JCI Accreditation Standards for Hospitals and Academic Medical Centers (AMC), 8th Edition

Draft Standards for Field Review

Proposed New Standards and Requirements

Note: This document does not include all standards for Hospitals and Academic Medical Centers (AMC), 8th Edition. The standards in this document are the proposed requirements in the Staff Qualifications and Education (SQE) chapter only. To participate in the field review of other chapters of the hospital and AMC standards, please refer back to the JCIA website.

As a reminder, the field review focuses on newly added or significantly revised requirements. To identify the difference:

- Standards, measurable elements, intents, and guidance that are new or have undergone significant changes that have impacted the intent of the requirement are in **RED font**.
- Standards, measurable elements, intents, and guidance that are in **BLACK font** may have undergone changes, but the intents remained the same.

Prior to the publication, a complete summary of changes will be included in the manual along with an updated and complete reference list for each chapter.

Field Review Questionnaire: To participate in the field review of this chapter, please complete the survey below:

https://www.surveymonkey.com/r/ZT753CN

Field Review Period: **October 23- November 13, 2023**

Staff Qualifications and Education (SQE)

Overview

A health care organization needs an appropriate variety of skilled, qualified individuals to fulfill its mission and to meet patient needs. The organization's leaders work together to identify the number and types of qualified staff needed based on the recommendations from department and service leaders.

Recruiting, evaluating, appointing, and retaining staff are best accomplished through a coordinated, efficient, and uniform process. It is also essential to document applicant skills, knowledge, education, and previous work experience. It is particularly important to carefully review the credentials of medical, nursing, and other clinical staff because they are involved in clinical care processes and work directly with patients. This represents the first and most important opportunity for the hospital to delivering safe care for our patient and provide as safe environment for the staff.

Orientation to the organization and programs, as well as orientation to specific duties related to the position is an important process. Health care organizations should provide staff with opportunities to learn and to advance personally and professionally. Thus, in-service education and other learning opportunities should be offered to staff.

To ensure staff physical and mental health, productivity, staff satisfaction, and safe working conditions, the organization provides a staff health and safety program that can be offered by the hospital or provided through contracted services. The program is proactive and includes matters affecting the health and well-being of staff such as initial employment health screening, control of harmful occupational exposures, preventive immunizations and examinations, safe patient handling, staff as second victims, and common work-related conditions. In addition, the higher incidence of workplace violence in the last decade has prompted hospitals to increase awareness of workplace violence and institute prevention practices that focus on safety measures such as effective workplace violence prevention systems, including leadership oversight, policies, procedures, reporting systems, data collection and analysis, post-incident strategies, training, and education to decrease workplace violence.

For the standards language in this chapter, the following terminology and associated definitions apply:

Medical Staff

*A*ll physicians, dentists, and other professionals who are licensed to practice independently (without supervision) and who provide preventive, curative, restorative, surgical, rehabilitative, or other medical or dental services to patients; or who provide interpretative services for patients, such as pathology, radiology, or laboratory services. All classifications of appointments, all types and levels of staff (employed, honorary, contract, visiting, and private community staff members), are included. Visiting staff include those who are locum tenens, or invited experts, "master class" teachers/tutors, and others allowed to provide patient care services temporarily. A hospital must define those other clinical staff, such as "house officers," "hospitalists," and "junior doctors," who are no longer in training, but may or may not be permitted by the hospital to practice independently.

The term *medical staff* is thus inclusive of all physicians and other professionals permitted to treat patients with partial or full independence, regardless of their relationship to the hospital (**for example**, employed staff or independent consultants). Partial independence can be defined as staff working under partial supervision awaiting the final decision for full employment, on probation "for cause," or under medical staff granted temporary clinical privileges for a limited period of time and for circumstances as defined by hospital policy. In some cultures, traditional medicine practitioners may be permitted by law and the hospital to practice independently Thus, they are considered medical staff members, and these standards apply in full.

Nursing Staff

Clinical nursing professionals within an organization who are accountable for the promotion of health, the prevention of illness and the provision of quality and safe patient care within the parameters of the nursing profession. Such personnel include registered, licensed, and vocational nurses and may include others such as nursing assistants or other designated unlicensed assistive personnel, as well as advanced practice nurses. Advanced practice nurses such as nurse practitioners, (NPs), and certified registered nurse anesthetists who have gained additional knowledge and skills through successful completion of an organized program of nursing education that prepares nurses for advanced practice roles, and who has been certified by the board of nursing to engage in the practice of advanced practice nursing.

Other Clinical Staff

Clinical professionals who are not licensed to practice independently (without supervision) that are employed or permitted by the hospital to provide care and services to patients or to participate in patient care processes **(for example**, midwives, surgical assistants, emergency medical care specialists, pharmacists, and pharmacy technicians). In some countries or cultures, this group also includes traditional healers or those who provide alternative services or services that complement traditional medical practice (**for example**, acupuncture, herbal medicine). Often, these individuals do not actually practice in the hospital; instead, they refer to the hospital or provide continuing or follow-up care for patients in the community. Many of these professionals complete formal training programs and receive licenses or certificates or are registered with local or national authorities. Others may complete less formal apprentice programs or other supervised experiences.

Note: Licensing for clinical professionals vary in each country. For example, midwives are licensed and can practice independently in some countries, and in other countries, licensing is not applicable.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, Guidance, and Measurable Elements.

Staff Recruitment and Retention

SQE.1 Leaders of hospital departments and services define the desired qualifications of all staff members.

SQE.1.1 The hospital defines the responsibilities for every staff member in a current job description.

SQE.2 Leaders of hospital departments and services implement processes for the recruitment and retention of staff.

SQE.3 The hospital evaluates performance.

SQE.4 There is documented personnel information for each staff member.

SQE.5 The hospital has the necessary staff to support the care, treatment, and services it provides.

SQE.6 The hospital provides orientation to all staff.

SQE.7 Staff participate in education and training.

SQE.7.1 Staff are competent in resuscitative techniques appropriate to their role in the hospital.

Staff Health and Safety

SQE.8 The hospital provides a staff health and safety program that addresses staff physical and mental health and safe working conditions.

SQE.9 The hospital identifies staff who are at risk for exposure to and possible transmission of vaccine-preventable diseases and implements a staff vaccination and immunization program.

Workplace Violence Prevention

SQE.10 Staff members who provide patient care are trained and demonstrate competence in workplace violence prevention.

Nursing Staff

SQE.11 The hospital has a uniform process to collect, verify, and evaluate credentials of the nursing staff.

SQE.12 The hospital has a standardized process to identify job responsibilities and to plan clinical work assignments based on the nursing staff member's credentials and any regulatory requirements.

SQE.12.1 The hospital has a standardized process for nursing staff participation in the hospital's continuous quality improvement activities, including evaluating individual performance when indicated.

Other Clinical Staff

SQE.13 The hospital has a uniform process to collect, verify, and evaluate credentials of other clinical staff.

SQE.14 The hospital has a uniform process to identify job responsibilities and to make clinical work assignments based on other clinical staff's credentials and any regulatory requirements.

SQE.14.1 The hospital has a uniform process for other clinical staff participation in the hospital's continuous quality improvement activities.

MEDICAL STAFF

Medical Staff Membership

SQE.15 The hospital has a uniform process for collecting the credentials of those medical staff members permitted to provide patient care without supervision.

SQE15.1 Medical staff members' education, licensure/registration, and other credentials required by law or regulation and the hospital are verified and kept current.

SQE.15.2 There is a uniform decision process for the initial appointment of medical staff members and others permitted to practice independently.

Medical Staff Clinical Privileges

SQE.16 The hospital has a standardized, objective, evidence-based process to grant or deny privileges for medical staff members and others permitted to practice independently.

Medical Staff Evaluations

SQE.17 The hospital uses an ongoing standardized process to evaluate the quality and safety of the patient care provided by each medical staff member.

SQE.18 Hospital leaders define the circumstances requiring monitoring and evaluation of a medical staff member's professional performance.

Medical Staff Temporary Appointment of Clinical Privileges

SQE.19 Hospital leaders may grant temporary clinical privileges to medical staff for a limited period of time and for circumstances as defined by hospital policy.

Medical Staff Reappointment and Renewal of Clinical Privileges

SQE.20 At minimum every three years, the hospital decides to grant, deny and/or modify requested medical staff membership and clinical privileges.

Standards, Intents, Guidance, and Measurable Elements

Staff Recruitment and Retention

Standard SQE.1

Leaders of hospital departments and services define the desired qualifications of all staff members.

Intent of SQE.1

A health care organization must maintain an appropriate variety of skilled, qualified people to fulfill its mission and to meet patient needs.

Guidance for SQE.1

Leaders of hospital departments and services define the desired education, skills, knowledge, and other requirements necessary for individual positions or for groups of similar positions, **for example**, intensive care nurses. To project staffing needs, department/service leaders consider a variety of factors such as:

- Hospital's mission and scope of services
- Patient populations
- Patient volumes
- Complex care needs
- Available resources

Multiple chronic conditions require complex patient care, treatment, and services in hospitals, increasing the demand for resources. The increase in demand of resources which are often limited in supply, even at the outset, is one of the well-known causes of the burdened health care systems. Hospital leaders consider many factors to determine staffing levels and skills to meet the needs of patients. These factors include identifying the following:

- Prevalence of complex chronic conditions and needs
- Scope of services
- Availability of equipment and technologies
- Percentage of the volume of patients the hospital services that comprise the complex care population

The hospital and/or service leaders consistently update their staffing needs based on the elements described in ME 1. The patterned staffing needs are considered when determining whether the job responsibilities and staff qualifications are accurately reflected in job description and in the recruitment and retention of staff. In addition, the hospital complies with laws and regulations that identify required education levels, skills, or other requirements of individual staff members or that define staffing numbers or a mix of staff for the hospital.

Measurable Elements of SQE.1

❑ 1. Department and/or service leaders consider the following elements to project department staffing needs:
   a) Hospital's mission
   b) Mix of patient populations served by the hospital and the complexity of patient care needs
   c) Scope of services provided by the hospital

d) Volume of patients
e) Medical equipment and technology used in patient care

- ❑ 2. The hospital defines staff qualifications specific to their job responsibilities.
- ❑ 3. The recruitment and retention of all staff comply with applicable laws and regulations.

Standard SQE.1.1

The hospital defines the responsibilities for every staff member in a current job description.

Intent of SQE.1.1

Job descriptions are the basis for staff member assignments, orientation to their work, and evaluation of how well job responsibilities are fulfilled.

Guidance for SQE.1.1

Job descriptions may vary for each staff member and are based on a variety of factors. For other clinical staff members who are permitted by law and hospital policy to practice independently, there is a process to identify and to authorize the individual to practice based on education, training, and experience, and where a formal job description is replaced by other requirements such as the privileging process.

