The hospital engages in planning activities prior to developing its written Emergency Operations Plan. Note: An emergency is an unexpected or sudden event that significantly disrupts the organization’s ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand for the organization’s services. Emergencies can be either human-made (for example, an electrical system failure or cyberattack) or natural (for example, a tornado or an infectious disease outbreak such as Ebola, Zika, influenza), or a combination of both, and they exist on a continuum of severity. A disaster is a type of emergency that, due to its complexity, scope, or duration, threatens the organization’s capabilities and requires outside assistance to sustain patient care, safety, or security functions.

Element(s) of Performance for EM.01.01.01

4. The hospital communicates its needs and vulnerabilities to community emergency response agencies and identifies the community’s capability to meet its needs. This communication and identification occur at the time of the hospital’s annual review of its Emergency Operations Plan and whenever its needs or vulnerabilities change. (See also EM.03.01.01, EP 1)

4. The hospital communicates its needs and vulnerabilities to community emergency response agencies and identifies the community’s capability to meet its needs. This communication and identification occur at the time of the hospital’s review of its Emergency Operations Plan, which occurs at least every two years and whenever its needs or vulnerabilities change. (See also EM.03.01.01, EP 1)

EM.02.01.01

Key: ☐ indicates that documentation is required; ☐ indicates an identified risk area;
The hospital has an Emergency Operations Plan. 
Note: The hospital’s Emergency Operations Plan (EOP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, EM.02.02.09, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This all-hazards approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan’s response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.

**Element(s) of Performance for EM.02.01.01**

13. For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital has one or more transplant centers (see Glossary), the following must occur:
   - A representative from each transplant center must be included in the development and maintenance of the hospital’s emergency preparedness program
   - The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant center, and the organ procurement organization (OPO) for the donation service area where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency

13. For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital has one or more transplant programs (see Glossary), the following must occur:
   - A representative from each transplant program must be included in the development and maintenance of the hospital’s emergency preparedness program
   - The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant program, and the organ procurement organization (OPO) for the donation service area where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency

16. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has one or more emergency management policies based on the emergency plan, risk assessment, and communication plan. Procedures guiding implementation are defined in the emergency management plan, continuity of operations plan, and other preparedness and response protocols. Policy and procedure documents are reviewed and updated on an annual basis; the format of these documents is at the discretion of the hospital.

16. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has one or more emergency management policies based on the emergency plan, risk assessment, and communication plan. Procedures guiding implementation are defined in the emergency management plan, continuity of operations plan, and other preparedness and response protocols. Policy and procedure documents are reviewed and updated at least every two years; the format of these documents is at the discretion of the hospital.

**EM.02.02.01**

As part of its Emergency Operations Plan, the hospital prepares for how it will communicate during emergencies.

**Element(s) of Performance for EM.02.02.01**
22. For hospitals that use Joint Commission accreditation for deemed status purposes: The organization maintains documentation of completed and attempted contact with the local, state, tribal, regional, and federal emergency preparedness officials in its service area. This contact is made for the purpose of communication and, where possible, collaboration on coordinated response planning for a disaster or emergency situation.

Note: Examples of these contacts may be written or e-mail correspondence; in-person meetings or conference calls; regular participation in health care coalitions, working groups, boards, and committees; or educational events sponsored by a third party (such as a local or state health department).

22. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a process for cooperation and collaboration with the local, state, tribal, regional, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.

EM.02.02.07

As part of its Emergency Operations Plan, the hospital prepares for how it will manage staff during an emergency.

Element(s) of Performance for EM.02.02.07

13. For hospitals that use Joint Commission accreditation for deemed status purposes: Initial and ongoing training relevant to their emergency response roles is provided to staff, volunteers, and individuals providing on-site services under arrangement. This training is documented and then reviewed and updated annually and when these roles change. Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization.

13. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides emergency preparedness training to staff, volunteers, and individuals providing on-site services under arrangement at the following intervals:
- Initial training
- At least every two years
- When roles or responsibilities change
- When policies and procedures are significantly updated

This training is documented.

Note: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization.

21. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has an emergency preparedness training program based on its Emergency Operations Plan. This training program is reviewed and updated at least every two years.

EM.03.01.01

The hospital evaluates the effectiveness of its emergency management planning activities.

