Effective 1 April 2014

Joint Commission International Accreditation Standards for Hospitals

Including Standards for Academic Medical Center Hospitals

5th Edition
Joint Commission International

A division of Joint Commission Resources, Inc.

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Printed in the U.S.A. 5 4 3 2 1

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ISBN: 978-1-59940-787-6
Library of Congress Control Number: 2013948698

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Joint Commission International Accreditation Standards for Hospitals, 5th Edition
Joint Commission International (JCI) is proud to present this fifth edition of its international standards for hospitals. Our customers have told us clearly and repeatedly they want standards that are challenging, achievable, and focused on the safety and quality of patient care. We have listened and we believe these standards exceed those expectations.

In this edition, we are publishing fewer standards and requirements than we have since our second set of standards were published in 2002. We have combined similar requirements, eliminated others that we did not consider essential to better patient outcomes, and reorganized the content across many chapters to ensure a better, more logical flow of requirements. We have provided more examples of proper compliance within the standards’ intents to ensure that our requirements are clear. We have also included two chapters of standards for Academic Medical Center Hospitals, consolidating all of our requirements for our hospital customers in one place.

We are thankful for the input and feedback we received from our esteemed Standards Advisory Panel, which reviewed, informed, and otherwise guided us through the development of these standards. We are grateful to our customers, who responded in record numbers to our field review, confirming that we were headed in the right direction with our proposed standards and making us think longer and more fully about other requirements, all of which eventually pushed us to do our jobs better and in a more patient-centric way.

We hope you appreciate the effort that we put into this edition of standards. As always, let us know what you think—your opinion is as much on these pages as ours is.

Paula Wilson
President and CEO
Joint Commission International and Joint Commission Resources
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Joint Commission International also thanks Ana Tereza Cavalcanti de Miranda, MD, PhD, MBA, Rio de Janeiro, Brazil, for her contributions to the Standards Advisory Panel.
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Introduction

This fifth edition of the Joint Commission International Accreditation Standards for Hospitals contains the standards, intents, measurable elements (MEs), a summary of key changes to this edition of the Joint Commission International (JCI) hospital standards, a summary of key accreditation policies and procedures, a glossary of key terms, and an index. This Introduction is designed to provide you with information on the following topics:

- The origin of these standards
- How the standards are organized
- How to use this standards manual
- What is new in this edition of the manual

If, after reading this publication, you have questions about the standards or the accreditation process, please contact JCI:

+1-630-268-7400
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How were the standards developed and refined for this fifth edition?

A 13-member Standards Advisory Panel, composed of experienced physicians, nurses, administrators, and public policy experts, guided the development and revision process of the JCI accreditation standards. The panel consists of members from most major world regions. Its work is refined based on the following:

- Focus groups composed of JCI-accredited organization leaders and other health care experts conducted in 16 countries
- An international field review of the standards
- Input from experts and others with unique content knowledge
- Ongoing literature searches for key health care practices

How are the standards organized?

The standards are organized around the important functions common to all health care organizations. The functional organization of standards is now the most widely used around the world and has been validated by scientific study, testing, and application.

The standards are grouped by functions related to providing patient care: those related to providing a safe, effective, and well-managed organization; and, for academic medical center hospitals only, those related to medical professional education and human subjects research programs. These standards apply to the entire organization as well as to each department, unit, or service within the organization. The survey process gathers standards compliance information throughout the entire organization, and the accreditation decision is based on the overall level of compliance found throughout the entire organization.
What are the Medical Professional Education and Human Subjects Research Programs standards and do they apply to my organization?

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

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

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

Are the standards available for the international community to use?

Yes. These standards are available in the international public domain for use by individual health care organizations and by public agencies in improving the quality of patient care. The standards only can be downloaded at no cost from the JCI website for consideration of adapting them to the needs of individual countries. The translation and use of the standards as published by JCI requires written permission.

When there are national or local laws related to a standard, what applies?

When standard compliance is related to laws and regulations, whichever sets the higher or stricter requirement applies. For example, if a JCI standard on documenting services in the patient record is more stringent than a hospital’s national standard, the JCI standard is applied.

How do I use this standards manual?

This international standards manual can be used to

- guide the efficient and effective management of a health care organization;
- guide the organization and delivery of patient care services and efforts to improve the quality and efficiency of those services;
- review the important functions of a health care organization;
- become aware of those standards that all organizations must meet to be accredited by JCI;
- review the compliance expectations of standards and the additional requirements found in the associated intent;
- become aware of the accreditation policies and procedures and the accreditation process; and
- become familiar with the terminology used in the manual.

JCI requirements by category are described in detail below. JCI’s policies and procedures are also summarized in this manual. Please note that these are neither the complete list of policies nor every detail of each policy. Current JCI policies are published on JCI’s public website, www.jointcommissioninternational.org.
A glossary of important terms and a detailed index follow the standards chapters.

**JCI Requirement Categories**

JCI requirements are described in these categories:
- Accreditation Participation Requirements (APR)
- Standards
- Intents
- Measurable Elements (MEs)

**Accreditation Participation Requirements (APR)**
The Accreditation Participation Requirements (APR) section, new to JCI in this edition, is composed of specific requirements for participation in the accreditation process and for maintaining an accreditation award. Hospitals must be compliant with the requirements in this section at all times during the accreditation process. However, APRs are not scored like standards during the on-site survey; hospitals are considered either compliant or not compliant with the APR. When a hospital is not compliant with a specific APR, the hospital will be required to become compliant or risk losing accreditation.

**Standards**

JCI standards define the performance expectation, structures, or functions that must be in place for a hospital to be accredited by JCI. JCI’s International Patient Safety Goals (page ) are considered standards and are evaluated as are standards in the on-site survey.

**Intents**

A standard’s intent helps explain the full meaning of the standard. The intent describes the purpose and rationale of the standard, providing an explanation of how the standard fits into the overall program, sets parameters for the requirement(s), and otherwise “paints a picture” of the requirements and goals.

**Measurable Elements (MEs)**

Measurable elements (MEs) of a standard indicate what is reviewed and assigned a score during the on-site survey process. The MEs for each standard identify the requirements for full compliance with the standard. The MEs are intended to bring clarity to the standards and to help the organization fully understand the requirements, to help educate leaders and health care workers about the standards, and to guide the organization in accreditation preparation.

**What is new in this fifth edition of the manual?**

There are many changes to this fifth edition of the hospital manual. A thorough review is strongly recommended. In general, all of the significant changes—changes that, in the view of JCI and the experts and customers who helped develop the standards, “raise the bar” on compliance expectations—are listed in a table at the beginning of the chapter in which those standards appear.

In addition to requirement changes, JCI has edited nearly all of the text that appeared in the fourth edition for clarity, so it will be important for users to compare this and the fourth edition carefully to ensure a full understanding of the new requirements.

In response to the field’s request to eliminate all but the most essential accreditation requirements, JCI has reduced the total number of standards by more than 10% and MEs by more than 5% in this edition.

Other changes include the following:
- A table at the front of each chapter detailing the key changes to that chapter in this edition (compared to the fourth edition standards). If a standard is not listed in the table, it has not changed since the fourth edition standards. Changes are classified in four ways:
  - No significant change—Wording changes were made in the interest of clarity, but the requirements in the standard have not changed.
How frequently are the standards updated?
Information and experience related to the standards will be gathered on an ongoing basis. If a standard no longer reflects contemporary health care practice, commonly available technology, quality management practices, and so forth, it will be revised or deleted. It is current practice that the standards are revised and published approximately every three years.
What does the “effective” date on the cover of this fifth edition of the standards manual mean?

The “effective” date found on the cover means one of two things:

- For hospitals already accredited under the fourth edition of the standards, this is the date by which they now must be in full compliance with all the standards in the fifth edition. Standards are published at least six months in advance of the effective date to provide time for organizations to come into full compliance with the revised standards by the time they are effective.

- For hospitals seeking accreditation for the first time, the effective date indicates the date after which all surveys and accreditation decisions will be based on the standards of the fifth edition. Any survey and accreditation decisions before the effective date will be based on the standards of the fourth edition.
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General Eligibility Requirements

Any hospital may apply for Joint Commission International (JCI) accreditation if it meets all the following criteria:

- The hospital is located outside of the United States and its territories.
- The hospital is currently operating as a health care provider in the country, is licensed to provide care and treatment as a hospital (if required), and, at minimum, does the following:
  - Provides a complete range of acute care clinical services—diagnostic, curative, and rehabilitative.
  - In the case of a specialty hospital, provides a defined set of services, such as pediatric, eye, dental, and psychiatry, among others.
  - For all types of hospitals, provides services that are available 365 days per year; ensures all direct patient care services are operational 24 hours per day, 7 days per week; and provides ancillary and support services as needed for emergent, urgent, and/or emergency needs of patients 24 hours per day, 7 days per week (such as diagnostic testing, laboratory, and operating theatre, as appropriate to the type of acute care hospital).
- The hospital provides services addressed by the JCI fifth edition hospital accreditation standards.
- The hospital assumes, or is willing to assume, responsibility for improving the quality of its care and services.
- The hospital is open and in full operation, admitting and discharging a volume of patients that will permit the complete evaluation of the implementation and sustained compliance with all the JCI fifth edition hospital accreditation standards.
- The hospital meets the conditions described in the “Accreditation Participation Requirements” (APR) section of the JCI fifth edition hospital accreditation standards.