The requirements of this standard apply to all "types" of staff who require job descriptions (**for example**, full-time, part-time, employed, voluntary, temporary, or contract).

When a hospital uses national or generic job descriptions (**for example**, a job description for a "nurse"), it is necessary to augment this type of job description (such as an addendum or a set of competencies) with specific job responsibilities for the types of nurses, **for example:**

- intensive care nurse
- pediatric nurse
- operating theatre nurse

Individual clinical staff members who are not licensed to practice independently have their responsibilities defined in current job descriptions. For medical staff members and other clinical staff permitted by law and regulations and the hospital to practice independently, thereby practicing under privileges, and not a formal job description, there may be circumstances where some roles or circumstances will require a formal job description. **Examples** of these circumstances include a managerial role, such as a department manager, learning a new clinical skill which requires supervision, participating in an educational or training program requiring supervision, or temporary staff.

Regardless of the type of job description, it is the hospital's responsibility to maintain a policy that specifies how frequent each job description is reviewed and updated and ensures that the job description complies with the hospital policy.

Measurable Elements of SQE.1.1

- ❑ 1. Each staff member not permitted to practice independently has a job description.
- 2. Each job description includes defined responsibilities for the staff member with this job.
- ❑ 3. Job descriptions and/or specified privileges are required for medical staff when present in the hospital for the following circumstances:
  a) Serves in primarily a managerial role or in dual clinical and managerial roles, with the managerial responsibilities identified in a job description.

b) Has select clinical responsibilities for which they have not been authorized to practice independently.
c) Involved in an educational program and under supervision.
d) Permitted to temporarily provide services in the hospital.

❑ 4. Job descriptions are kept current according to hospital policy.

Standard SQE.2

Leaders of hospital departments and services implement processes for the recruitment and retention of staff.

Intent of SQE.2

The leaders of hospital departments and services implement processes for the recruitment and retention of all staff required to deliver the hospital's scope of services to its patient populations.

Guidance for SQE.2

The hospital and its leaders provide an efficient, coordinated, or centralized process for

- Recruiting individuals for available positions
- Evaluating the training, skills, and knowledge of candidates
- Appointing individuals to the hospital's staff

If the process is centralized, similar criteria, processes, and forms result in a uniform process across the hospital for similar types of staff; **for example**, for nurses or physical therapists. Department/service leaders participate by recommending the number and qualifications of staff needed to provide clinical care, treatment, and services to patients, as well as nonclinical support functions, and to fulfill any teaching, research, or other departmental responsibilities. Department /service leaders also help make decisions about individuals to be appointed to the staff. The standards in this chapter complement the Governance, Leadership, and Direction (GLD) standards that describe the responsibilities of a department/service leader.

Measurable Elements of SQE.2

❑ 1. The hospital implements a coordinated process to recruit staff.

❑ 2. The hospital implements a coordinated process to evaluate the qualifications of new staff.

❑ 3. The hospital implements a coordinated process to appoint individuals to the staff.

❑ 4. The hospital implements a process that is uniform across the hospital for similar types of staff.

Standard SQE.3

The hospital evaluates staff performance.

Intent of SQE.3

Qualified staff members are hired by the hospital through a process that matches the requirements of the position with the qualifications of the prospective staff member. This evaluation process also ensures that the clinical staff member's skills are consistent with the needs of patients and the nonclinical staff member's skills are consistent with the responsibilities of the nonclinical staff role at the time of hire and throughout employment.

Guidance for SQE.3

The hospital uses a defined process to ensure that staff qualifications, knowledge, and skills are consistent with the requirements of the position. Orientation to the position includes supervision to ensure that the staff member can fulfill the responsibilities of the job description. The staff member receives the required level of supervision and on a periodic basis is evaluated to ensure continuing competence in the position.

For clinical staff under job descriptions, the process includes the following:

- An initial evaluation to ensure that they can assume the responsibilities listed in the job description. This evaluation is carried out before or at the time of starting to perform work responsibilities. The hospital may have a "probationary" or other period during which the clinical staff member is closely supervised and evaluated, or the process may be less formal. Whatever the process, the hospital ensures that staff providing care, treatment and services to patients are evaluated at the time they begin providing the care, treatment, and service and before the probationary or orientation period is completed. The department or service leader who manages the staff member evaluates the staff member's skills, knowledge, and work behaviors. Competence is assessed by an individual with similar or relatable education, experience, or knowledge of the skills being reviewed.
- The evaluation also includes an assessment of the staff member's ability to operate medical equipment , technology, medication management, and complex patient care management unique to the specific area (**for example**, staff working in intensive care units should be able to effectively manage ventilators, infusion pumps, and continuous cardiac monitoring, and staff working in labor and delivery should be able to effectively manage fetal monitoring equipment).
- The hospital defines the process for and the frequency of the ongoing evaluation of clinical staff performance.

For nonclinical staff under job descriptions, the process includes the following:

- An initial evaluation to ensure that they can assume the responsibilities listed in the job description. This evaluation is carried out before or at the time of starting to perform work responsibilities. The hospital may have a "probationary" or other period during which the nonclinical staff member is closely supervised and evaluated, or the process may be less formal. Whatever the process, the hospital ensures that staff are evaluated at the time they begin performing work responsibilities and before the probationary or orientation period is completed. The department or service leader who manages the staff member evaluates the staff member's skills, knowledge, and work behaviors. Competence is assessed by an individual with similar or relatable education, experience, or knowledge of the skills being reviewed.
- The hospital defines the process for and the frequency of the ongoing evaluation of nonclinical staff performance.

For the hospital's clinical staff, such as the medical staff who practice independently (that is, they do not practice under job descriptions), the process is identified in SQE.16 through SQE.21.

An ongoing evaluation ensures that training occurs when needed and that the staff member can assume new or changed responsibilities. Although such evaluations are best carried out in an ongoing manner, there is at least one documented evaluation of each staff member working under a job description completed each year or more frequently as defined by hospital policy or consistent with law and regulation.

Measurable Elements of SQE.3

❑ 1. The hospital uses a defined process to ensure that staff qualifications are consistent with the care, treatment, and services it provides.

2. The hospital evaluates staff based on performance expectations that reflect their job responsibilities.

3. New staff members are evaluated before or at the time they begin their work responsibilities.

4. The department or service to which the individual is assigned conducts the evaluation.

5. An individual with the educational background, experience, or knowledge related to the skills being reviewed conducts the evaluation.

6. Clinical staff member evaluations are completed and documented annually or more frequently as defined by hospital policy or consistent with laws and regulations.

Standard SQE.4

There is documented personnel information for each staff member.

Intent of SQE.4

An accurate personnel record provides documentation of staff knowledge, skill, competency, and training required for carrying out job responsibilities.

Guidance for SQE.4

A staff member's personnel record shows evidence of staff performance and whether they are meeting job expectations. As a result, personnel records may contain sensitive information and must be kept confidential.

Each staff member in the hospital, including those permitted by law and the hospital to work independently, has a personnel record(s) with the following information:

- Their qualifications
- Required health information, such as immunizations and/or evidence of immunity
- Evidence of participation in orientation, ongoing in-services, and continuing education
- Results of evaluations, including individual performance of job responsibilities and competencies
- Work history

The records are standardized and kept current consistent with hospital policy.

Measurable Elements of SQE.4

❑ 1. Personnel records for each staff member are standardized, current, maintained.

2. Personnel records are kept confidential and secure consistent with the hospital policy.

3. Personnel records contain documented evidence of the following:

   a) Current job description that includes job qualifications and responsibilities, as indicated
   b) Staff member work history
   c) Record of completed orientation to the hospital
   d) Record of completed orientation to specific job/role
   e) Record of training and education attended by the staff member
   f) Completed annual performance evaluations and other evaluations as defined by hospital policy or consistent with laws and regulations
   g) Completed annual staff competence assessments and other competence assessments as defined by hospital policy or consistent with laws and regulations

Standard SQE.5

The hospital has the necessary staff to support the care, treatment, and services it provides.

Intent of SQE.5

Appropriate and adequate staffing is critical to patient care and to all teaching and research activities. Staff planning is carried out by department/service leaders.

Guidance for SQE.5

The planning process uses recognized methods for determining levels of staffing. **For example**, a patient acuity system is used to determine the number of licensed nurses with pediatric intensive care experience to staff a 10-bed pediatric intensive care unit. The process is written and identifies the number and types of required staff and the skills, knowledge, and other requirements needed in each department and service. The staffing process addresses the following:

- Reassignment of staff from one department or service to another in response to changing patient needs or staff shortages
- Consideration of staff requests for reassignment based on personal, spiritual/religious, and cultural beliefs
- Compliance with local laws and regulations

The staff planning process assesses the levels of complexity in care and the volume of these patient populations present in the hospital in comparison with the skill mix of available staffing resources. Medical equipment and the availability of other pertinent patient care resources are considered when planning for hospital allocation of staffing resources. With a global staffing shortage, the impact staffing has on staff retention should also be considered. Planned and actual staffing is monitored on an ongoing basis, and the process is revised as necessary. There is a coordinated process for the department/service leaders to update the overall process.

Measurable Elements of SQE.5

- ❑ 1. Hospital leaders implement a hospital staffing process that supports the care, treatment, and services it provides.
- ❑ 2. The hospital staffing process indicates the number, types, and desired qualifications of staff using a recognized staffing method.
- ❑ 3. The hospital staffing process describes the assignment and reassignment of staff.
- 4. The hospital staffing process complies with local laws and regulations.
- ❑ 5. The effectiveness of the hospital staffing process is monitored on an ongoing basis.
- ❑ 6. The hospital staffing process is reviewed and revised consistent with the hospital policy and when indicated.
- ❑ 7. The hospital staffing process involves coordination with various hospital department/service leaders.

Standard SQE.6

The hospital provides orientation to all staff.

Intent of SQE.6

Orientation to the hospital allows staff members to understand how their specific roles will contribute to the organization. New staff members must understand how their specific role and responsibilities contribute to the hospital's mission.

Guidance for SQE.6

Orientation is accomplished through the following:

- General orientation to the hospital
- Specific orientation to the staff member's role and job responsibilities
- Key safety information related to the staff member's role

The staff member's completed orientation is documented in their personnel record. The orientation includes key safety content according to the staff member's role and as determined by the hospital. **Examples** of key safety content that may be included in orientation are:

- the reporting of medical errors
- infection prevention and control practices,
- the hospital's policies on telephone medication orders,
- hospital safety codes and emergency procedures.

Contract staff, volunteers, students, and trainees are also oriented to the hospital and their specific assignments or responsibilities, such as patient safety and infection prevention and control.

Measurable Elements of SQE.6

❑ 1. The hospital completes orientation before staff provides care, treatment, and services.