Element(s) of Performance for EM.03.01.01

Key: ☐ indicates that documentation is required; ☐ indicates an identified risk area;
1. The hospital conducts an annual review of its risks, hazards, and potential emergencies as defined in its hazard vulnerability analysis (HVA). The findings of this review are documented. (See also EM.01.01.01, EPs 2 and 4)

1. The hospital conducts a review at least every two years of its risks, hazards, and potential emergencies as defined in its hazard vulnerability analysis (HVA). The findings of this review are documented. (See also EM.01.01.01, EPs 2 and 4)

2. The hospital conducts an annual review of the objectives and scope of its Emergency Operations Plan. The findings of this review are documented.

2. The hospital conducts a review at least every two years of the objectives and scope of its Emergency Operations Plan. The findings of this review are documented.

4. The annual emergency management planning reviews are forwarded to senior hospital leadership for review. (See also LD.04.01.10, EP 2)
   Note: Senior hospital leadership refers to those leaders with responsibility for organizationwide strategic planning and budgets (vice presidents and officers). The hospital may determine that all senior hospital leaders participate in reviewing emergency management reviews, or it may designate specific senior hospital leaders to review this information.

4. At least every two years, the emergency management planning reviews are forwarded to senior hospital leadership for review. (See also LD.04.01.10, EP 2)
   Note: Senior hospital leadership refers to those leaders with responsibility for organizationwide strategic planning and budgets (vice presidents and officers). The hospital may determine that all senior hospital leaders participate in reviewing emergency management reviews, or it may designate specific senior hospital leaders to review this information.

**EM.03.01.03**

The hospital evaluates the effectiveness of its Emergency Operations Plan.

**Element(s) of Performance for EM.03.01.03**

1. As an emergency response exercise, the hospital activates its Emergency Operations Plan twice a year at each site included in the plan.
   Note 1: If the hospital activates its Emergency Operations Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises.
   Note 2: Staff in freestanding buildings classified as a business occupancy (as defined by the Life Safety Code®) that do not offer emergency services nor are community designated as disaster-receiving stations need to conduct only one emergency management exercise annually.
   Note 3: Tabletop sessions, though useful, are not acceptable substitutes for these exercises.
   Note 4: In order to satisfy the twice-a-year requirement, the hospital must first evaluate the performance of the previous exercise and make any needed modifications to its Emergency Operations Plan before conducting the subsequent exercise in accordance with EPs 13–17.

Footnote *: The Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA. Refer to NFPA 101-2012 for occupancy classifications.

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Key: D indicates that documentation is required; R indicates an identified risk area;
2. For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital’s two emergency response exercises includes an influx of simulated patients.
   Note 1: Tabletop sessions, though useful, cannot serve for this portion of the exercise.
   Note 2: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 3 and 4.

3. For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital’s two emergency response exercises includes an escalating event in which the local community is unable to support the hospital.
   Note 1: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 2 and 4.
   Note 2: Tabletop sessions are acceptable in meeting the community portion of this exercise.

3. The hospital conducts exercises to test the emergency plan at least twice per year.
   The first annual exercise is selected from one of the following:
   - A full-scale, community-based exercise
   - When a community-based exercise is not possible, a facility-based, functional exercise

   The second annual exercise includes, but is not limited to, one of the following:
   - A second full-scale, community-based exercise
   - A second facility-based, functional exercise
   - Mock disaster drill
   - Tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan
   Note 1: If the hospital experiences an actual emergency (natural or man-made) that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full-scale, community-based exercise or facility-based, functional exercise following the onset of the emergency event.
   Note 2: See the Glossary for the definitions of community-based exercise, full-scale exercise, and functional exercise.

4. For each site of the hospital with a defined role in its community’s response plan, at least one of the two emergency response exercises includes participation in a communitywide exercise.
   Note 1: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 2 and 3.
   Note 2: Tabletop sessions are acceptable in meeting the community portion of this exercise.

**EM.04.01.01**

For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital is part of a health care system that has an integrated emergency preparedness program, and it chooses to participate in the integrated emergency preparedness program, the hospital participates in planning, preparedness, and response activities with the system.