The applicant academic medical center hospital must meet each of the criteria above in addition to the following three criteria:

1) The applicant hospital is organizationally or administratively integrated with a medical school.
2) The applicant hospital is the principal site for the education of both medical students (undergraduates) and postgraduate medical specialty trainees (for example, residents or interns) from the medical school noted in criterion 1.
3) At the time of application, the applicant hospital is conducting academic and/or commercial human subjects research under multiple approved protocols involving patients of the hospital.

*Definition of full operation:

- The hospital accurately identifies the following in its electronic application (E-App) at the time of application:
  - All clinical services currently provided for inpatients and outpatients. (Those clinical services that are planned and thus not identified in the E-App and begin operations at a later time will require a separate extension survey to evaluate those services.)
  - Utilization statistics for clinical services showing consistent inpatient and outpatient activity levels and types of services provided for at least four months or more prior to submission of the E-App.
- All inpatient and outpatient clinical services, units, and departments identified in the E-App are available for a comprehensive evaluation against all relevant JCI standards for hospitals consistent with JCI’s normal survey process for the size and type of organization (see, for example, the JCI fifth edition hospital survey process guide), such as
  - patient tracer activities, including individual patient and systems tracers;
open and closed medical record review;
direct observation of patient care processes;
talks with patients; and
interviews with medical students/trainees.

Note: Contact JCI Accreditation prior to submitting an E-App to discuss the criteria and validate whether the hospital meets the above criteria for “in full operation” at least four months or more prior to submitting its E-App and at its initial survey. JCI may request documentation of the hospital’s utilization statistics prior to accepting the E-App or conducting the on-site survey. In addition, JCI will not begin an on-site survey, may discontinue an on-site survey, or may cancel a scheduled survey when it determines the hospital is not “in full operation.”

†Principal site means the hospital provides the majority of medical specialty programs for postgraduate medical trainees (for example, residents or interns) and not just one specialty, as in a single-specialty hospital (for example, an ophthalmologic hospital, dental hospital, or orthopedic hospital).

Note: If in its reasonable discretion JCI determines that the applicant hospital does not meet the published eligibility criteria, JCI will not accept the application or will not process the application for accreditation from the hospital and will notify the hospital of its decision.
Section I: Accreditation Participation Requirements
Section I: Accreditation Participation Requirements
Overview
This section, new to this accreditation manual, consists of specific requirements for participation in the Joint Commission International accreditation process and for maintaining an accreditation award.

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

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

Please note that the APR requirements are not scored similarly to the standards chapters, and their evaluation does not directly impact the outcome of an on-site initial or triennial accreditation survey. Please also note that the following table, “History of These Requirements,” is provided here because most of these requirements have existed in past editions of this manual, but not in the form of this section.

History of These Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Where Previously Published</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>APR.1</td>
<td>Policies and procedures (4th edition)</td>
<td>Moves requirement from the “Reporting Requirements Between Surveys” section to this section</td>
</tr>
<tr>
<td>APR.2</td>
<td>Policies and procedures (4th edition)</td>
<td>Moves requirement from “Information Accuracy and Truthfulness Policy” section to this section</td>
</tr>
<tr>
<td>APR.3</td>
<td>Policies and procedures (4th edition)</td>
<td>Moves requirement from “Information Accuracy and Truthfulness Policy” section to this section</td>
</tr>
<tr>
<td>APR.4</td>
<td>Policies and procedures (4th edition)</td>
<td>Moves requirement from “JCI Focused Survey Policy” section of JCI accreditation manual (4th edition) to this section</td>
</tr>
<tr>
<td>APR.5</td>
<td>Accreditation survey process</td>
<td>Extends accreditation process for report review to JCI’s requesting reports from agencies directly</td>
</tr>
</tbody>
</table>
### Accreditation Participation Requirements (APR)

**Requirements, Rationales, Evaluation Methods, and Consequences of Noncompliance**

**Requirement: APR.1**
The hospital meets all requirements for timely submissions of data and information to Joint Commission International (JCI).

**Rationale for APR.1**
There are many points in the accreditation process at which data and information are required. Some examples include the completion of the electronic application (E-App), submission of a Strategic Improvement Plan (SIP), submission of data for the measures from the Joint Commission International Library of Measures, any changes in hospital executive leadership such as a change in ownership, Office of Quality and Safety Monitoring requests for information, JCI Accreditation Program requests for verification of information received from a regulatory or other authority, or timely notification of intent to appeal an accreditation decision. Relevant accreditation policies and procedures inform the hospital of what data and/or information are required and the time frame for submission.

**Evaluation of APR.1**
Evaluation occurs throughout the accreditation life cycle in relation to the required submissions.

**Consequences of Noncompliance with APR.1**
If the hospital fails to meet the requirements for the timely submission of data and information to JCI, the hospital will be considered At Risk for Denial of Accreditation and may be required to undergo a focused survey.
Failure to resolve this issue in a timely manner or at the time of the focused survey may result in Denial of Accreditation. These consequences address only compliance with the requirement itself and not the content of the hospital’s submissions to JCI. For example, if information in a hospital’s E-App leads to inaccuracies in the appropriate length of the survey and a longer survey is required, the hospital will incur the additional costs of the longer survey. In addition, if there is evidence that the hospital has falsified or withheld the information or intentionally deleted information submitted to JCI, the requirement at APR.2 and its consequences will apply.

**Requirement: APR.2**
The hospital provides JCI with accurate and complete information through all phases of the accreditation process.

**Rationale for APR.2**
JCI requires each hospital seeking accreditation or already accredited to engage in the accreditation process with honesty, integrity, and transparency. This type of engagement in the accreditation process is evident by providing complete and accurate information during all phases of the three-year cycle of the accreditation process.

Hospitals provide information to JCI in any of the following ways:
- Verbally
- Direct observation by, or in an interview or any other type of communication with, a JCI employee
- Electronic or hard-copy documents through a third party, such as the media, or a government report

For the purpose of this requirement, falsification of information is defined as the fabrication, in whole or in part, of any information provided by an applicant or accredited organization to JCI. Falsification may include redrafting, reformatting, or deleting document content or submitting false information, reports, data, or other materials.

**Evaluation of APR.2**
Evaluation of this APR begins during the application process and continues as long as the hospital is accredited by or seeking accreditation by JCI.

**Consequences of Noncompliance with APR.2**
If JCI is reasonably convinced that the hospital has submitted inaccurate or falsified information to JCI or has presented inaccurate or falsified information to surveyors, the hospital will be considered At Risk for Denial of Accreditation and may be required to undergo a focused survey. Failure to resolve this issue in a timely manner or at the time of the focused survey may result in Denial of Accreditation.

**Requirement: APR.3**
The hospital reports within 15 days any changes in the hospital’s profile (electronic database) or information provided to JCI via the E-App before and between surveys.

**Rationale for APR.3**
JCI collects core information regarding each hospital’s profile in its E-App to understand ownership, licensure, scope and volume of patient services, and types of patient care facilities, among other factors. When any of these factors change, JCI must make a deliberate determination if the change is within or outside of the scope of a planned initial survey or the scope of a current accreditation award. Thus, the hospital notifies JCI before the change or within 15 days of changes in such core information from the hospital’s profile, including, but not limited to, the following:
- A change in hospital ownership and/or name
- The revocation or restriction of operational licenses or permits, any limitation or closure of patient care services, any sanctions of professional or other staff, or other actions under laws and regulations brought by relevant health authorities
• Alteration or changes in use of patient care buildings, construction of new or expansion of patient care buildings, or the occupation of buildings in new locations in the community, to expand the types and volume of patient care services 25% or more than was stated in the hospital's profile or was not reported as a patient care location in the E-App, or was not included in the scope of the previous accreditation survey.

• Intentional expansion of the hospital’s capacity to provide services in the absence of new, renovated, or expanded facilities by 25% or greater, as measured by patient volume, scope of services, or other relevant measures.

• The addition or deletion of one or more types of health care services, such as addition of a dialysis unit or discontinuation of trauma care.

• The hospital has merged with, consolidated with, or acquired an unaccredited site, service, or program for which there are applicable JCI standards.

When significant change occurs, JCI may conduct a focused survey for all or a portion of the hospital again or for the first time in the case of new facilities or services. JCI accreditation does not automatically extend accreditation to new services and facilities without an on-site evaluation.

**Evaluation of APR.3**
Evaluation of this APR begins during the electronic application process and continues as long as the hospital is accredited by or seeking accreditation by JCI. Changes reported may be evaluated off-site or by a focused survey.

**Consequences of Noncompliance with APR.3**
If the hospital does not provide notification to JCI in advance or within 15 days of these changes, the hospital will be placed At Risk for Denial of Accreditation and a focused survey will be conducted.

---

**Requirement: APR.4**
The hospital permits on-site evaluations of standards and policy compliance or verification of quality and safety concerns, reports, or regulatory authority sanctions at the discretion of JCI.

**Rationale for APR.4**
Achieving JCI accreditation implies to the public, governmental agencies, and payment sources, among others, that the hospital is in compliance with JCI standards and accreditation policies at all times. Thus, it is important that JCI has the right to enter all or any portion of the hospital on an announced or unannounced basis to confirm standards and accreditation policy compliance and/or evaluate patient safety and quality concerns at any time during all phases of accreditation. Surveyors will always present an official letter of introduction and at least one other form of identification as a JCI representative when the visit is unannounced.