2. The hospital orients staff on the following according to their job description:

   a) High-risk quality and safety issues (for example, reporting of medical errors, infection prevention and control practices, the hospital's policies on telephone medication orders).
   b) The hospital, the department, and/or unit to which they are assigned.
   c) Their specific job responsibilities and any specific assignments
   d) Relevant hospitalwide and department and/or unit-specific policies and procedures
   e) Patient rights, including ethical aspects of care, treatment, or services and the process used to address ethical issues based on their job duties and responsibilities.

❑ 3. Other clinical staff who accompany the medical staff and provide care, treatment, and services are oriented to the hospital.

❑ 4. Students, trainees, and volunteers are oriented to the hospital and assigned responsibilities.

5. All staff have the content and completion orientation documented in their personnel record.

Standard SQE.7

Staff participate in education and training.

Intent of SQE.7

Staff must participate in education and training to maintain acceptable staff performance, to learn new skills, and to be trained on new medical equipment, technology, and procedures. The hospital provides resources such as facilities, educators, and time for ongoing in-service and other education.

Guidance for SQE.7

The training and education provided by the hospital must be relevant to each staff member as well as to the continuing advancement of the hospital in meeting patient needs. **For example**, medical staff members may receive education on infection prevention and control, advances in medical practice, culture of safety, or new medical equipment. Each staff member's training and educational achievements are documented in their personnel record.

The hospital collects data from several sources to understand ongoing education needs, **for example:**

- Results of quality and safety measurement activities
- Monitoring data from the facility management program
- Introduction of new medical equipment
- Skill and knowledge areas identified through job performance review
- New clinical procedures
- Strategic plans to provide new services

The hospital has a process to collect and integrate data from various sources to plan staff training and education programs. The hospital determines which staff are required to obtain continuing education to maintain their credentials and how the education of these staff will be monitored and documented.

Hospital leadership supports ongoing staff education by providing equipment, time and other necessary resources for education and training programs. Current scientific information, such as evidence-based guidelines and practices, is used to support the education and training programs. The education and training can take place in a centralized location, various smaller learning and skill development locations throughout the facility, or through online training portals. Educational opportunities can be offered using various methods and at various times and settings, to minimize the disruption to staff scheduling and any potential affects this may have on patient care.

Measurable Elements of SQE.7

1. Staff participate in ongoing education and training to maintain or increase their competency, and as needed.
2. Hospital staff are provided ongoing education and training.
3. The hospital uses various sources of data and information, including the results of quality and safety measurement activities, to identify staff education needs.

❑ 4. Staff education programs are developed and provided based on these data and information.

❑ 5. The education is relevant to each staff member's ability to meet patient needs and/or continuing education requirements.

❑ 6. The hospital provides adequate time and resources for all staff to participate in relevant education and training opportunities.

7. All staff have the content and completion of training and education documented in their personnel record.

Standard SQE.7.1

Staff are competent in resuscitative techniques appropriate to their role in the hospital.

Intent of SQE.7.1

All staff who provide patient care, treatment, and services, including medical staff, and nonclinical staff whom the hospital identifies are trained in basic resuscitative techniques.

Guidance for SQE.7.1

The hospital identifies the level of training (basic or advanced life support), appropriate to their roles in the hospital, for all clinical staff who provide patient care. **For example**, the hospital may determine that all clinical staff who provide care in specific departments, such as the emergency department or intensive care unit, or all staff who administer or monitor procedural sedation, are required to be trained in advanced life support. The appropriate level of training is repeated based on the requirements and/or

time frames identified by a recognized resuscitation training program, or every two years if a recognized training program is not used. Recognized training programs such as the American Red Cross and the American Heart Association are programs that offer medical emergency preparedness globally. As an alternative to offering a recognized training program, the hospital can choose to develop its own training program as long as the program is based on the requirements and/or time frames established by a recognized training program. Medical emergency preparedness training options include first aid, basic life support (BLS) also known as cardiopulmonary resuscitation (CPR), and advanced cardiovascular life support (ACLS).

It is important that clinical staff are trained to promptly recognize life-threatening emergencies and to respond to them by competently performing CPR and other basic cardiovascular life support skills according to their roles. The hospital may also determine that nonclinical staff who do not provide patient care, treatment, or services, such as transporters or registration clerks, may require training in basic life support again, as appropriate to their role. There must be evidence to show if each staff member who attended and completed the training course in resuscitation achieved the desired competency level appropriate for their role.

Measurable Elements of SQE.7.1

- ❑ 1. Clinical staff who provide patient care, treatment, and services including medical staff, are trained in at least basic life support (BLS).
- ❑ 2. The hospital identifies the level of training (basic or advanced life support), appropriate to their roles in the hospital, for all clinical staff who provide patient care.
- ❑ 3. Evidence that the clinical staff member completed and passed the level of training appropriate to their role is documented in the personnel record.
- ❑ 4. The level of training appropriate to their role for clinical staff is repeated based on the requirements and/or time frames established by a recognized training program, or every two years if a recognized training program is not used.
- ❑ 5. The hospital identifies nonclinical staff to be trained in basic life support (BLS).
- ❑ 6. Evidence that the nonclinical staff member completed and passed the level of training appropriate to their role is documented in the personnel record.
- ❑ 7. The level of training appropriate to their role for nonclinical staff is repeated based on the requirements and/or time frames established by a recognized training program, or every two years if a recognized training program is not used.

Staff Health and Safety

Standard SQE.8

The hospital provides a staff health and safety program that addresses staff physical and mental health and safe working conditions.

Intent of SQE.8

A hospital's staff health and safety program is important to maintain staff physical and mental health, satisfaction, productivity, and safe conditions for work.

Guidance for SQE.8

Many factors in the workplace support the health and wellbeing of staff, including the following:

- Staff orientation and training
- A safe workplace

- Maintenance of medical equipment
- Prevention and control of health care–associated infections

The program includes elements such as education, training, evaluation, interventions, and treatments. The design of the program includes staff input and draws upon the hospital's clinical resources as well as those in the community. Follow up and/or periodic evaluations for potential impact as indicated for work-related injuries are key factors in maintaining staff health and safety.

Staff must understand and be able to verbalize the process for handling work-related injuries, including

- how to report,
- be treated for, and
- receive counseling and follow-up as indicated

Examples of these injuries include

- needlesticks injuries
- back injuries
- exposure to infectious diseases
- handling of patients
- hazardous conditions in the facility
- exposure to chemicals (chemo, CSSD, radio/nuclear materials)

Nursing and other clinical staff who assist with mobilizing patients are at increased risk of back injuries and other musculoskeletal injuries due to the physical demands of patient handling. Improper patient handling techniques can also have a negative impact on patient safety and quality of care. Interventions appropriate to the care area and type of patient are implemented. **Examples** of safe handling interventions include the following:

- Use of gait belts
- Lateral transfer aids
- Training on body mechanics
- Implementation of a patient transfer team

The caregiving environment often presents challenges that can be mentally, emotionally, and physically stressful. Repeated exposure to emotional and physical challenges such as providing empathy and emotional support to patients and families, ethical decision making, and frequent exposure to death and dying, can create compassion fatigue and can lead to many adverse health and quality-of-life outcomes for health care workers. Promoting and sustaining staff resiliency to minimize stress are essential to creating a positive culture for the benefit of patients and staff.

Clinical staff are often the second victims of errors and sentinel events. The National Institute of Health defines the *second victim* as being "any health care worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional health care error, or patient injury, and becomes victimized in the sense that also the worker is negatively impacted." The remorse and anxiety felt by caregivers and their feelings of moral distress are frequently not acknowledged or addressed when patients and their family members are affected by clinical errors. Hospitals need to acknowledge that the emotional health and performance of the clinical staff involved in adverse and sentinel events can have an impact on the quality and safety of patient care.

Compared to the general population, clinical staff historically have higher incidents of depression, anxiety, stress, and thoughts of self-harm and suicide due to the psychological distress attributed to the workplace environment. Common traumatic workplace stressors include:

- Constant work demands
- Poor organizational support
- Short staffing
- Long hours
- Exposure to death, dying, and workplace violence

Recurring stressors compounded by the ethical decisions that clinical staff contend with that often create conflict with moral or ethical values has played a pivotal role in the deterioration of mental health in clinical staff, even more so in relation to crisis events. Mental health impairment among clinical staff due to workplace posttraumatic stress and psychological distress was historically present in crisis events. Most recently, the Covid-19 pandemic has increased rates of self-harm and suicidal ideations, high levels of depression, anxiety, sleep disorders, burnout and post-traumatic stress disorder symptoms among clinical staff.

Research related to compassion fatigue and 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 staff health and well-being. Programs would benefit from models that incorporate compassionate leadership and a workplace environment that offers psychological safety and support to clinical staff. Such models incorporate elements such as facilitating a sense of belonging, support in way of preparation and debrief for challenging workplace events, and staffing plans that prohibit the shift of burden to other clinical staff. **Examples** of support intervention best practices include suicide and self-harm prevention crisis hotlines and online interventions.

Measurable Elements of SQE.8

- ❑ 1. The hospital implements a staff health and safety program that is responsive to urgent and nonurgent staff needs through direct treatment and referral.
- ❑ 2. The staff health and safety program at a minimum includes the following:
  - a) Initial employment health screening
  - b) Measures to control harmful occupational exposures, such as exposure to toxic drugs and harmful noise levels
  - c) Education, training, and resources on safe patient handling
  - d) Education, training, and resources for staff who may be second victims of adverse or sentinel events
  - e) Treatment for common work-related conditions or injuries

3. The staff health and safety program evaluates and provides resources to address the following:
   - a) Staff mental health
   - b) Burnout
   - c) Compassion fatigue
   - d) Risk of self-harm
   - e) Suicide

4. The hospital implements a process for follow up and support to staff who are second victims of adverse or sentinel events.
5. The hospital promotes staff well-being by creating a culture of wellness that supports physical well-being and mental health.
6. The hospital demonstrates actions taken for staff mental health prevention to, at a minimum, address the following:
   - a) Burnout
   - b) Compassion fatigue
   - c) Risk of self-harm
   - d) Suicide

Standard SQE.9

The hospital identifies staff who are at risk for exposure to and possible transmission of vaccine-preventable diseases and implements a staff vaccination and immunization program.

Intent of SQE.9

Many clinical staff are at risk for exposure to and possible transmission of vaccine-preventable diseases due to their contact with patients and infectious materials.

Guidance for SQE.9

Asymptomatic infections are common, and individuals can be infectious prior to having any symptoms, including from highly transmittable diseases such as COVID-19, influenza, and tuberculosis. Studies show that clinical staff often report to work even when ill. Hospitalized patients are at significant risk of injury or death from health care–associated infectious disease transmissions. Infectious disease outbreaks in hospitalized patients have been traced to unvaccinated clinical staff, particularly in cases of COVID-19, influenza A, and tuberculosis.