**Element(s) of Performance for EM.04.01.01**

Key: ☑ Indicates that documentation is required; ✋ Indicates an identified risk area;
1. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital demonstrates its participation in the development of its system’s integrated emergency preparedness program through the following:
   - Designation of a staff member(s) who will collaborate with the system in developing the program
   - Documentation that the hospital has reviewed the community-based risk assessment developed by the system’s integrated all-hazards emergency management program
   - Documentation that the hospital’s individual risk assessment is incorporated into the system’s integrated program
   - Documentation that the hospital’s patient population, services offered, and any unique circumstances of the hospital are reflected in the system’s integrated program
   - Documentation of an integrated communication plan, including information on key contacts in the system’s integrated program
   - Documentation that the hospital participates in the annual review of the system’s integrated program

Human Resources (HR) Chapter

HR.01.01.01

The hospital defines and verifies staff qualifications.

Element(s) of Performance for HR.01.01.01

17. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The activities program is directed by a professional who meets one of the following criteria:
   - Is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the state in which he or she practices and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990
   - Has two years of experience in a social or recreational program within the last five years, one year of which was full time in a patient activities program in a health care setting
   - Is a qualified occupational therapist or occupational therapy assistant
   - Has completed a training course approved by the state

Infection Prevention and Control (IC) Chapter

Key: ☐ indicates that documentation is required; R indicates an identified risk area;
IC.01.01.01

The hospital identifies the individual(s) responsible for the infection prevention and control program.

Element(s) of Performance for IC.01.01.01

4. For hospitals that use Joint Commission accreditation for deemed status purposes: The individual with clinical authority over the infection prevention and control program is responsible for the following:
   - Developing policies governing control of infections and communicable diseases
   - Implementing policies governing control of infections and communicable diseases
   - Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases

4. For hospitals that use Joint Commission accreditation for deemed status purposes: The individual with clinical authority over the infection prevention and control program is responsible for the following:
   - Developing and implementing hospital-wide infection surveillance, prevention and control policies and procedures that adhere to nationally recognized guidelines
   - Documenting the infection prevention and control program surveillance, prevention, and control activities
   - Communicating and collaborating with the quality assessment and performance improvement program on infection prevention and control issues
   - Training and educating staff, including medical staff, on the practical applications of infection prevention and control guidelines, policies, and procedures
   - Preventing and controlling health care–associated infections, including auditing of adherence to infection prevention and control policies and procedures by hospital staff, including medical staff
   - Communicating and collaborating with the antibiotic stewardship program

6. For hospitals that use Joint Commission accreditation for deemed status purposes: An individual(s) who is qualified through education, training, experience, or certification in infection, prevention, and control is appointed by the governing body to be responsible for the infection, prevention, and control program. The appointment is based on recommendations of medical staff leadership and nursing leadership.

Leadership (LD) Chapter

LD.01.02.01

The hospital identifies the responsibilities of its leaders.

Element(s) of Performance for LD.01.02.01

4. For hospitals that use Joint Commission accreditation for deemed status purposes: The chief executive officer, medical staff, and nurse executive make certain that the hospitalwide quality assessment and performance improvement and training programs address problems identified by the individual responsible for infection prevention and control and that corrective action plans are successfully implemented. (See also IC.03.01.01, EP 7)

LD.01.03.01

Key: □ indicates that documentation is required; □ indicates an identified risk area;
The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

**Element(s) of Performance for LD.01.03.01**

14. For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital is part of a system consisting of multiple separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member hospitals after determining that such decision is in accordance with all applicable state and local laws. The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 482.21.

Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program has the following characteristics:
- Structured in a manner that accounts for each member hospital’s unique circumstances and any significant differences in patient populations and services offered in each hospital
- Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated program has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed

27. For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital is part of a hospital system consisting of separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member hospitals after determining that such a decision is in accordance with applicable law and regulation. The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meet all of the requirements at 42 CFR 482.42(d).

Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program have the following characteristics:
- Structured in a manner that accounts for each member hospital’s unique circumstances and any significant differences in patient populations and services offered at each hospital
- Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified hospital, regardless of practice or location, are given due consideration
- Have mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed
- A qualified individual(s) with expertise in infection prevention and control and in antibiotic stewardship has been designated at the hospital as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to hospital staff

**LD.03.02.01**

Key: ☑ indicates that documentation is required; ☐ indicates an identified risk area;
The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

**Element(s) of Performance for LD.03.02.01**

4. For hospitals that use Joint Commission accreditation for deemed status purposes: The quality assessment and performance improvement program incorporates quality indicator data, including patient care data and other relevant data such as that submitted to or received from Medicare quality reporting and quality performance programs (for example, data related to hospital readmissions and hospital-acquired conditions).

**Medication Management (MM) Chapter**

**MM.05.01.07**

The hospital safely prepares medications.