**Evaluation of APR.4**
Evaluation of this requirement is ongoing during any phase of accreditation.

**Consequences of Noncompliance with APR.4**
JCI will withdraw the accreditation of a hospital that denies or limits access to authorized JCI staff to perform an on-site evaluation.

---

**Requirement: APR.5**
The hospital allows JCI to request (from the hospital or outside agency) and review an original or authenticated copy of the results and reports of external evaluations from publicly recognized bodies.

**Rationale for APR.5**
In order to conduct a thorough accreditation survey, JCI collects information on many aspects of hospital operations. External bodies other than JCI evaluate areas related to safety and quality—for example, fire safety
inspections, staff working conditions inspections, and evaluation of safety incidents or quality complaints by
local authorities. These evaluations complement accreditation reviews but may have a different focus or
emphasis. These evaluations may produce information JCI needs to make accreditation decisions.

Evaluation of APR.5
When requested, the hospital provides JCI with all official records, reports, and recommendations of outside
agencies, such as licensing, examining, reviewing, government, or planning bodies. JCI may also request such
reports directly from the outside agency. The reports can be requested during any phase of accreditation,
including during an accreditation survey or as part of the evaluation of a quality concern or incident.

Consequences of Noncompliance with APR.5
When the hospital fails to provide an official report when requested during an on-site survey, relevant standards
will be scored out of compliance and the hospital may be required to undergo a follow-up survey to review the
report and the relevant standards. When the hospital fails to provide a requested report during other phases of
accreditation, a focused survey may be required.

Requirement: APR.6
The hospital allows JCI Accreditation Program staff and members of JCI’s Board of Directors to observe the
on-site survey.

Rationale for APR.6
JCI Accreditation Program staff have reason to observe new surveyors, evaluate new standards, and evaluate
changes in the on-site survey process, among other activities. JCI’s Board of Directors approves accreditation
strategies and policies, which is best done with a full understanding of the accreditation process gained from
such an observation.

Evaluation of APR.6
Observations can occur at any phase of the accreditation process related to any type of on-site survey. For
observers other than staff and JCI’s Board of Directors, the hospital will receive a request specific to that
observer.

Consequences of Noncompliance with APR.6
A hospital will be charged for all the nonreimbursable travel expenses associated with the hospital’s refusal to
allow observation by a JCI Accreditation Program staff or Board member.

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

The hospital uses the current Library measure specifications and follows Library measure selection, use, and data
submission requirements as found on the JCI Library of Measures website, which can be accessed directly from
the JCI Direct Connect customer portal. The JCI Library of Measures website describes current requirements
related to the following:
1) Any required minimum number of measures sets or individual measures that must be selected and
implemented
2) The process for obtaining an exemption from APR.7 requirements when the Library measures are not
applicable to the hospital’s patient populations and services provided
3) The collection and aggregation process for Library measure data
4) The effective date and the process for submission of quarterly discharge data
5) The use of Library measure data in the accreditation process
6) The criteria for determining continued use or replacement of Library measures
7) How data quality issues are to be managed

Rationale for APR.7
The Joint Commission International Library of Measures provides uniform, precise specifications for the collection of data standardized to permit comparison over time within a hospital and for comparisons among hospitals.

The collection, analysis, and use of data are at the core of the JCI accreditation process. Data can support continuous improvement in a hospital. Data can also provide a continuous flow of information to JCI in support of the hospital's ongoing improvement in its continuous accreditation process.

Both of these purposes are best served when the hospital selects Library measures that address process and outcomes for which the data will guide improvement in the delivery of patient care. Measures that are convenient and easy rarely serve this important purpose; and also do not uphold JCI's expectation for the hospital to demonstrate continuous improvement in the accreditation process.

The selection and use of Library measures is integrated into the hospital's measurement priorities as described in Standards GLD.5, GLD.11, and GLD.11.1.

Evaluation of APR.7
The selection, use, and data submission for at least a minimum number of measures from the JCI Library of Measures is evaluated throughout all phases of accreditation, both during the on-site survey process and through evaluation of the data submitted during the continuous accreditation process.

Consequences of Noncompliance with APR.7
The hospital will be considered At Risk for Denial of Accreditation and a focused survey may be conducted if the hospital is found not to be in compliance with applicable requirements found on the JCI Library of Measures website.

Requirement: APR.8
The hospital accurately represents its accreditation status and the programs and services to which JCI accreditation applies.

Rationale for APR.8
The hospital’s website, advertising and promotion, and other information made available to the public accurately reflect the scope of programs and services that are accredited by JCI.

Evaluation of APR.8
Conformance with this requirement is evaluated throughout all phases of accreditation of the hospital.

Consequences of Noncompliance with APR.8
Failure of a hospital to withdraw or otherwise correct inaccurate information will place the organization At Risk for Denial of Accreditation and a focused survey may be conducted.

Requirement: APR.9
Any individual hospital staff member (clinical or administrative) can report concerns about patient safety and quality of care to JCI without retaliatory action from the hospital.

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

**Rationale for APR.9**
To create a “safe” reporting environment, the hospital educates all staff that concerns about the safety or quality of patient care provided in the hospital may be reported to JCI. The hospital also informs its staff that it will take no disciplinary or punitive action because a staff member reports safety or quality-of-care concerns to JCI.

**Evaluation of APR.9**
The evaluation of this requirement is throughout all phases of accreditation and includes, but is not limited to, information from both on-site and off-site activities or from investigation of complaints submitted to JCI.

**Consequences of Noncompliance with APR.9**
Confirmed reports of retaliatory actions to staff who reported a quality and patient safety issue to JCI will place the hospital At Risk for Denial of Accreditation and a focused survey may be conducted.

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**Requirement: APR.10**
Translation and interpretation services arranged by the hospital for an accreditation survey and any related activities are provided by licensed translation and interpretation professionals who have no relationship to the hospital.

**Rationale for APR.10**
The integrity of the on-site evaluation process, as well as the integrity of the outcome, depend on the surveyor obtaining an unbiased, accurate understanding of his or her conversations with staff; and the hospital’s staff communicating effectively in their language with the surveyor. To ensure this accurate, unbiased exchange, translation and interpretation is provided by individuals licensed to provide translation and interpretation services, with evidence of experience in health care translation and/or interpretation services. Individuals providing translation and interpretation services are not current or former employees of the hospital and do not have any conflicts of interest, such as immediate family members or employees of an affiliated hospital. Individuals providing translation and interpretation services have not served in any consultation capacity to the hospital in relation to accreditation or accreditation preparation, with the possible exception of assistance in translating the documents required by JCI to be in English or providing translation and interpretation services at a previous survey.

**Evaluation of APR.10**
The hospital will submit the licenses and resumes of the selected translators no later than six (6) weeks prior to the start of any JCI on-site survey. JCI Accreditation Program staff will obtain a signed conflict-of-interest statement from each translator. For other types of on-site evaluations, such as a focused survey, the surveyor and/or JCI Accreditation Program staff member will evaluate the credentials of the translators.

**Consequences of Noncompliance with APR.10**
When translators are found to be unqualified due to lack of professional license or a conflict of interest, the survey will be stopped until a suitable replacement can be found. The hospital is responsible for any additional costs related to the delay, including rescheduling of survey team members when necessary.

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**Requirement: APR.11**
The hospital notifies the public it serves about how to contact its hospital management and JCI to report concerns about patient safety and quality of care.

Methods of notice may include, but are not limited to, distribution of information about JCI, including contact information in published materials such as brochures and/or posting this information on the hospital’s website.
Rationale for APR.11

JCI standards for hospitals require hospitals to have a mechanism to receive and respond to complaints, conflicts, and other patient care quality and safety concerns in a timely manner. The hospital needs to inform the public it serves about how to access this process.

The hospital also needs to inform the public about how to report concerns about patient safety and quality of care to JCI, in particular when the hospital process has not been effective in resolving the concern.

Evaluation of APR.11

Surveyors will evaluate how the hospital meets this requirement during the on-site evaluation process.

Consequences of Noncompliance with APR.11

An SIP will be required when a hospital is found to not meet this requirement.

 Requirement: APR.12

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

Rationale for APR.12

Patients, staff, and the public trust hospitals to be low-risk, safe places. Thus, hospitals maintain that trust with ongoing vigilant review and supervision of safety practices.

Evaluation of APR.12

Evaluation occurs primarily during the on-site survey process, and also through other hospital reports or complaints, and/or sanctions by a regulatory authority, during all phases of accreditation.