The incidence of infectious disease transmission can be significantly reduced by

- identifying epidemiologically important infections
- determining staff at high risk for these infections
- implementing screening and prevention programs (such as immunizations, vaccinations, and prophylaxis)

Hospitals reduce the risks associated with the transmission of infectious diseases by unvaccinated staff, which includes the implementation of a staff vaccination and immunization program policy and a process to guide the administration and management of staff vaccinations and immunizations. Clinical staff have an ethical and professional obligation to protect themselves, their coworkers, and patients/families. Vaccination is a duty for all Clinical staff.

Strategies for reducing patient and staff risk of exposure to infectious diseases, such as COVID-19, influenza A, and tuberculosis, may include efforts to promote vaccination, encouraging staff to get vaccinated, and requiring unvaccinated staff to wear masks at high-risk times of the year such as the flu season, or in high-risk areas such as a unit that frequently cares for patients diagnosed with COVID-19 or tuberculosis. Unvaccinated staff providing care to patients who are vulnerable to infection, such as the immunocompromised, the elderly, and infants, increases the risks to those patients already at high risk for infection. Therefore, staff immunization status needs to be considered when making staff assignments.

Measurable Elements of SQE.9

- ❑ 1. The hospital identifies epidemiologically significant infections, as well as staff who are at high risk for exposure to and transmission of infections.
- ❑ 2. The hospital develops and implements a staff vaccination and immunization program.
- 3. The staff vaccination and immunization program includes a policy and a process for the administration and management of staff vaccinations and immunizations.
- ❑ 4. The hospital evaluates the risks associated with unvaccinated staff and identifies strategies for reducing patient and staff risk of exposure to infectious diseases from unvaccinated staff.
- ❑ 5. The infection prevention and control program guides the evaluation, counseling, and follow-up of staff exposed to infectious diseases.

Workplace Violence Prevention

Standard SQE.10

Staff members who provide patient care are trained and demonstrate competence in workplace violence prevention.

Intent for SQE.10

Exposure to workplace violence can impair effective patient care and lead to psychological distress, job dissatisfaction, absenteeism, high turnover, and higher costs. Recognition of what constitutes workplace violence begins with awareness of the different types of physical and nonphysical acts and threats of workplace violence.

Guidance for SQE.10

Studies have demonstrated the negative impact that unhealthy cultures have on the work environment; in particular to the employee retention, personal well-being, engagement, and ultimately, patient outcomes. A 2022 study concluded that the number one cause of burnout and intention to leave the workplace is toxic work behaviors. Another study determined that a "toxic culture" is greater than ten times more likely to contribute to attrition than compensation. According to US Bureau of Labor Statistics data, the incidence of violence–related health care worker injuries has steadily increased for at least a decade. Incidence data reveal that in 2018 health care and social service workers were five times more likely to experience workplace violence than all other workers—comprising 73% of all nonfatal workplace injuries and illnesses requiring days away from work. However, workplace violence is underreported, indicating that the actual rates may be much higher.

The hospital provides training, education, and resources on the workplace violence prevention program to leaders and staff at time of hire, annually, and whenever changes occur. The required aspects of the workplace violence prevention program training are based on individual roles and responsibilities, but training should begin with clearly defining the matter. Workplace violence is defined as "an act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving all staff, patients, or visitors."

Workplace violence can occur between staff, patient and/or visitor to staff, leader to staff, staff to leader. Education and training should focus on prevention, including early detection and immediate intervention. De-escalation and intervention techniques are also important to learn when confronted with incidents of workplace violence. Incorporating violence prevention tools and encouraging the use of a simple and accessible reporting process can ultimately reduce the likelihood of health care staff being victims of workplace violence.

Measurable Elements of SQE.10

1. The hospital provides training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention program) to leaders, and staff.
2. The hospital determines what aspects of training are appropriate for individuals based on their roles and responsibilities.
3. The training, education, and resources address prevention, recognition, response, and reporting of workplace violence as follows:
   a) What constitutes workplace violence
   b) Education on the roles and responsibilities of leaders, clinical staff, security personnel, and external law enforcement.
   c) Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents
   d) The reporting process for workplace violence incidents

Standard SQE.11

The hospital has a uniform process to collect, verify, and evaluate credentials of the nursing staff.

Intent of SQE.11

The hospital needs to ensure that it has a qualified nursing staff that appropriately matches its mission, care, treatment, services, and associated resources with the needs of the patient populations it serves.

Guidance for SQE.11

Nursing is the driving force behind patient care, and directly contributes to the overall patient outcomes; Therefore the hospital must ensure that nurses are qualified to provide nursing care and must specify the types of care they are permitted to provide if not identified in laws or regulations. The hospital ensures that each nurse is qualified to provide safe and effective care and treatment to patients by meeting the following expectations:

- Understanding the applicable laws and regulations that apply to nurses and nursing practice
- Collecting all available credentials on each nurse, including at least
    - Evidence of education/training
    - Evidence of current licensure
    - Evidence of current competence through information from other sources in which the nurse was employed
    - Letters of recommendation and/or other information the organization may require, such as health history, pictures, among others
    - Verification of the essential information, such as current registry or licensure, particularly when such documents are periodically renewed, and any certifications and evidence of completion of specialized or advanced education

The hospital must make every effort to verify essential information, even when the education took place in another country or a significant time ago. Standards compliance requires that primary source verification is carried out for all nurses.

***Exception* for SQE.11, ME 1, for initial surveys only.** At the time of the initial JCI accreditation survey, hospitals are required to have completed primary source verification for new nurse applicants within the twelve (12) months leading up to the initial survey. During the twelve (12) months following the initial survey, hospitals are required to complete primary source verification for all other currently employed nurses. This process is accomplished over the 12-month postsurvey period according to a plan that places priority on the verification of the credentials of currently employed nurses providing high-risk services.

This exception refers only to the verification of credentials. All nursing staff members must have their credentials collected and reviewed, and any advanced practice privileges granted. A "phasing in" of this process is not acceptable.

Verification

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 in the following ways:

1. An inquiry to a secure online database of, **for example**, those individuals licensed in the hospital's city or country.
2. Documenting a telephone conversation with the issuing source.
3. Corresponding via e-mail or conventional postal letter inquiry with the source.

Verification of credentials from outside the country may be more complex and, in some cases, not possible. There should, however, be evidence of a credible effort to verify the credential. A credible effort is characterized by multiple (at least two within 60 days) attempts by various methods (**for example**, phone, e-mail, and letter) with documentation of the attempts and result(s).

The three following situations are acceptable substitutes for a hospital performing primary source verification of credentials:

1. **Applicable to hospitals overseen directly by governmental bodies,** the government's verification process, supported by the availability of published governmental regulations about primary source verification; plus, government licensure, or equivalent such as a registration; and the granting of specific status (**for example**, consultant, specialist, and others) are acceptable. As with all third-party verification processes, it is important to verify that the third party (**for example**, a government agency) implements the verification process as described in policy or regulations and that the process meets the expectations described in these standards.
2. **Applicable to all hospitals,** 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 (JCI) accreditation with "full compliance" on its verification process found in 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.
3. **Applicable to all hospitals,** the credentials have been verified by an independent third party, such as a designated, official, governmental, or nongovernmental agency, as long as the following conditions apply: Any hospital that bases its decisions in part on information from a designated, official, governmental, or nongovernmental agency should have confidence in the completeness, accuracy, and timeliness of that information. To achieve this level of confidence in the information, the hospital should evaluate the agency providing the information initially and then periodically thereafter to ensure that JCI standards continue to be met.

The hospital has a process that ensures that the credentials of each contract nurse have also been collected, verified, and reviewed to ensure current nurse competence prior to assignment. Various methods can be used to conduct primary source verification. Examples include secure websites, documented phone confirmation from the source, written confirmation, and third parties, such as a designated, official governmental or nongovernmental agency. The hospital collects and maintains a record of each nurse's credentials. The records contain current licenses when regulations require periodic renewal. There is documentation of training related to any additional competencies.

It is important to understand the process for issuing select credentials. Information to consider when determining the issuance of credentials:

- Does the government agency that issues the license to practice base its decision on any or all of the following:
  - verification of education
  - an examination of competence
  - training by a nursing specialty association, or membership
  - payment of fees
- If admission to a specialty education program is based on verification of education and experience to date, the hospital does not need to verify education again.
- The process used by the government agency is documented by the hospital
- The hospital must perform its own verification if:
  - the hospital does not have direct knowledge of the process used by the agency to verify education
  - the hospital has never had an opportunity to verify that the agency carries out the process as described

Measurable Elements of SQE.11

❑ 1. The hospital has a standardized procedure to collect, verify, and document the education, certifications, and experience of each nursing staff member.

❑ 2. Education, training, and certifications are verified from the original source consistent with parameters found in the intent and are documented.

❑ 3. Licensure is verified from the original source consistent with the following parameters and is documented:

a) The hospital must verify that the third party implements the verification process as described in hospital policy or regulations and that the process meets the expectations described in these standards.

b) The affiliated hospital that has already conducted primary source verification of the nursing staff applicant is acceptable if the affiliated hospital has current Joint Commission International (JCI) accreditation with "full compliance" on its verification process found in MEs 1 and 2.

c) The hospital who bases its decisions in part on information from a designated, official, governmental, or nongovernmental agency must evaluate the agency providing the information initially and then periodically thereafter to ensure that JCI standards continue to be met.

- ❑ 4. A record is maintained with the credentials for every nursing staff member.
- ❑ 5. The hospital has a process to ensure that the credentials of contracted nurses are valid and complete prior to assignment.
- ❑ 6. The hospital has a process to ensure that nurses who are not employees of the hospital but accompany private physicians and provide services to the hospital's patients have valid credentials.

Standard SQE.12

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

Intent of SQE.12

Review of the qualifications of the nursing staff member provides the basis for assigning job responsibilities and clinical work assignments.

Guidance for SQE.12

Safe and appropriate staffing has been linked to the health status of the workplace. Staffing challenges affect patient and staff safety, patient quality of care and outcomes, hospital costs, staff mental health, and staff performance and retention. Appropriate staffing requires a healthy balance between the assessment of patient needs, including the complexity of care and the appropriate clinical staff skills to match those needs. Work assignments may be described in more detail in a job description or described or documents that support how nurse staffing assignments are made, such as assignment to geriatric or pediatric units or to high-acuity units. Assignments made by the hospital are consistent with any applicable laws and regulations regarding nursing responsibilities and clinical care.

Hospitals committed to establishing staffing policies and standardized processes to support staffing models that match patient needs with clinical staff competencies will continuously evaluate their staffing decisions and adjust their processes to ensure that their staffing model continues to support patient and staff safety and high-quality care. It is important to measure how supportive the staffing plan process is. Examples of measures include reviewing independent nursing performance improvement projects, and evidence of nursing participation in departmental and/or service quality improvement activities. Additional supportive measures include continuous data monitoring and analysis, availability of support services, and evaluating the need to adopt technologies, including any training and education reflective of the work assignments and job descriptions supported by the hospital policies and processes.