**Element(s) of Performance for MM.05.01.07**

5. For hospitals that use Joint Commission accreditation for deemed status purposes: Medications are prepared and administered in accordance with the orders of a licensed independent practitioner or other practitioner responsible for the patient's care, and in accordance with hospital policies; medical staff bylaws, rules, and regulations; and law and regulation. 

Footnote *: For law and regulation guidance pertaining to those responsible for the care of patients, refer to 42 CFR 482.12(e).

5. For hospitals that use Joint Commission accreditation for deemed status purposes: Medications are prepared and administered in accordance with the orders of a licensed independent practitioner or other practitioner responsible for the patient's care, and in accordance with hospital policies; medical staff bylaws, rules, and regulations; and law and regulation.

**MM.09.01.01**

The hospital has an antimicrobial stewardship program based on current scientific literature.

**Element(s) of Performance for MM.09.01.01**

7. The hospital collects, analyzes, and reports data on its antimicrobial stewardship program. Note: Examples of topics on which to collect and analyze data may include evaluation of the antimicrobial stewardship program, antimicrobial prescribing patterns, and antimicrobial resistance patterns.

7. The hospital collects, analyzes, and reports data on its antimicrobial stewardship program. Note 1: Examples of topics on which to collect and analyze data may include evaluation of the antimicrobial stewardship program, antimicrobial prescribing patterns, and antimicrobial resistance patterns. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The antibiotic stewardship program documents the evidence-based use of antibiotics in all departments and services of the hospital.

**Key:** 说得 indicates that documentation is required; 说得 indicates an identified risk area;
9. For hospitals that use Joint Commission accreditation for deemed status purposes: An individual(s) who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body as the leader(s) of the antibiotic stewardship program. The appointment is based on recommendations of medical staff leadership and pharmacy leadership.

10. For hospitals that use Joint Commission accreditation for deemed status purposes: The antibiotic stewardship program demonstrates coordination among all components of the hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the quality assessment and performance improvement program, the medical staff, nursing services, and pharmacy services.

11. For hospitals that use Joint Commission accreditation for deemed status purposes: The leader of the antibiotic stewardship program is responsible for the following:
   - Developing and implementing a hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics
   - Documenting antibiotic stewardship activities
   - Communicating and collaborating with the medical staff, nursing, and pharmacy leadership, as well as with the hospital’s infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues
   - Training and educating staff, including medical staff, on the practical applications of antibiotic stewardship guidelines, policies, and procedures

Medical Staff (MS) Chapter

**MS.01.01.01**

Medical staff bylaws address self-governance and accountability to the governing body.

**Element(s) of Performance for MS.01.01.01**
16. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. (For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6–11.)

Note 1: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Note 2: The requirements referred to in this element of performance are, at a minimum, those described in the element of performance and Standard PC.01.02.03, EPs 4 and 5.

38. For hospitals that use Joint Commission accreditation for deemed status purposes: When the medical staff has chosen to allow an assessment, in lieu of a comprehensive medical history and physical examination, for patients receiving specific outpatient surgical or procedural services, the medical staff bylaws specify that an assessment of the patient is completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the patient is receiving specific outpatient surgical or procedural services. Note: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(i), (ii), (iii), and (v). Refer to “Appendix A: Medicare Requirements for Hospitals” (AXA) for full text.

**MS.03.01.01**

The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

**Element(s) of Performance for MS.03.01.01**

**Key:** [ ] indicates that documentation is required; [ ] indicates an identified risk area;
19. For hospitals that use Joint Commission accreditation for deemed status purposes: If the medical staff chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements would apply, in lieu of a comprehensive medical history and physical examination, the policy is based on the following:
- Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure
- Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures
- Applicable state and local health and safety laws

Note: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii). Refer to “Appendix A: Medicare Requirements for Hospitals” (AXA) for full text.
(See also PC.01.02.03, EP 5)

**MS.05.01.01**

The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.

**Element(s) of Performance for MS.05.01.01**

17. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital attempts to secure autopsies in all cases of unusual deaths and cases of medical, legal, and educational interest, and informs the medical staff (specifically the attending physician or clinical psychologist) of autopsies that the hospital intends to perform.

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

**Nursing (NR) Chapter**

**NR.02.03.01**

The nurse executive directs the implementation of nursing policies and procedures, nursing standards, and a nurse staffing plan(s).