Consequences of Noncompliance with APR.12

Immediate threats discovered on-site during a survey interrupt the survey until the threat can be resolved or until the hospital, survey team, and JCI Accreditation Program staff can mediate the issue. Until the issue is resolved, the hospital is placed At Risk for Denial of Accreditation and a focused survey is conducted.
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## Changes to the IPSG Chapter

<table>
<thead>
<tr>
<th>Standard</th>
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<th>Explanation</th>
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<tr>
<td>IPSG.1</td>
<td>Requirement</td>
<td>Eliminates two MEs for overall clarity of the requirements</td>
</tr>
<tr>
<td></td>
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<tr>
<td>IPSG.2</td>
<td>Requirement</td>
<td>Expands intent to include two additional standards for verbal/telephone communications: reporting of critical results of diagnostic tests (IPSG.2.1; formerly Standard AOP.5.3.1, 4th edition) and handovers of patient care (IPSG.2.2, new standard); emphasizes the need for more focused compliance on three distinct communication-related issues</td>
</tr>
<tr>
<td></td>
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<tr>
<td>IPSG.2.1</td>
<td>Requirement</td>
<td>Moves requirement from AOP.5.3.1 (4th edition) to highlight reporting of critical results of diagnostic tests as an important communication issue</td>
</tr>
<tr>
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<tr>
<td>IPSG.2.2</td>
<td>New standard</td>
<td>Introduces a new requirement for effective handovers of patient care within the hospital</td>
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<tr>
<td>IPSG.3</td>
<td>Requirement</td>
<td>Divides IPSG.3 (4th edition) into two standards to clarify expectations for high-alert medications (including medications involved in a high percentage of errors/sentinel events and look-alike/sound-alike medications; IPSG.3) and concentrated electrolytes (IPSG.3.1), emphasizing more focused compliance on two distinct medication-related issues</td>
</tr>
<tr>
<td></td>
<td>change</td>
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<tr>
<td>IPSG.3.1</td>
<td>Requirement</td>
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<td></td>
<td>change</td>
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</tr>
<tr>
<td>IPSG.4</td>
<td>Requirement</td>
<td>Divides IPSG.4 (4th edition) into two standards to clarify the purpose and content of the preoperative verification process and the approach for the time-out procedure</td>
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<tr>
<td></td>
<td>change</td>
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<tr>
<td>IPSG.4.1</td>
<td>Requirement</td>
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<td></td>
<td>change</td>
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<tr>
<td>IPSG.5</td>
<td>Requirement</td>
<td>Incorporates elements of PCI.9 (4th edition), thereby consolidating hand-hygiene requirements into one standard</td>
</tr>
<tr>
<td></td>
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<tr>
<td>IPSG.6</td>
<td>Requirement</td>
<td>Clarifies the need to address fall risk assessment and reassessment in both inpatients and outpatients</td>
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<td></td>
<td>change</td>
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</tbody>
</table>

**Note:** This table lists changes to requirements in this chapter only. Requirements that were in this chapter in the 4th edition of this manual and are now contained either in their entirety or in part in another chapter of this 5th edition are listed in that chapter’s “Changes” table.

The following standards appeared in this chapter of the 4th edition standards but were deleted from this edition (listed with 4th edition numbers): None.

**Note:** Some standards require the hospital to have a written policy or procedure for specific processes. Those standards are indicated by a 📄 icon after the standard text.
Goals, Standards, Intents, and Measurable Elements

Goal 1: Identify Patients Correctly

Standard IPSG.1
The hospital develops and implements a process to improve accuracy of patient identifications.

Intent of IPSG.1
Wrong-patient errors occur in virtually all aspects of diagnosis and treatment. Patients may be sedated, disoriented, not fully alert, or comatose; may change beds, rooms, or locations within the hospital; may have sensory disabilities; may not remember their identity; or may be subject to other situations that may lead to errors in correct identification. The intent of this goal is twofold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual.

The identification process used throughout the hospital requires at least two ways in which to identify a patient, such as the patient’s name, identification number, birth date, a bar-coded wristband, or other ways. The patient’s room number or location cannot be used for identification. These two different identifiers are utilized in all locations within the hospital; for example, in the ambulatory care or other outpatient location, the emergency department, the operating theatre, diagnostic departments, and the like.

Two different patient identifiers are required in any circumstance involving patient interventions. For example, patients are identified before providing treatments (such as administering medications, blood, or blood products; serving a restricted diet tray; or providing radiation therapy); performing procedures (such as insertion of an intravenous line or hemodialysis); and before any diagnostic procedures (such as taking blood and other specimens for clinical testing, or performing a cardiac catheterization or diagnostic radiology procedure). Identification of the comatose patient with no identification is also included.

Measurable Elements of IPSG.1
1. Patients are identified using two patient identifiers, not including the use of the patient’s room number or location.
2. Patients are identified before providing treatments and procedures.
3. Patients are identified before any diagnostic procedures. (Also see AOP.5.7, ME 2)

Goal 2: Improve Effective Communication

Standard IPSG.2
The hospital develops and implements a process to improve the effectiveness of verbal and/or telephone communication among caregivers.

Standard IPSG.2.1
The hospital develops and implements a process for reporting critical results of diagnostic tests.

Standard IPSG.2.2
The hospital develops and implements a process for handover communication.
Intent of IPSG.2 Through IPSG.2.2
Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces errors and results in improved patient safety. Communication can be electronic, verbal, or written. Patient care circumstances that can be critically impacted by poor communication include verbal or telephone patient care orders, verbal or telephone communication of critical test results, and handover communications. Handover communications can also be referred to as handoff communications. The most error-prone communications are patient care orders given verbally and those given over the telephone, when permitted under local laws and regulations. Different accents, dialects, and pronunciations can make it difficult for the receiver to understand the order being given. For example, drug names and numbers that sound alike, such as erythromycin instead of azithromycin or fifteen instead of fifty can affect the accuracy of the order. Background noise, interruptions, and unfamiliar drug names and terminology often compound the problem. Once received, a verbal order must be transcribed as a written order, which adds complexity and risk to the ordering process.

The reporting of critical results of diagnostic tests is also a patient safety issue. Diagnostic tests include, but are not limited to, laboratory tests, radiology exams, nuclear medicine exams, ultrasound procedures, magnetic resonance imaging, and cardiac diagnostics. This includes critical results from any diagnostic tests performed at the bedside, such as point-of-care testing, portable radiographs, bedside ultrasounds, or transthoracic echocardiograms. Results that are significantly outside the normal range may indicate a high-risk or life-threatening condition. A formal reporting system that clearly identifies how critical results of diagnostic tests are communicated to health care practitioners and how the information is documented reduces patient risks. (Also see AOP.5.4)

Safe practices for verbal or telephone communications include the following:
- Limiting verbal communication of prescription or medication orders to urgent situations in which immediate written or electronic communication is not feasible. For example, verbal orders can be disallowed when the prescriber is present and the patient’s chart is available. Verbal orders can be restricted to situations in which it is difficult or impossible for hard-copy or electronic order transmission, such as during a sterile procedure.
- The development of guidelines for requesting and receiving test results on an emergency or STAT basis, the identification and definitions of critical tests and critical values, to whom and by whom critical test results are reported, and monitoring compliance.
- Writing down (or entering into a computer) the complete order or test result by the receiver of the information; the receiver reading back the order or test result; and the sender confirming that what has been written down and read back is accurate. Permissible alternatives for when the read-back process may not always be possible may be identified, such as in the operating theatre and in emergent situations in the emergency department or intensive care unit. (Also see COP.2.2; MMU.4; MMU.4.1; and MOL.11, ME 1)

Handovers of patient care within a hospital occur
- between health care providers, such as between physicians and other physicians or health care providers, or from one provider to another provider during shift changes;
- between different levels of care in the same hospital such as when the patient is moved from an intensive care unit to a medical unit or from an emergency department to the operating theatre; and
- from inpatient units to diagnostic or other treatment departments, such as radiology or physical therapy.

Breakdowns in communication can occur during any handover of patient care and can result in adverse events. Background noises, interruptions, and other distractions from unit activities can inhibit clear communication of important patient information. Standardized, critical content for communication between the patient, family, caregiver, and health care providers can significantly improve the outcomes related to handovers of patient care. (Also see ACC.3)

Measurable Elements of IPSG.2
- The complete verbal order is documented and read back by the receiver and confirmed by the individual giving the order.
2. The complete telephone order is documented and read back by the receiver and confirmed by the individual giving the order.

3. The complete test result is documented and read back by the receiver and confirmed by the individual giving the result.

**Measurable Elements of IPSG.2.1**

1. The hospital has defined critical values for each type of diagnostic test.

2. The hospital has identified by whom and to whom critical results of diagnostic tests are reported.

3. The hospital has identified what information is documented in the patient record.

**Measurable Elements of IPSG.2.2**

1. Standardized critical content is communicated between health care providers during handovers of patient care.

2. Standardized forms, tools, and methods support a consistent and complete handover process.

3. Data from handover communications are tracked and used to improve approaches to safe handover communication.

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**Goal 3: Improve the Safety of High-Alert Medications**

**Standard IPSG.3**

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

**Standard IPSG.3.1**

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

**Intent of IPSG.3 and IPSG.3.1**

When medications are part of the patient treatment plan, appropriate management is critical to ensuring patient safety. Any medication, even those that can be purchased without a prescription, if used improperly can cause injury. However, high-alert medications cause harm more frequently, and the harm they produce is likely to be more serious when they are given in error. This can lead to increased patient suffering and potentially additional costs associated with caring for these patients.

High-alert medications include:

- medications that are involved in a high percentage of errors and/or sentinel events, such as insulin, heparin, or chemotherapeutics; and
- medications whose names, packaging and labeling, or clinical use, look alike and/or sound alike, such as Xanax and Zantac or hydralazine and hydroxyzine

There are many medication names that sound or look like other medication names. Confusing names is a common cause of medication errors throughout the world. Contributing to this confusion are:

- incomplete knowledge of drug names;
- newly available products;
- similar packaging or labeling;
- similar clinical use;
- similar strengths, dosage forms, and frequency of administration; and
- illegible prescriptions or misunderstanding during issuing of verbal orders.
Lists of high-alert medications and look-alike/sound-alike medications are available from organizations such as the World Health Organization (WHO) and the Institute for Safe Medication Practices (ISMP), as well as in the literature.