Measurable Elements of SQE.12

1. Nursing staff have education, experience, training, and/or certification, consistent with the hospital's scope of services, as indicated in their job description and as applicable to their role.
2.. Core criteria for evaluating nursing staff in the program include, at a minimum, current licensure, and current competence.
3. Licensure, education, training, and experience of a nursing staff member are used to plan clinical work assignments.

- ❑ 4. The process considers applicable laws and regulations.
- ❑ 5. The process supports nurse staffing plans.

Standard SQE.12.1

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

Intent of SQE.12.1

The nursing staff's essential clinical role requires them to actively participate in the hospital's continuous quality improvement program.

Guidance for SQE.12.1

The hospital determines the information that should be kept in the nursing staff's personnel record. **Examples** include:

- completed education,
- training, in-service and skills/competency documentation,
- performance reviews,
- job descriptions that include roles and responsibilities, and
- disciplinary actions and discussions, license, and credential information.

If at any point during clinical quality measurement, evaluation, and improvement, a nursing staff member's performance is in question, the hospital has a process to evaluate that individual's performance. The results of reviews, actions taken, and any impact on job responsibilities are documented in the nurse's personnel record or in a separate credential record.

A standardized process to gather relevant performance data on each nurse for evaluation by appropriate leaders allows for identification of practice trends, negative or positive, that affect the quality of care and patient safety. Including measures related to individual staff member performance in the program in nursing staff evaluations provides opportunities to identify performance deficiencies. When deficiencies or substandard performance are identified, corrective actions are implemented. Documentation of corrective actions taken, and the outcome produced, is necessary when evaluating the performance of nursing staff. Evaluations are accomplished via various methods such as data analysis, peer and leadership feedback, and assessments of competence for knowledge and performance of skills, which are proven to directly impact quality and safety.

Measurable Elements of SQE.12.1

- ❑ 1. Nursing staff participate in the hospital's continuous quality improvement activities.
- ❑ 2. The performance of individual nursing staff members is reviewed when indicated by variances noted on trend or as negative deviations to continuous quality improvement activities.
- ❑ 3. Information from the review process is documented in the nurse's personnel record or in a separate credential record, consistent with hospital policy.

Other Clinical Staff

Standard SQE.13

The hospital has a uniform process to collect, verify, evaluate credentials of other clinical staff.

Intent of SQE.13

The hospital is responsible for collecting and verifying credentials of other clinical staff permitted to work or to practice in the hospital.

Guidance for SQE.13

Hospitals employ or may permit other clinical staff to provide care and services to their patients or to participate in patient care processes. **For example**,

- midwives,
- surgical assistants,
- emergency medical care specialists,
- pharmacists, and
- pharmacy technicians.

In some countries or cultures, this group also includes traditional healers or those who provide alternative services or services that complement traditional medical practice (**for example**, acupuncture, herbal medicine). Often, these individuals do not actually practice in the hospital; instead, they refer to the hospital or provide continuing or follow-up care for patients in the community. Many of these professionals complete formal training programs and receive licenses or certificates or are registered with local or national authorities. Others may complete less formal apprentice programs or other supervised experiences.

The hospital must ensure that other clinical staff are qualified to provide care and treatments and must specify the types of care and treatment they are permitted to provide if not identified in laws or regulations. The hospital ensures that other clinical staff are qualified to provide safe and effective care and treatment to patients by

- understanding the applicable laws and regulations that apply to such clinical staff;
- collecting all available credentials on each individual, including at least evidence of education and training and evidence of current licensure or certification when required; and
- verification of the essential information, such as current registry, licensure, or certification.

The hospital must make every effort to verify essential information relevant to the individual's intended responsibilities, even when the education took place in another country or a significant time ago. Standards compliance requires that primary source verification is carried out for all other clinical staff.

***Exception* for SQE.13, ME 1, for initial surveys only.** At the time of the initial JCI accreditation survey, hospitals are required to have completed primary source verification for new clinical staff applicants within the twelve (12) months leading up to the initial survey. During the twelve (12) months following the initial survey, hospitals are required to complete primary source verification for all other currently employed clinical staff. This process is accomplished over the 12-month postsurvey period according to a plan that places priority on the verification of the credentials of currently employed clinical staff providing high-risk services. When there is no required formal education process, licensure, or registry process or other credential or evidence of competency, this is documented in the individual's record.

This exception refers only to the verification of credentials. All clinical staff members must have their credentials collected and reviewed, and any advanced practice privileges granted. A "phasing in" of this process is not acceptable.

Verification

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 in the following ways:

1. An inquiry to a secure online database of, **for example**, those individuals licensed in the hospital's city or country.
2. Documenting a telephone conversation with the issuing source
3. Corresponding via e-mail or conventional postal letter inquiry with the source

Verification of credentials from outside the country may be more complex and, in some cases, not possible. There should, however, be evidence of a credible effort to verify the credential. A credible effort is characterized by multiple (at least two within 60 days) attempts by various methods (**for example**, phone, e-mail, and letter) with documentation of the attempts and result(s).

The three following situations are acceptable substitutes for a hospital performing primary source verification of credentials:

1. **Applicable to hospitals overseen directly by governmental bodies,** the government's verification process, supported by the availability of published governmental regulations about primary source verification; plus, government licensure, or equivalent such as a registration; and the granting of specific status (**for example**, consultant, specialist, and others) are acceptable. As with all third-party verification processes, it is important to verify that the third party (**for example**, a government agency) implements the verification process as described in policy or regulations and that the process meets the expectations described in these standards.
2. **Applicable to all hospitals,** 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 (JCI) accreditation with "full compliance" on its verification process found in 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.
3. **Applicable to all hospitals,** the credentials have been verified by an independent third party, such as a designated, official, governmental, or nongovernmental agency, as long as the following conditions apply: Any hospital that bases its decisions in part on information from a designated, official, governmental, or nongovernmental agency should have confidence in the completeness, accuracy, and timeliness of that information. To achieve this level of confidence in the information, the hospital should evaluate the agency providing the information initially and then periodically thereafter to ensure that JCI standards continue to be met.

The hospital has a process that ensures that the credentials of each contract clinical staff member have also been collected, verified, and reviewed to ensure current clinical competence prior to assignment. Various methods can be used to conduct primary source verification. Examples include secure websites, documented phone confirmation from the source, written confirmation, and third parties, such as a designated, official governmental or nongovernmental agency. The hospital collects and maintains a record of each clinical staff member's credentials. The records contain current licenses when regulations require periodic renewal. There is documentation of training related to any additional competencies.
It is important to understand the process for issuing select credentials. Information to consider when determining the issuance of credentials:

- Does the government agency that issues the license to practice base its decision on any or all of the following:
  - verification of education
  - an examination of competence
  - training by a clinical specialty association, or membership
  - payment of fees
- If admission to a specialty education program is based on verification of education and experience to date, the hospital does not need to verify education again.
- The process used by the government agency is documented by the hospital
- The hospital must perform its own verification if:
  - the hospital does not have direct knowledge of the process used by the agency to verify education
  - the hospital has never had an opportunity to verify that the agency carries out the process as described

Measurable Elements of SQE.13

- ❑ 1. The hospital has a standardized process to collect, document, and verify the education, certifications, and experience of each clinical staff member.
- ❑ 2. Education, training, and certifications are verified from the original source consistent with the parameters found in the intent and are documented.
- ❑ 3. Licensure is verified from the original source consistent with the following parameters and is documented:
  - a) The hospital must verify that the third party implements the verification process as described in hospital policy or regulations and that the process meets the expectations described in these standards.

b) The affiliated hospital that has already conducted primary source verification of the clinical staff applicant is acceptable if the affiliated hospital has current Joint Commission International (JCI) accreditation with "full compliance" on its verification process found in MEs 1 and 2.

c) The hospital who bases its decisions in part on information from a designated, official, governmental, or nongovernmental agency must evaluate the agency providing the information initially and then periodically thereafter to ensure that JCI standards continue to be met.

- ❑ 4. A record is maintained with copies of any required license, certification, or registration for other clinical staff.
- ❑ 5. The hospital has a process to ensure that staff who are not employees of the hospital but accompany private physicians and provide services to the hospital's patients have valid credentials that are comparable to the hospital's requirement for credentials.

Standard SQE.14

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

Intent of SQE.14

The hospital is responsible for identifying the types of activities or range of services these individuals will provide in the hospital. This can be accomplished through agreements, job assignments, job descriptions, or other methods.

Guidance for SQE.14

Work assignments may be described in more detail in a job description or described in other ways or documents that support how clinical staff staffing assignments are made, such as assignment to geriatric or pediatric units or to high-acuity units. Assignments made by the hospital are consistent with any applicable laws and regulations regarding applicable clinical responsibilities and clinical care.

Hospitals continuously evaluate their staffing decisions and adjust their processes to ensure that their staffing model continues to support patient and staff safety and high-quality care. Additional supportive measures include continuous data monitoring and analysis, availability of support services, and evaluating the need to adopt technologies, including any training and education reflective of the work assignments and job descriptions supported by the hospital policies and processes.

Measurable Elements of SQE.14

- ❑ 1. Licensure, education, training, and experience of other clinical staff are used to make clinical work assignments.
- ❑ 2. The process considers relevant laws and regulations.
- ❑ 3. The process supports the staffing process for other clinical staff.

Standard SQE.14.1

The hospital has a uniform process for other clinical staff participation in the hospital's continuous quality improvement activities.

Intent of SQE.14.1

The hospital defines the level of supervision (consistent with existing laws and regulations), if any, for these professionals. Other clinical staff are included in the hospital's continuous quality improvement program.

Guidance for SQE.14.1

The hospital determines the information that should be kept in the other clinical staff's personnel record. **Examples** include:

- completed education,
- training,
- in-service and skills/competency documentation,
- performance reviews,
- job descriptions that include roles and responsibilities, and
- disciplinary actions and discussions, license, and credential information.

If at any point during clinical quality measurement, evaluation, and improvement, a clinical staff member's performance is in question, the hospital has a process to evaluate that individual's performance. The results of reviews, actions taken, and any impact on job responsibilities are documented in the clinical staff's personnel record or in a separate credential record.

A standardized process to gather relevant performance data on each staff member allows for identification of practice trends that affect the quality of care and patient safety. Including measures related to individual staff member performance in the program in clinical staff evaluations provides opportunities to identify performance deficiencies. Corrective actions are implemented when deficiencies or substandard performances are identified. Documentation of corrective actions taken, and the outcome produced, is necessary when evaluating the performance of clinical staff. Evaluations are accomplished via various methods such as data analysis, peer and leadership feedback, and assessments of competence for knowledge and performance of skills, which are proven to directly impact quality and safety.