**Element(s) of Performance for NR.02.03.01**

7. A registered nurse provides or supervises the nursing services 24 hours a day, 7 days a week.

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse is immediately available for the provision of bedside care of any patient.

7. A registered nurse provides or supervises the nursing services 24 hours a day, 7 days a week.

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse is immediately available for the provision of care of any patient.
For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has policies and procedures that establish which outpatient departments, if any, are not required to have a registered nurse present. The policies and procedures are as follows:

- Establish criteria that such outpatient departments need to meet, taking into account the types of services delivered, the general level of acuity of patients served by the department, and established standards of practice for the services delivered
- Describe alternative staffing plans
- Approved by the director of nursing
- Reviewed at least once every three years

Provision of Care, Treatment, and Services (PC) Chapter

**PC.01.02.03**

The hospital assesses and reassesses the patient and his or her condition according to defined time frames.

**Element(s) of Performance for PC.01.02.03**

4. The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 6; RC.02.01.03, EP 3)

4. The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 6; RC.02.01.03, EP 3)

**Note 1:** For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except any specific outpatient surgical or procedural services for which an assessment is performed instead.

**Note 2:** For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(ii) and 482.51(b)(1)(iii). Refer to “Appendix A: Medicare Requirements for Hospitals” (AXA) for full text.

5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)

5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

**Note 1:** For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except any specific outpatient surgical or procedural services for which an assessment is performed instead.

**Note 2:** For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(ii) and 482.51(b)(1)(iii). Refer to “Appendix A: Medicare Requirements for Hospitals” (AXA) for full text.

(See also MS.03.01.01, EPs 8, 19; RC.02.01.03, EP 3)
PC.02.01.03

The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

Element(s) of Performance for PC.02.01.03

1. For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. *

Note 1: Outpatient services may be ordered by a practitioner not appointed to the medical staff as long as he or she meets the following:
- Responsible for the care of the patient
- Licensed to practice in the state where he or she provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements
- Acting within his or her scope of practice under state law
- Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services

Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Patient diets, including therapeutic diets, are ordered by the practitioner responsible for the patient’s care, or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals.

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

PC.02.02.01

The hospital coordinates the patient’s care, treatment, and services based on the patient’s needs.

Element(s) of Performance for PC.02.02.01

Key: ☑ indicates that documentation is required; ☑ indicates an identified risk area;
8. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides activity services directly or through referral for ambulatory and nonambulatory residents at various functional levels.

12. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides 24-hour emergency dental services directly or through arrangement with an external provider.
   Note 1: The hospital may charge a Medicare resident an additional amount for routine and emergency dental services.
   Note 2: The hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan.

PC.03.05.05

The hospital initiates restraint or seclusion based on an individual order.

**Element(s) of Performance for PC.03.05.05**

1. A physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient’s ongoing care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation.
   Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

5. Unless state law is more restrictive, every 24 hours, a physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient’s ongoing care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with hospital policy and law and regulation.
   Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

PC.03.05.07

The hospital monitors patients who are restrained or secluded.

**Element(s) of Performance for PC.03.05.07**

Key: D indicates that documentation is required; R indicates an identified risk area;
1. Trained physicians, clinical psychologists, or other licensed independent practitioners or staff monitor the condition of patients in restraint or seclusion. (See PC.03.05.17, EPs 2–5 for training requirements)

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The training requirements in PC.03.05.17, EPs 2–5, are in accordance with 42 CFR 482.13(f).

PC.03.05.09

The hospital has written policies and procedures that guide the use of restraint or seclusion.

Element(s) of Performance for PC.03.05.09

1. The hospital's policies and procedures regarding restraint or seclusion include the following:
   - Physician, clinical psychologist, and other authorized licensed independent practitioner training requirements
   - Staff training requirements
   - The determination of who has authority to order restraint and seclusion
   - The determination of who has authority to discontinue the use of restraint or seclusion
   - The determination of who can initiate the use of restraint or seclusion
   - The circumstances under which restraint or seclusion is discontinued
   - The requirement that restraint or seclusion is discontinued as soon as is safely possible
   - A determination of who can assess and monitor patients in restraint or seclusion
   - Time frames for assessing and monitoring patients in restraint or seclusion
   - A definition of restraint
   - A definition of seclusion
   - A definition or description of what constitutes the use of medications as a restraint

Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of restraint or the use of medications as a restraint is in accordance with 42 CFR 482.13(e)(1)(i)(A–C):