A frequently cited medication safety issue is the incorrect or unintentional administration of concentrated electrolytes (for example, potassium chloride [equal to or greater than 2 mEq/mL concentration], potassium phosphate [equal to or greater than 3 mmol/mL concentration], sodium chloride [greater than 0.9% concentration], and magnesium sulfate [equal to or greater than 50% concentration]). Errors can occur when staff are not properly oriented to the patient care unit, when contract nurses are used and not properly oriented, or during emergencies. The most effective means to reduce or to eliminate these occurrences is to develop a process for managing high-alert medications that includes removing the concentrated electrolytes from the patient care units to the pharmacy. (Also see MMU.3)

The hospital makes a list of all medications that pose a significant risk to patients using hospital data related to medication use within the hospital, adverse and near-miss events, and other relevant information. The list includes medications identified as high risk for adverse outcomes as well as those at risk for look-alike/sound-alike confusion. Information from the literature and/or Ministry of Health may also be useful in helping to identify which medications should be included.7–9 These medications are stored in a way that reduces the likelihood of inadvertent administration or ideally provides directions on the proper use of the medication. Strategies to improve the safety of high-alert medications may be tailored to the specific risk of each medication and should include consideration of prescribing, preparation, administration, and monitoring processes, in addition to safe storage strategies.10–14 The hospital also identifies any areas where concentrated electrolytes are clinically necessary as determined by evidence and professional practice, such as the emergency department or operating theatre, and identifies how they are clearly labeled and how they are stored in those areas in a manner that restricts access to prevent inadvertent administration.

Measurable Elements of IPSG.3

- 1. The hospital has a list of all high-alert medications, including look-alike/sound-alike medications, that is developed from hospital-specific data.
- 2. The hospital implements strategies to improve the safety of high-alert medications, which may include specific storage, prescribing, preparation, administration, or monitoring processes.
- 3. The location, labeling, and storage of high-alert medications, including look-alike/sound-alike medications, is uniform throughout the hospital.

Measurable Elements of IPSG.3.1

- 1. The hospital has a process that prevents inadvertent administration of concentrated electrolytes.
- 2. Concentrated electrolytes are present only in patient care units identified as clinically necessary.
- 3. Concentrated electrolytes that are stored in patient care units are clearly labeled and stored in a manner that promotes safe use.

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

Standard IPSG.4

The hospital develops and implements a process for ensuring correct-site, correct-procedure, and correct-patient surgery.
**Standard IPSG.4.1**

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

**Intent of IPSG.4 and IPSG.4.1**

Wrong-site, wrong-procedure, wrong-patient surgery is an alarmingly common occurrence in hospitals. These errors are the result of ineffective or inadequate communication between members of the surgical team, lack of patient involvement in site marking, and lack of procedures for verifying the operative site. In addition, inadequate patient assessment, inadequate medical record review, a culture that does not support open communication among surgical team members, problems related to illegible handwriting, and the use of abbreviations are frequent contributing factors.

Surgery and invasive procedures include all procedures that investigate and/or treat diseases and disorders of the human body through cutting, removing, altering, or insertion of diagnostic/therapeutic scopes. Organizations need to identify all areas within the hospital where surgical and invasive procedures take place; for example, the cardiac catheterization lab, interventional radiology department, gastrointestinal lab, and the like. The approach the hospital takes to ensuring correct-site, correct-procedure, and correct-patient surgery applies to all areas of the hospital in which surgical and invasive procedures occur.

Evidence-based practices are described in The (US) Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™. The essential processes found in the Universal Protocol are:

- marking the surgical site;
- a preoperative verification process; and
- a time-out that is held immediately before the start of a procedure.

Marking the surgical and invasive procedure site involves the patient and is done with an instantly recognizable mark. The mark must be consistent throughout the hospital; must be made by the person performing the procedure; should take place with the patient awake and aware, if possible; and must be visible after the patient is prepped and draped. The surgical site is marked in all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine).

The purpose of the preoperative verification process is to:

- verify the correct site, procedure, and patient;
- ensure that all relevant documents, images, and studies are available, properly labeled, and displayed; and
- verify that any required special medical technology and/or implants are present.

There are various elements of the preoperative verification process that can be completed before the patient arrives at the preoperative area—such as ensuring that documents, imaging and test results, and paperwork are properly labeled and available; and marking the surgical site. In fact, waiting until the time-out to complete the preoperative verification process may unnecessarily delay surgery if paperwork or imaging are not labeled and available when surgery is about to begin. It is more likely that portions of the preoperative verification may occur more than once and in more than one place. For example, the surgical consent may be obtained in the surgeon’s office and then verification that it is completed may take place in the preoperative holding area; marking the surgical site may occur in the preoperative holding area; and verifying that the right medical technology is available may occur in the operating theatre.

The time-out, held immediately before the start of the procedure with all team members present, permits any unanswered questions or confusion to be resolved. The time-out is conducted in the location at which the procedure will be done, just before starting the procedure, and involves the entire operative team. The patient does not have to participate in the time-out procedure. The hospital determines how the time-out process is to be documented.
Measurable Elements of IPSG.4

1. The hospital uses an instantly recognizable mark for surgical- and invasive procedure–site identification that is consistent throughout the hospital.

2. Surgical- and invasive procedure–site marking is done by the person performing the procedure and involves the patient in the marking process.

3. The hospital uses a checklist or other process to document, before the procedure, that the informed consent is appropriate to the procedure; that the correct site, correct procedure, and correct patient are identified; and that all documents and medical technology needed are on hand, correct, and functional.

Measurable Elements of IPSG.4.1

1. The full surgical team conducts and documents a time-out procedure in the area in which the surgery/invasive procedure will be performed, just before starting a surgical/invasive procedure.

2. The components of the time-out include correct patient identification, correct side and site, agreement of the procedure to be done, and confirmation that the verification process has been completed.

3. When surgery is performed, including medical and dental procedures done in settings other than the operating theatre, the hospital uses uniform processes to ensure the correct site, correct procedure, and correct patient.

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

Standard IPSG.5

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

Intent of IPSG.5

Infection prevention and control are challenging in most health care settings, and rising rates of health care–associated infections are a major concern for patients and health care practitioners. Infections common to all health care settings include catheter-associated urinary tract infections, bloodstream infections, and pneumonia (often associated with mechanical ventilation).

Central to the elimination of these and other infections is proper hand hygiene. Internationally acceptable hand-hygiene guidelines are available from the World Health Organization (WHO), the United States Centers for Disease Control and Prevention (US CDC), and various other national and international organizations. (Also see GLD.11.2)

The hospital adopts and implements currently published evidence-based hand-hygiene guidelines. Hand-hygiene guidelines are posted in appropriate areas, and staff are educated in proper hand-washing and hand-disinfection procedures. Soap, disinfectants, and towels or other means of drying are located in those areas where hand-washing and hand-disinfecting procedures are required. (Also see PCI.9)

Measurable Elements of IPSG.5

1. The hospital has adopted currently published, evidence-based hand-hygiene guidelines.

2. The hospital implements an effective hand-hygiene program throughout the hospital.

3. Hand-washing and hand-disinfection procedures are used in accordance with hand-hygiene guidelines throughout the hospital.
Goal 6: Reduce the Risk of Patient Harm Resulting from Falls

Standard IPSG.6
The hospital develops and implements a process to reduce the risk of patient harm resulting from falls.

Intent of IPSG.6
Many injuries in hospitals to both inpatients and outpatients are a result of falls. The risk for falls is related to the patient, the situation, and/or the location. Risks associated with patients might include patient history of falls, medications use, alcohol consumption, gait or balance disturbances, visual impairments, altered mental status, and the like. Patients who have been initially assessed to be at low risk for falls may suddenly become at high risk. Reasons include, but are not limited to, surgery and/or anesthesia, sudden changes in patient condition, and adjustment in medications. Many patients require reassessment during their hospitalization. Documented criteria identify the types of patients who are considered at high risk for falls.

An example of a situational risk is the patient who arrives at the outpatient department from a long term care facility via ambulance for a radiologic examination. The patient may be at risk for falls in that situation when transferring from ambulance cart to exam table, or when changing positions while lying on the narrow exam table. Specific locations may present higher fall risks because of the services provided. For example, a physical therapy department (inpatient or outpatient) has many types of specialized equipment used by patients that may increase the risk of fall, such as parallel bars, freestanding staircases, and exercise equipment.

In the context of the populations it serves, the services it provides, and its facilities, the hospital should evaluate patient falls and take action to reduce the risk of falling and to reduce the risk of injury should a fall occur. A fall reduction program may include risk assessment and periodic reassessment of a particular patient population and/or of the environment in which care and services are provided (such as those conducted during periodic safety tours). The hospital has a responsibility to identify the locations (such as the physical therapy department), situations (such as patients arriving by ambulance, patient transfers from wheelchairs or carts, or the use of patient-lifting devices), and types of patients (such as patients with gait or balance disturbances, visual impairments, altered mental status, and the like) who may be at high risk for falls.

The hospital establishes a fall-risk reduction program based on appropriate policies and/or procedures. The program monitors both the intended and unintended consequences of measures taken to reduce falls. For example, the inappropriate use of physical restraints or fluid intake restriction may result in injury, impaired circulation, or compromised skin integrity. The program is implemented. (Also see AOP.1.4)

Measurable Elements of IPSG.6
- The hospital implements a process for assessing all inpatients and those outpatients whose condition, diagnosis, situation, or location identifies them as at high risk for falls.
- The hospital implements a process for the initial and ongoing assessment, reassessment, and intervention of inpatients and outpatients identified as at risk for falls based on documented criteria.
- Measures are implemented to reduce fall risk for those identified patients, situations, and locations assessed to be at risk.