Measurable Elements of SQE 14.1

- ❑ 1. Other clinical staff participate in the hospital's continuous quality improvement activities.
- ❑ 2. The performance of other clinical staff is reviewed when indicated by the findings of the continuous quality improvement activities.
- ❑ 3. Appropriate information from the review process is documented in the clinical staff member's record.

MEDICAL STAFF

Medical Staff Membership

Standard SQE.15

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

Intent of SQE.15

A uniform decision process ensures that the expectations for medical staff membership appointment are understood and that the decision process is unbiased.

Guidance for SQE.15

A hospital's uniform process for the management of credentials requires a singular, structured process for the verification of the education, licensure/registration, and other credentials required by laws and regulations and the hospital's policy for the medical staff membership initial appointment and/or reappointment of each medical staff member.

Definitions and further explanations of terms and expectations found in these standards are as follows:

Credentials

A Credential is a document issued to an individual from a recognized entity to indicate the completion and/or meeting of requirements that addresses some aspect of the applicant's professional history such as a qualification, competence, or authority. **Examples** of credentialing documents include:

- a diploma from a medical school,
- specialty training (residency) completion letter or certificate,
- completion of the requirements of a medical professional organization,
- a license to practice,
- recognition of registration with a medical or dental council
- letters of recommendation,
- a history of all previous hospital medical staff appointments,
- records of previous clinical care, treatment, services, health history,
- Picture for identification, or
- police background check.

These documents, some of which are required by law or regulation, but some by hospital policy, must be verified from the original source that issued the document. Credential verification requirements will vary by the position the applicant is seeking. **For example**, for an applicant for leader of a department/clinical service, the hospital may want to verify information regarding the individual's previous administrative positions and experience. Also, for clinical positions, the hospital may require a certain number of years of experience and thus would verify this level of experience.

Measurable Elements of SQE.15

- ❑ 1. The hospital has an ongoing, uniform process to manage the credentials of medical staff members.
- ❑ 2. Medical staff members permitted by laws, regulations, and the hospital to provide patient care without supervision are identified.
- ❑ 3. Education, licensure/registration, and other credentials required by law or regulation are copied by the hospital and maintained for each medical staff member in their personnel record or in a separate credential record.
- ❑ 4. All credentials required by hospital policy are copied by the hospital and maintained for each medical staff member in their personnel record or in a separate credential record.

Standard SQE.15.1

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

Intent of SQE.15.1

Maintaining current verifications of medical staff credentials helps minimize safety risk to patients by ensuring that medical staff members are credentialed and meet all the qualifications to direct and provide patient care.

Guidance for SQE.15.1

Verification

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 in the following ways:

1. An inquiry to a secure online database of, **for example**, those individuals licensed in the hospital's city or country.
2. Documenting a telephone conversation with the issuing source.
3. Corresponding via e-mail or conventional postal letter inquiry with the source.

Verification of credentials from outside the country may be more complex and, in some cases, not possible. There should, however, be evidence of a credible effort to verify the credential. A credible effort is characterized by multiple (at least two within 60 days) attempts by various methods (**for example**, phone, e-mail, and letter) with documentation of the attempts and result(s).

The three following situations are acceptable substitutes for a hospital performing primary source verification of credentials:

1. **Applicable to hospitals overseen directly by governmental bodies,** the government's verification process, supported by the availability of published governmental regulations about primary source verification; plus, government licensure, or equivalent such as a registration; and the granting of specific status (**for example**, consultant, specialist, and others) are acceptable. As with all third-party verification processes, it is important to verify that the third party (**for example**, a government agency) implements the verification process as described in policy or regulations and that the process meets the expectations described in these standards.
2. **Applicable to all hospitals,** 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 (JCI) accreditation with "full compliance" on its verification process found in SQE.11.1, 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.
3. **Applicable to all hospitals,** the credentials have been verified by an independent third party, such as a designated, official, governmental, or nongovernmental agency, as long as the following conditions apply: Any hospital that bases its decisions in part on information from a designated, official, governmental, or nongovernmental agency should have confidence in the completeness, accuracy, and timeliness of that information. To achieve this level of confidence in the information, the hospital should evaluate the agency providing the information initially and then periodically thereafter to ensure that JCI standards continue to be met.

The hospital has a process that ensures that the credentials of each contract medical staff have also been collected, verified, and reviewed to ensure current medical competence prior to assignment. Various methods can be used to conduct primary source verification. Examples include secure websites, documented phone confirmation from the source, written confirmation, and third parties, such as a designated, official governmental or nongovernmental agency. The hospital collects and maintains a record of each medical staff member's credentials. The records contain current licenses when regulations require periodic renewal. There is documentation of training related to any additional competencies.

It is important to understand the process for issuing select credentials. Information to consider when determining the issuance of credentials:

- Does the government agency that issues the license to practice base its decision on any or all of the following:
  - verification of education
  - an examination of competence
  - training by a medical specialty association, or membership
  - payment of fees
- If admission to a specialty education program is based on verification of education and experience to date, the hospital does not need to verify education again.
- The process used by the government agency is documented by the hospital
- The hospital must perform its own verification if:
  - the hospital does not have direct knowledge of the process used by the agency to verify education

- the hospital has never had an opportunity to verify that the agency carries out the process as described

Exception for SQE.15.1, ME 1, for initial surveys only. At the time of the initial JCI accreditation survey, hospitals are required to have completed primary source verification for new medical staff members who joined the medical staff within the twelve (12) months leading up to the initial survey. During the twelve (12) months following the initial survey, hospitals are required to complete primary source verification for all other medical staff members. This process is accomplished over the 12-month postsurvey period according to a plan that places priority on the verification of the credentials of active medical staff providing high-risk services.

Note: This exception refers only to the verification of credentials. All medical staff members must have their credentials collected and reviewed, and their privileges granted. A "phasing in" of this process is not acceptable.

Measurable Elements of SQE.15.1

- ❑ 1. Education, licensure/registration, and other credentials required by law or regulation or issued by recognized education or professional entities as the basis for clinical privileges are verified from the original source that issued the credential.
- ❑ 2. Additional credentials required by hospital policy are verified from the source that issued the credential when required by hospital policy.
- ❑ 3. When third-party verification is used, the hospital verifies that the third party (**for example**, a government agency) implements the verification process as described in hospital policy and/or laws and regulations and that the process meets the following expectations:

  a) The hospital verifies that the third party implements the verification process as described in hospital policy or regulations and that the process meets the expectations described in these standards.

  b) The affiliated hospital that has already conducted primary source verification of the medical staff applicant is acceptable if the affiliated hospital has current Joint Commission International (JCI) accreditation with "full compliance" on its verification process found in SQE.11.1, MEs 1 and 2.

  c) The hospital who bases its decisions in part on information from a designated, official, governmental, or nongovernmental agency must evaluate the agency providing the information initially and then periodically thereafter to ensure that JCI standards continue to be met.

Standard SQE.15.2

There is a uniform decision process for the initial appointment of medical staff members and others permitted to practice independently.

Intent of SQE.15.2

Established processes and select criteria ensure validation in the granting of appointments for medical staff.

Guidance for SQE.15.2

Appointment is the process of reviewing an initial applicant's credentials to decide if the individual is qualified to provide patient care services that the hospital's patients need, and the hospital can support with qualified staff and technical capabilities. For initial applicants, the information reviewed is primarily from outside sources. Hospital policy identifies the individuals or mechanism accountable for this review, any criteria used to make decisions, and how decisions will be documented. Hospital policy identifies the process of appointment of medical staff for emergency needs or a temporary period. Emergency or temporary appointments and identification of privileges are not made until at minimum licensure has been verified.

Medical staff membership may not be granted if the hospital does not have the appropriate resources (i.e., special medical equipment or staff) to support the professional practice of the individual. **For example**, a nephrologist seeking to provide dialysis services at the hospital may not be granted medical staff membership if the hospital does not provide such services.

Finally, when an applicant's licensure/registration has been verified from the issuing source, but other documents—such as education and training—have yet to be verified, the individual may be granted medical staff membership, and privileges may be identified for the applicant for a period not to exceed 90 days. Under such circumstances, these individuals may not practice independently and require supervision until all credentials have been verified. Supervision is clearly defined in hospital policy as to level and conditions and is not to exceed 90 days.

Measurable Elements of SQE.15.2

- ❑ 1. Medical staff appointments are made consistent with hospital policy and are consistent with the hospital's patient population, mission, and the care, treatment, and services provided.
- ❑ 2. Appointments are not made until at least licensure/registration has been verified from the primary source, and the medical staff member then provides patient care services under supervision until all credentials required by laws and regulations have been verified from the original source, up to a maximum of 90 days.
- ❑ 3. The method of supervision, frequency of supervision, and accountable supervisors are documented in the credential record of the individual.

Medical Staff Clinical Privileges

Standard SQE.16

The hospital has a standardized, objective, evidence-based process to grant or deny privileges for medical staff members and others permitted to practice independently.

Intent of SQE.16

Privileging is the determination of a medical staff member's current clinical competence and deciding what clinical services the medical staff member will be permitted to perform. Privileging is a critical process that protects the safety of patients and to advance the quality of its clinical services. The hospital establishes a uniform process to manage the applications for the granting, renewal, or revision of medical staff clinical privileges to ensure that the expectations for the appointment of medical staff membership are consistently followed.

Guidance for SQE.16

Considerations for clinical privilege delineation at initial appointment include the following:

Decisions regarding a medical staff member's clinical competence and clinical privileges are based primarily on information and documentation received from sources outside the hospital. The sources may include

- specialty education programs,
- letters of recommendation from previous medical staff appointments and/or close colleagues,
- and any quality data that may be released to the hospital.

Sources of information, other than those from educational institutions such as medical specialty programs, are not verified from the source unless required by hospital policy. These sources are used to identify the areas of presumed competence. Ongoing professional practice evaluation validate the areas of presumed competence.

There is no one best way to delineate which clinical activities the new medical staff member is privileged to perform. Specialty training programs may identify and list the general competencies of that specialty in areas of diagnosis and treatment—with the hospital assigning privileges to diagnose and treat patients in those specialty competency areas. Other organizations may choose to list out in detail each type of patient and treatment procedure.

Within each specialty area the process of privilege delineation is uniform; however, this process may not be the same in all specialty areas. **For example**, the privileges will be different for general surgeons, pediatricians, dentists, or radiologists. The process for privilege delineation will be standardized within each specialty group. The privilege delineation identifies which "specialty" services can be provided by family practitioners, primary care practitioners, and others who provide a variety of general medicine, obstetrics, pediatrics, and other services.