42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 42 CFR 482.13(e)(1)(i)(B) (A restraint is— ) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of seclusion is in accordance with 42 CFR 482.13(e)(1)(ii):

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior.
1. The hospital’s policies and procedures regarding restraint or seclusion include the following:
   - Physician and other licensed practitioner training requirements
   - Staff training requirements
   - The determination of who has authority to order restraint and seclusion
   - The determination of who has authority to discontinue the use of restraint or seclusion
   - The determination of who can initiate the use of restraint or seclusion
   - The circumstances under which restraint or seclusion is discontinued
   - The requirement that restraint or seclusion is discontinued as soon as is safely possible
   - A determination of who can assess and monitor patients in restraint or seclusion
   - Time frames for assessing and monitoring patients in restraint or seclusion
   - A definition of restraint
   - A definition of seclusion
   - A definition or description of what constitutes the use of medications as a restraint

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Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital’s definition of seclusion is in accordance with 42 CFR 482.13(e)(1)(ii):

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior.

2. Physicians, clinical psychologists, and other licensed independent practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working knowledge of the hospital policy regarding the use of restraint and seclusion.

   Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

2. Physicians and other licensed practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working knowledge of the hospital policy regarding the use of restraint and seclusion.

PC.03.05.11

The hospital evaluates and reevaluates the patient who is restrained or secluded.

Element(s) of Performance for PC.03.05.11

Key: © indicates that documentation is required; R indicates an identified risk area;
1. A physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3.

Note 1: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.

Note 2: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

2. When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse or physician assistant, he or she consults with the attending physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy.

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

2. When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse, he or she consults with the attending physician or other licensed practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy.

PC.03.05.17

The hospital trains staff to safely implement the use of restraint or seclusion.

Element(s) of Performance for PC.03.05.17

4. Individuals providing staff training in restraint or seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion. (See also PC.03.05.07, EP 1)

4. Individuals providing staff training in restraint or seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion.
5. The hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed. (See also PC.03.05.07, EP-1)

5. The hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed.

**PC.03.05.19**

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports deaths associated with the use of restraint and seclusion.

**Element(s) of Performance for PC.03.05.19**

3. For hospitals that use Joint Commission accreditation for deemed status purposes: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the hospital does the following:
   - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient.
   - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient.
   - Documents in the patient record the date and time that the death was recorded in the log or other system.
   - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed independent practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es).
   - Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request.

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

3. For hospitals that use Joint Commission accreditation for deemed status purposes: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the hospital does the following:
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   - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient.
   - Documents in the patient record the date and time that the death was recorded in the log or other system.
   - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed independent practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es).
   - Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request.

**PC.04.01.01**

Key: D indicates that documentation is required; R indicates an identified risk area;
The hospital follows a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer.

**Element(s) of Performance for PC.04.01.01**

22. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient or the patient’s family of his or her freedom to choose among participating Medicare providers and, when possible, respects the patient’s and family’s preferences when they are expressed. The hospital does not limit the qualified providers that are available to the patient.

22. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient or the patient’s representative of his or her freedom to choose among participating Medicare providers and suppliers of post-discharge services and, when possible, respects the patient’s or patient representative’s goals of care and treatment preferences, as well as other preferences when they are expressed. The hospital does not limit the qualified providers who are available to the patient.

23. For hospitals that use Joint Commission accreditation for deemed status purposes: When the discharge planning evaluation indicates a need for home health care, the hospital includes in the discharge plan a list of participating Medicare home health agencies (which have requested to be on the list) that are available and serve the patient’s geographic area. For patients enrolled in managed care organizations, the hospital lists home health agencies that have a contract with the managed care organization.

24. For hospitals that use Joint Commission accreditation for deemed status purposes: When the discharge planning evaluation indicates a need for posthospital extended care services, the hospital includes in the discharge plan a list of participating Medicare skilled nursing facilities that are available and in the geographic area requested by the patient. For patients enrolled in managed care organizations, the hospital lists skilled nursing facilities that have a contract with the managed care organization.

25. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital documents in the patient’s medical record that the list of home health agencies or skilled nursing facilities was presented to the patient or to the individual acting on the patient’s behalf. The discharge plan identifies disclosable financial interests between the hospital and any home health agency or skilled nursing facility on the list.

Note: Disclosure of financial interest is determined in accordance with the provisions in 42 CFR 420.206.

