until July of 2021. However, JCI recognizes that the COVID-19 pandemic is unprecedented and is currently an evolving situation. Due to this, JCI is continually monitoring the situation and will extend the timeframe that the COVID-19 Impact Assessment process applies to, if needed. If this decision is made, JCI will communicate this with the organizations that will be affected by this decision. The COVID-19 Impact Assessment is sent by the team leader to the survey coordinator approximately 4-6 weeks prior to the survey and the information gathered is intended to help the team leader plan the survey agenda. The COVID-19 Impact Assessment is only designed to be taken once. The survey team will further assess the impact of COVID-19 on the hospital during the survey. To note: the information gathered from the COVID-19 Impact Assessment will not be used to evaluate compliance with the JCI Standards.
2	Survey Process	COVID-19 Impact Assessment	Would you tell us what to enter in the COVID-19 Impact Assessment?	The COVID-19 Impact Assessment is a tool that is sent from the survey team leader to the hospital’s survey coordinator in the form of an Excel spreadsheet. The assessment is sent approximately 4-6 weeks prior to the scheduled survey and contains specific questions for the survey coordinator to answer, such as the hospital’s role in responding to COVID-19 in the community, availability of personal protective equipment, and suspension of services. The information gathered from this assessment is used by the team leader to plan the survey agenda and prepare the survey team, it is not used to determine standards compliance and does not factor into the overall survey results.