The decision as to how clinical privileges are delineated in a specialty area is linked with other processes, including

- Selection by the department/service leaders of what processes are to be monitored through data collection
- Use of those data in the ongoing professional practice evaluation process of the medical staff in the department/service
- Use of the monitoring data in the process of reappointment and the renewal of privileges

In addition to the privileges granted in relation to the individual's education and training, the hospital identifies high risk areas for which the medical staff member is explicitly granted such privileges or denied such privileges, **for example:**

1. the administration of chemotherapeutic agents
2. other classes of high-risk drugs
3. high-risk procedures

The high-risk procedures, drugs, or other services are identified by each specialty area and evident in the privilege delineation process. Finally, some procedures may be high risk due to the instrumentation used, such as robotic and other computerized or remotely operated surgical or therapeutic equipment. Also, implantable medical devices require skills in implantation, calibration, and monitoring for which privileges should be specifically granted.

Privileges are not granted if the hospital does not have the special medical equipment or staff to support the exercise of a privilege. **For example**, robotic surgeries, a nephrologist competent to do dialysis, or a cardiologist competent to insert stents, are not privileged for these procedures if the hospital does not provide such services.

Finally, when an applicant's licensure/registration has been verified from the issuing source, but other documents—such as education and training—have yet to be verified, privileges are identified for the applicant. However, these applicants may not practice independently until all credentials have been verified by the processes described above. Such supervision is clearly defined in hospital policy as to level, conditions, and duration.

Hospital policy, laws and regulations, and/or other documents may stipulate that, in an emergency, any medical staff member with clinical privileges is permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm—regardless of their medical staff status or clinical privileges—provided that the care, treatment, and services provided are within the scope of the individual's license.

The clinical privileges of all medical staff members are made available by printed copy, electronic copy, or other means to individuals or locations (**for example**, operating room, emergency department) in the hospital where the medical staff member will provide services. The medical staff member is provided a copy of their clinical privileges. Updated information is communicated when the clinical privileges of a medical staff member change.

Measurable Elements of SQE.16

- ❑ 1. The privilege delineation process used by the hospital meets the following criteria:
  - a) Standardized, objective, and evidence-based
  - b) Documented in hospital policies
  - c) Active and ongoing as the credentials of medical staff members change
  - d) Followed for all classes of medical staff membership
  - e) Effectiveness of the process can be demonstrated

2. The hospital establishes criteria that determines a medical staff member's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested, including evaluation of the following:
   a) Current licensure and/or certification, as indicated, verified with the primary source
   b) The applicant's specific relevant training, verified with the primary source
   c) Evidence of physical ability to perform the requested privilege
   d) Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
   e) Peer and/or faculty recommendation
   f) When renewing privileges, review of medical staff member's performance within the hospital

❑ 3. The clinical privileges of all medical staff members are made available to those individuals or locations in the hospital in which the medical staff member will provide services.

❑ 4. Each medical staff member provides only those services that have been specifically granted by the hospital.

5. The hospital implements a process to respond to a patient's request for additional information about the medical staff member responsible for their care.

Medical Staff Evaluations

Standard SQE.17

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

Intent of SQE.17

The information collected during the ongoing professional practice evaluation process is factored into decisions to maintain, revise, or revoke existing privilege(s) prior to or at the end of the three-year renewal decision.

Guidance for SQE.17

Definitions and further explanations of terms and expectations found in these standards are as follows:

Ongoing Professional Practice Evaluation

The process of ongoing data collection for the purpose of assessing a medical staff member's clinical competence and professional behavior. The department/service leader is responsible for the integration of the data and information on medical staff and taking appropriate actions at different stages in the process **Examples** of actions are as follows:

Immediate: to counsel the staff member, place him or her under supervision, limit privileges, or other measures intended to limit risks to patients and improve quality of care and patient safety.

Longer-term: synthesizing the data and information into a recommendation for continued medical staff membership and clinical privileges.

Other: note to other medical staff members the benchmark behaviors and clinical results evident in the data and information of the medical staff member.

The ongoing professional practice evaluation (OPPE) of medical staff members provides critical information to the processes of maintaining medical staff membership and granting clinical privileges. Although three-year cycles are required for renewing medical staff membership and clinical privileges, the process is intended to be ongoing. Critical quality and patient safety incidents can arise if a medical staff member's clinical performance issues are not communicated and acted on when they arise.

The process of ongoing professional practice evaluation is intended to accomplish the following:

- Improve individual practices as they relate to high-quality, safe patient care

- Provide the basis for reducing variation within a department/service through comparisons among colleagues and the development of practice guidelines and clinical protocols.
- Provide the basis for improving the results of the entire department/service through comparisons with external benchmark practices and published research and clinical results.

The ongoing professional practice evaluation of medical staff members encompasses three general areas—behaviors, professional growth, and clinical results.

Behaviors

Medical staff members are models and mentors in creating a culture of safety in a hospital. A culture of safety, also known as a safety culture, is a culture comprised of skilled clinicians with beliefs, values, attitudes, perceptions, competencies, and patterns of behavior treat each other with respect and work in a collaborative environment; leaders drive effective teamwork and promote psychological safety; teams learn from errors and near misses; caregivers are aware of the inherent limitations of human performance in complex systems (stress recognition); and there is a visible process of learning and driving improvement through debriefings. Staff members are able to report concerns about safety or quality of care without fear of retaliation or marginalization from health care organization staff or leaders. Safety cultures also include high respect between professional groups in which disruptive and other behaviors do not occur. Staff feedback through surveys and other mechanisms can shape desired behaviors and can support medical staff role models.

An evaluation of behaviors can include the following:

- Evaluation of whether a medical staff member understands and supports the hospital's code of conduct and the identification of acceptable and unacceptable behaviors
- Absence of reported unacceptable behaviors by the medical staff member
- Collection, analysis, and utilization of data from staff surveys and other sources regarding the safety culture in the hospital

The ongoing professional practice evaluation process should indicate the relevant achievements and challenges of the medical staff member in efforts to be a full participant in a safety culture.

Professional Growth

Medical staff members grow and mature as the organizations in which they practice evolve and introduce new patient groups, technologies, and clinical science. Each medical staff member will reflect growth and improvement in the following six important dimensions of health care and professional practice:

- **Patient care**: including provision of patient care that is compassionate, appropriate, and effective for health promotion, disease prevention, treatment of disease, and care at the end of life.
  Examples of potential measures: frequency of preventive services and reports/complaints from patients and families.

- **Medical/clinical knowledge:** including knowledge of established and evolving biomedical, clinical, epidemiologic, and social-behavioral sciences, as well as the application of knowledge to patient care and the education of others.
  Examples of potential measures: application of clinical practice guidelines, including the adaptation and revision of guidelines; participation in professional conferences; and publications.

- **Practice-based learning and improvement**: including use of scientific evidence and methods to investigate, evaluate, and continuously improve patient care based on self-evaluation and lifelong learning.
  Examples of potential measures: self-motivated clinical inquiry/research, acquiring new clinical privileges based on study and acquiring new skills, and full participation in meeting professional specialty requirements or continuing education requirements of licensure.

- **Interpersonal and communication skills**: including establishment and maintenance of effective exchange of information and collaboration with patients, their families, and other members of health care teams.
  Examples of potential measures: participation in teaching rounds, team consultations, team leadership, and patient and family feedback.

- **Professionalism**: including commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward patients, their profession, and society.

  Examples of potential measures: an opinion leader within the medical staff on clinical and professional issues, service on an ethics panel or discussions of ethical issues, keeping appointed schedules, and community participation.

- **System-based practices**: including awareness of and responsiveness to the larger contexts and systems of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

  Examples of potential measures: understanding the meaning of frequently used hospitalwide systems, such as the medication system; and awareness of the implications of the overuse, underuse, and misuse of systems.

- **Stewardship of resources:** including understanding the need for stewardship of resources, and practicing cost-conscious care, including avoiding the overuse and misuse of diagnostic tests and therapies that do not benefit patient care but add to health care costs.

  Examples of potential measures: participation in key purchasing decisions within the medical staff member's practice area, participating in efforts to understand appropriate use of resources, and being aware of the cost to patients and payers of the services provided.

The ongoing professional practice evaluation process should recognize the relevant areas of achievement and potential improvement of the medical staff member in these professional growth areas.

Clinical Results

The ongoing professional practice evaluation process for a medical staff member reviews information common to all medical staff members as well as specific information related to the clinical privileges of the member and the services provided by their specialty. This evaluation is supported by a variety of data sources, including electronic and paper records, observations, and peer interactions.

Hospitalwide Data Sources

Hospitals collect a variety of data for use in management; **for example**, reporting to health authorities to support allocation of resources or payment of services. **Examples** of potential sources of data include length of stay, frequency of diagnostic testing, blood usage, and usage of certain drugs.

Department-Specific Data Sources

Data are also collected at the level of each department/service. The department/service leader sets the priorities for measurement in the department for purposes of monitoring as well as improvement. The measures are specific to the services provided and the clinical privileges of the individual medical staff members within the department. **Examples** of potential department/service data include frequency of clinical procedures performed, complications, outcomes, and use of resources such as consultants, among others.

It is likely that organizations collect data on key services on the department level for which all or most department/service staff members have privileges. Thus, there is no one set of data that will suffice to monitor and evaluate all medical staff members. The choice of data, the frequency of monitoring and analysis, and the actual use of the data and documentation in the personnel record of the medical staff member are very specific to the department/service, to the relevant profession, and to the privileges of the medical staff member.

A final step in the process is to ask the question: "How is this medical staff member doing compared to other colleagues within their department, and in comparison, with professional colleagues across other hospitals, regions, or countries?" This achieves the following:

Internal comparison: to reduce variation in practice and outcomes within the department and learn from the best practices within the department.

External comparison: to ensure that the hospital achieves best practices within the respective profession.

Each department will have knowledge of those professional databases, clinical practice guidelines, and scientific literature sources that describe those desirable benchmark practices. **For example**, oncology registries can be helpful, or data from medical staff

using the same science (clinical practice guidelines). Similarly, a national or international surgical society may collect outcome or complication data.

To be useful in the ongoing evaluation of an individual department/service medical staff member, both hospitalwide and department/service data must meet the following criteria:

- Collected in a manner that identifies the individual medical staff member
- Relates to the clinical practice of the individual medical staff member
- Benchmarked within the department/service, within the hospital, and, as possible, externally to understand individual medical staff member patterns.

The medical staff member ongoing professional practice evaluation process achieves the following:

- Is standardized by type of medical staff member and/or department or clinical services unit.
- Uses the monitoring data and information for:
    - Internal comparisons to reduce variation in behaviors, professional growth, and clinical results.
    - External comparisons with available, objective, evidence-based best practice or benchmark sources of clinical result data and information
- At least one review is conducted during a 12-month period, according to hospital policy, with the monitoring and evaluation of medical staff members intended as an ongoing process.
- Is conducted by the individual's department or service head, senior medical manager, or a medical staff review body.
- Results of reviews, actions taken, and the impact of those actions on privileges (if any) will be documented in the medical staff member's record.