25. For hospitals that use Joint Commission accreditation for deemed status purposes: The discharge plan identifies any home health agency or skilled nursing facility in which the hospital has a disclosable financial interest, and any home health agency or skilled nursing facility that has a disclosable financial interest in a hospital.

Note: Disclosure of financial interest is determined in accordance with the provisions in 42 CFR 420, subpart C and section 1861 of the Social Security Act.
31. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital assists patients, their families, or the patient’s representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency, skilled nursing facility, inpatient rehabilitation facility, and long term care hospital data on quality measures and resource-use measures. The hospital makes certain that the post-acute care data on quality measures and resource-use measures is relevant and applicable to the patient’s goals of care and treatment preferences.

33. For hospitals that use Joint Commission accreditation for deemed status purposes: For patients enrolled in managed care organizations, the hospital makes patients aware of the need to verify with their managed care organization which practitioners, providers, or certified suppliers are in the managed care organization’s network. If the hospital has information on which practitioners, providers, or certified suppliers are in the network of the patient’s managed care organization, it shares this information with the patient or the patient’s representative.

**PC.04.01.03**

The hospital discharges or transfers the patient based on his or her assessed needs and the organization’s ability to meet those needs.

**Element(s) of Performance for PC.04.01.03**

7. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has an effective discharge planning process that focuses on the patient’s goals and treatment preferences and includes the patient and his or her caregiver or support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process is consistent with the patient’s goals for care and his or her treatment preferences, makes certain that there is an effective transition of the patient from the hospital to post-discharge care, and reduces the factors leading to preventable hospital readmissions.

10. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital conducts reassessments of its discharge planning process within its established time frames for reassessment.

10. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital assesses its discharge planning process within its established time frames. The assessment includes ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to make certain that the plans are responsive to patient post-discharge needs.

11. For hospitals that use Joint Commission accreditation for deemed status purposes: The reassessment of the discharge planning process includes a review of discharge plans to determine if the discharge plans meet the needs of patients.

**Record of Care, Treatment, and Services (RC) Chapter**

**RC.02.01.01**

Key: ⚫ indicates that documentation is required; ⚪ indicates an identified risk area;
The medical record contains information that reflects the patient's care, treatment, and services.

**Element(s) of Performance for RC.02.01.01**

7. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Progress notes are recorded by the following individuals involved in the active treatment of the patient:
   - The doctor of medicine or osteopathy responsible for the care of the inpatient
   - A nurse
   - A social worker
   - Others involved in active treatment modalities
   The above individuals record progress notes at least weekly for the first two months of a patient’s stay and at least monthly thereafter. The progress notes include recommendations for revisions in the plan of care as indicated, as well as a precise assessment of the patient’s progress in accordance with the original or revised plan of care.

7. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Progress notes are recorded by the following individuals involved in the active treatment of the patient:
   - The physician(s), psychologist(s), or other licensed practitioner(s) responsible for the care of the inpatient
   - A nurse
   - A social worker
   - Others involved in active treatment modalities
   The above individuals record progress notes at least weekly for the first two months of a patient’s stay and at least monthly thereafter. The progress notes include recommendations for revisions in the plan of care as indicated, as well as a precise assessment of the patient’s progress in accordance with the original or revised plan of care.

**Rights and Responsibilities of the Individual (RI) Chapter**

**RI.01.07.07**

For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital protects the rights of patients and residents who work for or on behalf of the hospital.

For psychiatric hospital settings that provide longer term care (more than 30 days): The hospital protects the rights of patients and residents who work for or on behalf of the hospital.

**Element(s) of Performance for RI.01.07.07**

1. For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital follows a written policy that addresses situations in which patients and residents work for or on behalf of the hospital.

1. For psychiatric hospital settings that provide longer term care (more than 30 days): The hospital follows a written policy that addresses situations in which patients and residents work for or on behalf of the hospital.

Key:  ⬜ indicates that documentation is required;  ⚺ indicates an identified risk area;
3. For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Wages paid to patients and residents who work for or on behalf of the hospital are in accordance with law and regulation.

Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The plan of care specifies whether the work performed is voluntary or paid.

4. For psychiatric hospital settings that provide longer term care (more than 30 days): The hospital incorporates work performed by the patient or resident for or on behalf of the hospital into the plan of care.

5. For psychiatric hospital settings that provide longer term care (more than 30 days): Patients and residents have the right to refuse to work for or on behalf of the hospital.