References
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## Changes to the ACC Chapter

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<tr>
<th>Standard</th>
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<th>Explanation</th>
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<tr>
<td>ACC.1.1 and ACC.1.2</td>
<td>Renumbered</td>
<td>Renumbers standards from the 4th edition to improve overall chapter flow: ACC.1.1 (previously ACC.1.1.1) and ACC.1.2 (previously ACC.1.1.3)</td>
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<tr>
<td>ACC.2</td>
<td>Renumbered; Requirement change</td>
<td>Renumbers standard ACC.1.1 (4th edition); removes text from intent and deletes ME 5 (4th edition) to clarify requirements</td>
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<tr>
<td>ACC.2.1 and ACC.2.2</td>
<td>Renumbered</td>
<td>Renumbers standards from the 4th edition to improve overall chapter flow: ACC.2.1 (previously ACC.1.1.2) and ACC.2.2 (previously ACC.1.2)</td>
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<td>ACC.2.2.1</td>
<td>New standard</td>
<td>Adds a new requirement for hospitals to manage the flow of patients throughout the hospital</td>
</tr>
<tr>
<td>ACC.2.3 and ACC.2.3.1</td>
<td>Requirement change</td>
<td>Renumbers and separates requirements of ACC.1.4 (4th edition) to emphasize the need for established criteria for both admissions to and discharges from units providing intensive or specialized services</td>
</tr>
<tr>
<td>ACC.3</td>
<td>Renumbered; Requirement change</td>
<td>Moves requirement from ACC.2 (4th edition) and revises intent and MEs to clarify elements of continuity and coordination of patient care processes</td>
</tr>
<tr>
<td>ACC.3.1–ACC.4.4</td>
<td>Renumbered; No significant change</td>
<td>Renumbers several standards from the 4th edition, some with minor text changes to improve clarity: ACC.3.1 (previously ACC.2.1); ACC.3.2 (previously MCL8); ACC.4 (previously ACC.3); ACC.4.1 (previously PFE.4); ACC.4.2 (previously ACC.3.1); ACC.4.3 (previously ACC.3.2); ACC.4.3.1 (previously ACC.3.3); ACC.4.3.2 (previously ACC.3.2); ACC.4.4 (previously ACC.3.3)</td>
</tr>
<tr>
<td>ACC.4.5 and ACC.4.5.1</td>
<td>Renumbered; Requirement change</td>
<td>Renumbers and separates requirements of ACC.3.5 (4th edition) to emphasize the need to address follow-up processes for patients who notify hospital staff and those who do not notify staff before leaving against medical advice</td>
</tr>
<tr>
<td>ACC.5 and ACC.5.1</td>
<td>Renumbered; No significant change</td>
<td>Renumbers and reorganizes requirements and clarifies text of ACC.4, ACC.4.1, and ACC.4.3 (4th edition)</td>
</tr>
<tr>
<td>ACC.5.2</td>
<td>Renumbered</td>
<td>Moves requirement from ACC.4.2 (4th edition)</td>
</tr>
<tr>
<td>ACC.5.3</td>
<td>Renumbered</td>
<td>Moves requirement from ACC.4.4 (4th edition)</td>
</tr>
<tr>
<td>ACC.6</td>
<td>Renumbered; No significant change</td>
<td>Moves requirement from ACC.5 (4th edition); adds text to intent for clarity</td>
</tr>
</tbody>
</table>
Note: This table lists changes to requirements in this chapter only. Requirements that were in this chapter in the 4th edition of this manual and are now contained either in their entirety or in part in another chapter of this 5th edition are listed in that chapter’s “Changes” table.

The following standards appeared in this chapter of the 4th edition standards but were deleted from this edition (listed with 4th edition numbers): None.

Note: Some standards require the hospital to have a written policy or procedure for specific processes. Those standards are indicated by a icon after the standard text.

Standards, Intents, and Measurable Elements

Screening for Admission to the Hospital

Standard ACC.1
Patients who may be admitted to the hospital or who seek outpatient services are screened to identify if their health care needs match the hospital’s mission and resources. 

Intent of ACC.1
Matching patient needs with the hospital’s mission and resources depends on obtaining information on the patient’s needs and condition through screening, usually at the point of first contact. The screening may be through triage criteria, visual evaluation, a physical examination, or the results of previously conducted physical, psychological, clinical laboratory, or diagnostic imaging evaluations. The screening can occur at a referring source, during emergency transport, or when the patient arrives at the hospital. It is important that decisions to treat, to transfer, or to refer are made only after the results of screening evaluations are available. Only those patients for whom the hospital has the clinical capability to provide the needed services, consistent with its mission, are considered for inpatient admission or registered for outpatient services. Certain screening exams or diagnostic tests may be required for every patient being admitted, or the hospital may identify specific screenings and tests for particular patient populations. For example, all patients with active diarrhea must have a screen for *Clostridium difficile*, or certain types of patients require screening for methicillin-resistant *Staphylococcus aureus*, such as all patients coming from long term care facilities. Specific screening tests or evaluations are identified when the hospital requires them prior to admission or registration. (Also see AOP.1)

Measurable Elements of ACC.1

1. Based on the results of screening, it is determined if the needs of the patient match the hospital’s mission and resources. (Also see GLD.3.1, ME 1)
2. Patients are accepted only if the hospital can provide the necessary services and the appropriate outpatient or inpatient setting for care.
3. There is a process to provide the results of diagnostic tests to those responsible for determining if the patient is to be admitted, transferred, or referred.
4. Specific screening tests or evaluations are identified when the hospital requires them prior to admission or registration.
5. Patients are not admitted, transferred, or referred before the test results required for these decisions are available.

Standard ACC.1.1
Patients with emergent, urgent, or immediate needs are given priority for assessment and treatment.
**Intent of ACC.1.1**
Patients with emergent, urgent, or immediate needs (such as airborne infections) are identified by an evidence-based triage process. Once identified as emergent, urgent, or requiring immediate needs, these patients are assessed and receive care as quickly as necessary. Such patients may be assessed by a physician or other qualified individual before other patients, receive diagnostic services as rapidly as possible, and begin treatment to meet their needs. The triage process may include physiologic-based criteria, where possible and appropriate. The hospital trains staff to determine which patients need immediate care and how their care is given priority.

When the hospital is not able to meet the needs of the patient with an emergency condition and the patient requires transfer to a higher level of care, the transferring hospital must provide and document stabilizing treatment within its capacity prior to transport.

**Measurable Elements of ACC.1.1**
1. The hospital uses an evidence-based triage process to prioritize patients with immediate needs.
2. Staff are trained to use the criteria.
3. Patients are prioritized based on the urgency of their needs.
4. Emergency patients are assessed and stabilized within the capacity of the hospital prior to transfer.
5. Stabilizing treatment provided prior to transport is documented in a record maintained by the transferring hospital. *(Also see MOL.10.1.1)*

**Standard ACC.1.2**
The hospital considers the clinical needs of patients and informs patients when there are waiting periods or delays for diagnostic and/or treatment services.

**Intent of ACC.1.2**
Patients are informed when there are known long waiting periods for diagnostic and/or treatment services or when obtaining the planned care may require placement on a waiting list. Patients are informed of the associated reasons for the delay or wait and are informed of available alternatives. This requirement applies to inpatient and outpatient care and/or diagnostic services; it does not apply to minor waits in providing outpatient care or inpatient care, such as when a physician is behind schedule. For some services, such as oncology or transplant, delays may be consistent with national norms for those services and thus different than the delays for such services as diagnostic.

**Measurable Elements of ACC.1.2**
1. Inpatients and outpatients are informed when there will be a delay in care and/or treatment.
2. Patients are informed of the reasons for the delay or wait and provided with information on available alternatives consistent with their clinical needs.
3. The information is documented in the patient record.

**Admission to the Hospital**

**Standard ACC.2**
The hospital has a process for admitting inpatients and for registering outpatients.
**Intent of ACC.2**
The process for admitting inpatients to the hospital for care and for registering outpatients for services is standardized. Staff are familiar with and follow the standardized process.

The process addresses
- registration for outpatient services or admission for inpatient services;
- admission directly from the emergency service to an inpatient unit; and
- the process for holding patients for observation.

**Measurable Elements of ACC.2**
- 1. The outpatient registration process is standardized.
- 2. The inpatient admitting process is standardized.
- 3. There is a process for admitting emergency patients to inpatient units.
- 4. There is a process for holding patients for observation.
- 5. Staff are familiar with and follow all of the admission and registration processes.

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**Standard ACC.2.1**
Patient needs for preventive, palliative, curative, and rehabilitative services are prioritized based on the patient’s condition at the time of admission as an inpatient to the hospital.

**Intent of ACC.2.1**
When patients are considered for admission as an inpatient to the hospital, the screening assessment helps staff identify and prioritize the preventive, curative, rehabilitative, and palliative services needed by the patient and select the most appropriate service or unit to meet the patient’s most urgent or priority needs.

**Measurable Elements of ACC.2.1**
- 1. The screening assessment helps staff identify the patient’s needs.
- 2. The service or unit selected to meet these needs is based on the screening assessment findings.
- 3. Patients’ needs related to preventive, curative, rehabilitative, and palliative services are prioritized.