Measurable Elements of SQE.17

- ❑ 1. All medical staff members are included in an ongoing professional practice evaluation process and standardized evaluation at the department/service level as defined by hospital policy.
- ❑ 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.
- ❑ 3. The data and information from the monitoring are reviewed at least every 12 months by the individual's department or service head, senior medical manager, or medical staff body, and the results, conclusions, and any actions taken are documented in the medical staff member's credential record and other relevant records.
- ❑ 4. Hospitalwide and department/service data sources are utilized in ongoing evaluations of individual medical staff members. These data meet the following criteria:
    a) Collected in a manner that readily identifies the individual medical staff member
    b) Relates to the clinical practice of the individual medical staff member
    c) Benchmarked internally and, as available, externally to understand individual medical staff member patterns
- ❑ 5. When the findings affect the appointment or privileges of the medical staff member, there is a process to act on the findings, and such "for cause" actions are documented in the medical staff member's record and are reflected in the list of clinical privileges. Notification is sent to those sites in which the medical staff member provides services.

Standard SQE.18

Hospital leaders define the circumstances requiring monitoring and evaluation of a medical staff member's professional performance.

Intent for SQE.18

Focused professional practice evaluation (FPPE) is defined as a process that evaluates the privilege-specific competence of the medical staff member who does not have documented evidence of competently performing the requested privilege(s) at the

hospital. This process may also be used when a question arises regarding a currently privileged medical staff member's ability to provide safe, high quality patient care.

Guidance for SQE.18

The focused evaluation process is defined by the hospital's policy and includes the time period of the evaluation and other criteria as indicated. The criteria that indicate the need for performance monitoring are clearly defined. These criteria can be single incidents or evidence of a clinical practice trend, and other existing privileges in good standing should not be affected by this decision.

A period of FPPE is required for all new privileges, including privileges requested by new applicants and all newly requested privileges for existing medical staff. Exemptions based on board certification, documented experience, or reputation are prohibited. The focused professional practice evaluation accomplishes the following:

- Evaluates the medical staff member and other clinical staff without current performance documentation at the organization
- Evaluates the medical staff member and other clinical staff in response to concerns regarding the provision of safe, high-quality patient care
- Develops criteria for extending the evaluation period
- Communicates to the appropriate parties the evaluation results and recommendations based on results
- Implements changes to improve performance

FPPE begins at the time privileges are granted, regardless of which process was followed (**for example,** temporary, expedited, full privileges, etc.). Both qualitative and quantitative data are considered when designing the process.
Qualitative or "categorical" data are non-numerical data often collected through methods such as observations, discussions, record review, monitoring of diagnostic and treatment techniques, etc. **Examples** may include:

- Description of procedures performed
- Periodic record review
  - quality/accuracy of documentation
  - appropriateness of tests ordered / procedures performed
  - patient outcomes
- Types of patient complaints
- Code of conduct breaches
- Peer recommendations
- Discussion with individuals involved in patient care, treatment, or services (**for example,** consultants, surgical assistants, nursing, administration, etc.)

Quantitative data often represent a certain quantity, amount, or range and are generally expressed as a unit of measure. Contrasted with qualitative data, quantitative data generally relates to data in the form of numerical quantities such as measurements, counts, percentage compliant, ratios, thresholds, intervals, time frames, etc.
Examples may include:

- Length of stay trends
- Post-procedure infection rates
- Periodic Record Review
  - Date/time/signature entries
  - T.O./V.O. authenticated within defined time frame
  - Presence/absence of required information (history and physical assessments elements, etc.)
- Number of history and physical assessments / updates completed within 24 hours after patient admission/registration
- Compliance with medical staff laws, regulations, policies, etc.
- Documenting the minimum required elements of a history and physical assessments / update.
- Compliance with core measures

Data could represent either (or both) qualitative and quantitative information, depending on how the data is utilized. Relevant information resulting from the focused evaluation process is integrated into performance improvement activities, consistent with the hospital's policies and procedures that are intended to preserve confidentiality and privilege of information. The data source used for the FPPE process must include medical staff member activities performed at the organization where privileges have been requested and may include activities performed at any location under the hospital's accreditation. In a multihospital system, where each hospital operates independently under separate accreditations, data from those hospitals may be used to supplement local data. In addition, when medical staff activity at the 'medical staff member's main hospital is low or limited, supplemental data may be used from another JCI organization where the medical staff member holds the same privileges. The use of supplemental data may NOT be used in lieu of a process to capture local data. Organizations choosing to use supplemental data should assess and determine the supplemental data's relevance, timeliness, and accuracy.

Measurable Elements of SQE.18

1. A period of focused professional practice evaluation is implemented for all initially requested privileges.
2. Criteria are developed for evaluating the performance of the medical staff member or other medical staff when issues affecting the provision of safe, high quality patient care are identified.
3. The performance monitoring process is clearly defined and includes each of the following elements:
   a) Criteria for conducting performance monitoring
   b) Method for establishing a monitoring plan specific to the requested privilege
   c) Method for determining the duration of performance monitoring
   d) Circumstances under which monitoring by an external source is required
4. Focused professional practice evaluation is consistently implemented consistent with the criteria and process defined by the hospital policy.
5. The measures employed to resolve performance issues are clearly defined and implemented.

Medical Staff Temporary Appointment of Clinical Privileges

Standard SQE.19

Hospital leaders grant temporary clinical privileges to medical staff for a limited period of time and for circumstances as defined by hospital policy.

Intent of SQE.19

Temporary clinical privileges to a medical staff member may be granted by hospital leaders for specified reasons. These temporary privileges are for a limited time for circumstances defined by hospital policy and consistent with laws and regulations.

Guidance for SQE.19

There are two circumstances in which temporary privileges may be granted. Each circumstance has different criteria for granting privileges. The circumstances for which the granting of temporary privileges is acceptable are:

- To fulfill a specific patient care, treatment, and service need
- When an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the medical staff executive committee and the governing body

An applicant for new privileges is defined as an individual who is:

- Applying for clinical privileges at the hospital for the first time
- Currently holding clinical privileges who is requesting one or more additional privileges

- In the reappointment/ reprivileging process and is requesting one or more additional privileges

Hospital policy, laws and regulations, and/or other documents may stipulate that, in an emergency, any medical staff member with clinical privileges is permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm—regardless of their medical staff status or clinical privileges—provided that the care, treatment, and services provided are within the scope of the individual's license.

Measurable Elements of SQE.19

1. Temporary privileges are granted for the following circumstances:
   a) To fulfill a specific patient care, treatment, or service need
   b) When an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the medical staff executive committee and the governing body
2. When temporary privileges are granted to meet a specific need, the organized medical staff verifies current licensure and current competence.
3. Temporary privileges for applicants for new privileges may be granted while awaiting review and approval by the organized medical staff upon verification of the following:
   a) Current licensure
   b) Relevant training or experience
   c) Current competence
   d) Ability to perform the privileges requested
   e) Other criteria required by applicable laws and regulations
   f) A query and evaluation of any relevant medical staff data bank or platform information
   g) A complete application
   h) No current or previously successful challenge to licensure or registration
   i) No subjection to involuntary termination of medical staff membership at another organization
   j) No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
4. All temporary privileges are granted by the designated hospital leader per hospital policy.
5. All temporary privileges are granted on the recommendation of the medical staff leader or authorized designee per hospital policy.
6. Temporary privileges for applicants applying for new privileges are granted for a maximum of 120 days.

Medical Staff Reappointment and Renewal of Clinical Privileges

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Standard SQE.20

At minimum every three years, the hospital decides to grant, deny and/or modify requested medical staff membership and clinical privileges.

Intent of SQE.20

The hospital determines if medical staff membership and clinical privileges are to continue with or without modification.

Guidance for SQE.20

Explanations of terms and expectations found in these standards are as follows:

Reappointment

Reappointment is the process of reviewing, at least every three years, the medical staff member's record to verify the following:

- Active licensure
- Medical staff member is not compromised by disciplinary actions of licensing and certification agencies
- Record contains sufficient documentation for seeking new or expanded privileges or duties in the hospital
- Medical staff member is physically and mentally able to provide patient care and treatment without supervision

The information for this review is collected from the internal, ongoing professional practice evaluation of the medical staff member, as well as from external sources such as regulatory or professional organizations or agencies. Hospital policy identifies the individual (such as the leader of a specialty service) or mechanism (such as a medical staff or department office when a department/service leader is not present or accountable for this review), any criteria used to make decisions, and how decisions will be documented. The information in the credential record of a medical staff member should be reviewed on an ongoing basis.

For example, when a medical staff member presents a certificate of achievement related to an advanced degree or advanced specialty training, the new credential should be immediately verified from the issuing source. Similarly, when an outside agency investigates a sentinel event related to a medical staff member and issues sanctions, this information should be used promptly to reevaluate the clinical privileges of the medical staff member. To ensure that medical staff records are complete and accurate, the records are reviewed at least every three years, and a note in the record indicates any actions taken or that no action is necessary and the appointment to the medical staff continues.

Considerations for clinical privilege delineation at reappointment include the following:

- Medical staff members may be granted additional privileges based on advanced education and training. The education and training are verified from the source providing the education or training or issuing the credential. The full exercise of the added privilege may be delayed until the verification process is complete or when there is a required period of supervised practice prior to granting an unrestricted new privilege; **for example**, a required number of supervised cases of robotic surgery.
- Medical staff members may have their privileges continued, limited, reduced, or terminated based on the following:
    - Results of the ongoing professional practice review process
    - Limitations placed on the individual's privileges by an outside professional, governmental, or regulatory agency
    - Hospital's findings from an evaluation of a sentinel or other event
    - Health of the medical staff member
    - Request of the medical staff member

Measurable Elements of SQE.20

- ❑ 1. the hospital determines if medical staff membership and clinical privileges are to continue with or without modification based on the ongoing professional practice evaluation of the medical staff member at least every three years.
- ❑ 2. Each medical staff member's personnel file contains evidence that all credentials are current.
- ❑ 3. Medical staff member personnel files contain any credentials obtained subsequent to initial appointment and include evidence of primary source verification prior to use in modifying or adding to clinical privileges.
- 4. Medical staff members and other clinical staff requesting privileges are notified regarding the granting decision. In the case of privilege denial, the applicant is informed of the reason for denial.
- 5. The hospital has implemented a process to disseminate all granting, modification, or restriction decisions to all appropriate internal and external persons or entities, as defined by hospital policy and applicable laws and regulations.
- ❑ 6. The renewal decision is documented in the medical staff member's credential record and includes the identification of the reviewer and any special conditions identified during the review.

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**Not a complete literature review*