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**Standard ACC.2.2**
At admission as an inpatient, patients and families receive information on the proposed care, the expected outcomes of care, and any expected cost to the patient for care.

**Intent of ACC.2.2**
During the admission process, patients and their families receive sufficient information to make knowledgeable decisions. Information is provided about the proposed care, the expected outcomes, and any expected cost to the patient or family for the care when not paid for by a public or private source. When financial constraints related to the cost of care are present, the hospital seeks ways to overcome those constraints. Such information can be in written form or provided verbally, noting such in the patient’s record.

**Measurable Elements of ACC.2.2**
- 1. The patient and family are provided with information at admission.
- 2. The information includes proposed care.
- 3. The information includes expected outcomes of care.
- 4. The information includes any expected costs to the patient or family.
Standard ACC.2.2.1
The hospital develops a process to manage the flow of patients throughout the hospital.

Intent of ACC.2.2.1
Emergency department (ED) crowding and high hospital occupancy rates can lead to boarding patients in the ED or creating temporary inpatient holding areas. Managing the flow of patients throughout their care is essential to prevent crowding, which can undermine the timeliness of care and, ultimately, patient safety. Effective management of systemwide processes that support patient flow (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care.

The components of the patient flow process address the following topics:

a) The available supply of inpatient beds
b) Facility plans for allocation of space, utilities, equipment, medical technology, and supplies to support temporary patient locations
c) Staffing plans to support the addition of temporary patient locations and/or boarding in the ED
d) The patient flow of areas where patients receive care, treatment, and services (such as inpatient units, laboratory, operating rooms, telemetry, radiology, and the postanesthesia care unit)
e) The efficiency of the nonclinical services that support patient care and treatment (such as housekeeping and transportation)
f) The provision for the same level of care as provided to patients admitted to an inpatient unit
g) Access to support services (such as social work, religious or spiritual support, and the like)

Monitoring and improving these processes are useful strategies to reduce patient flow problems. Staff from throughout the hospital—inpatient units, ED, medical staff, nursing, administration, environmental services, risk management—can make a significant contribution to understanding and resolving problems in patient flow. Measures and goals help identify impacts across units, reveal cycles and trends over time, and support accountability at all levels of the organization.

Patients who come to a hospital ED for care are particularly vulnerable to boarding. Boarding in the ED must be used as only a temporary solution to hospital crowding. Hospital plans should identify a time frame by which boarded patients will be transferred from the ED to a standard or temporary inpatient area. The expectations here are intended to guide hospitals in providing for a safe location, the orientation and training of staff, and the assessment, reassessment, and care (within its capabilities) of patients who are subject to boarding.

Measurable Elements of ACC.2.2.1

1. The hospital develops and implements a process that supports the flow of patients throughout the hospital that includes at least a) through g) of the intent.
2. The hospital plans and provides for the care of patients needing admission who are boarded in the ED, including identifying a time limit for boarding.
3. The hospital plans and provides for care to patients when bed space is not available on the desired service or unit or elsewhere in the facility.
4. The individuals who manage patient flow processes review the effectiveness to identify and implement process improvements.

Standard ACC.2.3
Admission to units providing intensive or specialized services is determined by established criteria.

Standard ACC.2.3.1
Discharge from units providing intensive or specialized services is determined by established criteria.
**Intent of ACC.2.3 and ACC.2.3.1**

Units or services that provide intensive care (for example, a postsurgical intensive care unit) or that provide specialized services (for example, the care of burn patients or organ transplant units) are costly and usually are limited in space and staffing. Each hospital must establish criteria for determining those patients who require the level of care provided in such units.

When considering admission to specialized units that utilize expensive resources, hospitals may restrict admission to only those patients with reversible medical conditions, and not provide admission to patients whose conditions are terminal. To ensure consistency, the criteria should utilize prioritization and diagnostic and/or objective parameters, including physiologic-based criteria. Individuals from the emergency, intensive, or specialized services participate in developing the criteria. The criteria are used to determine direct entry to the unit; for example, directly from the emergency department. The criteria are also used to determine admission into the unit from within the hospital or from outside the hospital (such as when a patient is transferred from another hospital).

Patients admitted to a specialized unit require reassessment and reevaluation to identify when the patient’s condition has changed, such that specialized care may no longer be required. For example, when the patient’s physiological status has stabilized and intensive monitoring and treatment are no longer necessary, or when the patient’s status has deteriorated to the point that specialized care and services will no longer be provided, the patient may be discharged from the specialized unit or moved to a unit that provides a lower level of care (such as a medical/surgical unit, hospice, or palliative care unit). The criteria used for transfer from a specialized unit to a lower level of care should be the criteria that are used for admitting patients to the next level of care. For example, when the patient’s condition has deteriorated such that intensive treatment is no longer considered helpful, the patient’s admission to hospice or palliative care must be according to criteria for admission to those services.

When the hospital conducts research or provides specialized patient care services or programs, admission into such programs is through established criteria or an established protocol. Individuals from the research or other programs are involved in developing the criteria or protocol. Admission to such programs is documented in the patient’s record and includes the criteria or protocol conditions under which the patient was admitted. (Also see ACC.3)

**Measurable Elements of ACC.2.3**

- 1. The hospital has established entry and/or transfer criteria for admission to intensive and specialized services or units, including research and other programs to meet special patient needs.
- 2. The criteria utilize prioritization, diagnostic, and/or objective parameters, including physiologic-based criteria.
- 3. Individuals from intensive/specialty units are involved in developing the criteria.
- 4. Staff are trained to apply the criteria.
- 5. The records of patients who are admitted to units providing intensive/specialized services contain evidence that they meet the criteria for services.

**Measurable Elements of ACC.2.3.1**

- 1. The hospital has established discharge and/or transfer criteria from intensive and specialized services or units to a different level of care, including research and other programs.
- 2. The criteria used for discharge or transfer should include the criteria used for admission to the next level of care.
- 3. Individuals from intensive or specialty units are involved in developing the criteria.
- 4. Staff are trained to apply the criteria.
- 5. The records of patients who are transferred or discharged from units providing intensive or specialized services contain evidence that they no longer meet the criteria for services.
**Continuity of Care**

**Standard ACC.3**
The hospital designs and carries out processes to provide continuity of patient care services in the hospital and coordination among health care practitioners.

**Intent of ACC.3**
As patients move through the hospital from admission to discharge or transfer, several departments and services and many different health care practitioners may be involved in providing care. Throughout all phases of care, patient needs are matched with the required resources within and, when necessary, outside the hospital.

Continuity is enhanced when all patient-care providers have the information needed from the patient’s current and past medical experiences to help in decision making, and, when multiple decision makers are providing care, these decision makers agree on the care and services to be provided.

The patient’s record(s) is a primary source of information on the care process and the patient’s progress and thus is an essential communication tool. For this information to be useful and to support the continuity of the patient’s care, it needs to be available during inpatient care, for outpatient visits, and at other times as needed and kept up to date. Medical, nursing, and other patient care notes are available to all of the patient’s health care practitioners who need them for the care of the patient. (Also see AOP.2)

For patient care to appear seamless, the hospital needs to design and to implement processes for continuity and coordination of care among physicians, nurses, and other health care practitioners in

1. emergency services and inpatient admission;
2. diagnostic services and treatment services;
3. surgical and nonsurgical treatment services;
4. outpatient care programs; and
5. other organizations and other care settings.

The leaders of the departments and services work together to design and to implement the processes of care coordination and continuity. These processes may be supported with the use of tools such as guidelines, clinical pathways, care plans, referral forms, checklists, and the like. The hospital identifies individuals responsible for coordinating services. These individuals may coordinate all patient care (for example, between departments) or may be responsible for coordinating the care of individual patients (for example, case manager). This care coordination is best accomplished by using established criteria or policies that determine the appropriateness of transfers within the hospital. (Also see IPSG.2.2; ACC.2.3; ACC.2.3.1; COP.8.3; COP.9.3, ME 2; ASC.7.2; and MOI.1)

**Measurable Elements of ACC.3**

1. The leaders of departments and services design and implement processes that support continuity and coordination of care, including at least a) through c) identified in the intent. (Also see GLD.10)
2. The patient’s record(s) is available to those practitioners who are authorized to have access and need it for the care of the patient. (Also see AOP.1.1)
3. The patient’s record(s) is up to date to ensure communication of the latest information.
4. Continuity and coordination of care processes are supported by the use of tools, such as care plans, guidelines, or other such tools.
5. Continuity and coordination are evident throughout all phases of patient care.
Standard ACC.3.1
During all phases of inpatient care, there is a qualified individual identified as responsible for the patient’s care.

Intent of ACC.3.1
To maintain continuity of care throughout the patient’s stay in the hospital, the individual with overall responsibility for coordination and continuity of the patient’s care or particular phase of the patient’s care is clearly identified. This individual may be a physician or other qualified individual. The responsible individual is identified in the patient's record. A single individual providing the oversight of care during the entire hospital stay will improve continuity, coordination, patient satisfaction, quality, and potentially the outcomes and thus is desirable for certain complex patients and others the hospital may identify. This individual would need to collaborate and to communicate with the other health care practitioners. In addition, hospital policy identifies the process for the transfer of responsibility from the responsible individual to another individual during vacations, holidays, and other periods. The policy identifies those consultants, on-call physicians, locum tenentes, or others who take responsibility and how they are to assume that responsibility and to document their participation or coverage.

When a patient moves from one phase of care to another (for example, from surgical to rehabilitation), the individual responsible for the patient’s care may change, or the same individual may continue overseeing the entire patient’s care.

Measurable Elements of ACC.3.1
- 1. The individual(s) responsible for the coordination of the patient’s care is identified in the patient’s record and available through all phases of inpatient care.
- 2. The individual(s) is qualified to assume responsibility for the patient’s care.
- 3. There is a process for transferring the responsibility for coordination of care from individual to individual.
- 4. The process identifies how these individuals assume the transferred responsibility and document their participation or coverage.

Standard ACC.3.2
Information related to the patient’s care is transferred with the patient.

Intent of ACC.3.2
Patients may be transferred within the hospital from one service or inpatient unit to a different service or inpatient unit during their course of care and treatment. When the care team changes as a result of the transfer, continuity of patient care requires that essential information related to the patient be transferred with him or her. Thus, medications and other treatments can continue uninterrupted, and the patient’s status can be monitored. To ensure that each care team receives the information needed to provide care, the patient’s record(s) is transferred or information from the patient’s record is summarized at transfer and provided to the care team receiving the patient. Such a summary includes the reason for admission, significant findings, diagnosis, procedures performed, medications and other treatments, and the patient’s condition at transfer.

Measurable Elements of ACC.3.2
- 1. The patient’s record or a summary of patient care information is transferred with the patient to another service or unit in the hospital.
- 2. The summary contains the reason for admission.
- 3. The summary contains the significant findings.
4. The summary contains any diagnosis made.
5. The summary contains any procedures performed.
6. The summary contains any medications and other treatments.
7. The summary contains the patient’s condition at transfer.

**Discharge, Referral, and Follow-Up**

**Standard ACC.4**
There is a process for the referral or discharge of patients that is based on the patient’s health status and the need for continuing care or services.

**Intent of ACC.4**
Referring or discharging a patient to a health care practitioner outside the hospital, another care setting, home, or family is based on the patient’s health status and need for continuing care or services. The patient’s physician or individual responsible for his or her care must determine readiness for discharge based on the policies and relevant criteria or indications of referral and discharge established by the hospital. Criteria may also be used to indicate when a patient is ready for discharge. Continuing needs may mean referral to a medical specialist, rehabilitation therapist, or even preventive health needs coordinated in the home by the family. An organized process is required to ensure that any continuing needs are met by appropriate health care practitioners or outside organizations. The process includes referring patients to sources of care outside the region when required. When indicated, the hospital begins to plan for the continuing needs as early in the care process as possible. The family is included in the discharge planning process as appropriate to the patient and his or her needs. (Also see AOP.1.8) There is a process to guide when the hospital permits patients to leave the hospital for a period of time (such as on a weekend “pass”).

**Measurable Elements of ACC.4**
1. Patients are referred and/or discharged based on their health status and needs for continuing care.
2. The patient’s readiness for discharge is determined by the use of relevant criteria or indications that ensure patient safety.
3. Planning for referral and/or discharge begins early in the care process.
4. There is a process for patients being permitted to leave the hospital during the planned course of treatment on an approved pass for a defined period of time.

**Standard ACC.4.1**
Patient and family education and instruction are related to the patient’s continuing care needs.

**Intent of ACC.4.1**
The hospital routinely provides education in areas that carry high risk to patients. Education supports the return to previous functional levels and maintenance of optimal health.

The hospital uses standardized materials and processes in educating patients on at least the following topics:
- Safe and effective use of all medications taken by the patient (not just discharge medications), including potential medication side effects
- Safe and effective use of medical technology
Potential interactions between prescribed medications and other medications (including over-the-counter preparations) and food
- Diet and nutrition
- Pain management
- Rehabilitation techniques

**Measurable Elements of ACC.4.1**

1. Patients and families are educated about the safe and effective use of all medications, potential side effects of medications, and prevention of potential interactions with over-the-counter medications and/or food.

2. Patients and families are educated about safe and effective use of medical technology.

3. Patients and families are educated about proper diet and nutrition.

4. Patients and families are educated about pain management.

5. Patients and families are educated about rehabilitation techniques.

**Standard ACC.4.2**

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

**Intent of ACC.4.2**

Timely referral to the practitioner, organization, or agency that can best meet the patient’s continuing needs takes planning. The hospital becomes familiar with the health care practitioners in its community to understand the types of patients treated and services provided and to build formal or informal relationships with those practitioners. When patients come from a different community, the hospital attempts to make a referral to a qualified individual or agency in the patient’s home community.

Also, patients may need support services and medical services at discharge. For example, patients may need social, nutritional, financial, psychological, or other support at discharge. The availability and actual use of these support services may, to a large degree, determine the need for continuing medical services. The discharge planning process includes the type of support service needed and the availability of such services.

**Measurable Elements of ACC.4.2**

1. The discharge planning process includes the need for both support services and continuing medical services.

2. Referrals outside the hospital are to specific individuals and agencies in the patient’s home community whenever possible.

3. Referrals are made for support services.

**Standard ACC.4.3**

The complete discharge summary is prepared for all inpatients.

**Intent of ACC.4.3**

The discharge summary provides an overview of the patient’s stay within the hospital. The summary can be used by the practitioner responsible for providing follow-up care. The summary includes the following:

- Reason for admission, diagnoses, and comorbidities
- Significant physical and other findings
- Diagnostic and therapeutic procedures performed
• Medications administered during hospitalization with the potential for residual effects after the medication has been discontinued and all medications to be taken at home
• The patient’s condition/status at the time of discharge (examples include “condition improved,” “condition unchanged,” and the like)
• Follow-up instructions

Measurable Elements of ACC.4.3

1. The discharge summary contains the reason(s) for admission, diagnoses, and comorbidities.
2. The discharge summary contains significant physical and other findings.
3. The discharge summary contains diagnostic and therapeutic procedures performed.
4. The discharge summary contains significant medications, including discharge medications.
5. The discharge summary contains the patient’s condition/status at the time of discharge.
6. The discharge summary contains follow-up instructions.

Standard ACC.4.3.1
Patient education and follow-up instructions are given in a form and language the patient can understand.

Intent of ACC.4.3.1
For patients not directly referred or transferred to another health care practitioner, clear instructions on where and how to receive continuing care are essential to ensure optimal outcomes of care and that all care needs are met. The instructions include the name and location of sites for continuing care, any return to the hospital for follow-up, and when urgent care should be obtained. Families are included in the process when a patient’s condition or abilities prevent him or her from understanding the follow-up instructions. Families are also included when they play a role in the continuing care process. The hospital provides the instructions to the patient and, as appropriate, his or her family in a simple, understandable manner. The instructions are provided in writing or in the form most understandable to the patient when the patient is not able to understand written instructions.

Measurable Elements of ACC.4.3.1

1. Follow-up instructions are provided in writing and in a form and language the patient can understand.
2. The instructions include any return for follow-up care.
3. The instructions include when to obtain urgent care.

Standard ACC.4.3.2
The clinical records of inpatients contain a copy of the discharge summary.

Intent of ACC.4.3.2
A summary of the patient’s care is prepared at discharge from the hospital. Any qualified individual can compile the discharge summary, such as the patient’s physician, a house officer, or a clerk.

A copy of the discharge summary is provided to the practitioner who will be responsible for the continuing or follow-up care of the patient. A copy is given to the patient when indicated by hospital or by common practice consistent with laws and culture. In cases in which details of a patient’s follow-up care are unknown, such as with patients who are visiting from a different region or country, a copy of the discharge summary is given to the patient. The copy of the discharge summary is placed in the patient’s record.
Measurable Elements of ACC.4.3.2

- 1. A discharge summary is prepared by a qualified individual.
- 2. A copy of the discharge summary is provided to the practitioner responsible for the patient’s continuing or follow-up care.
- 3. A copy of the discharge summary is provided to the patient in cases in which information regarding the practitioner responsible for the patient’s continuing or follow-up care is unknown.
- 4. A copy of the completed discharge summary is placed in the patient’s record in a time frame identified by the hospital.

Standard ACC.4.4

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

Intent of ACC.4.4

When the hospital provides ongoing care and treatment for outpatients with complex diagnoses and/or who need complex care (for example, patients seen several times for multiple problems, multiple treatments, in multiple clinics, and/or the like), there may be an accumulated number of diagnoses and medications and an evolving clinical history and physical examination findings. It is important for any health care practitioner in all settings providing care to that outpatient to have access to information about the care being provided.

The process for providing this information to health care professionals includes:

- identifying the types of patients receiving complex care and/or with complex diagnoses (such as patients seen in the cardiac clinic with multiple comorbidities, or patients with end-stage renal failure);
- identifying the information needed by the clinicians who treat those patients;
- determining what process will be used to ensure that the medical information needed by the clinicians is available in an easy-to-retrieve and easy-to-review format; and
- evaluating the implementation results to verify that the information and process meet the needs of the clinicians and improve the quality and safety of outpatient clinical services.

Measurable Elements of ACC.4.4

- 1. The hospital identifies the types of outpatients receiving complex care and/or with complex diagnoses who require an outpatient profile.
- 2. The information to be included in the outpatient profile is identified by the clinicians who treat those patients.
- 3. The hospital uses a process that will ensure the outpatient profile is available in an easy to retrieve and review format.
- 4. The process is evaluated to see if it meets the needs of the clinicians and improves the quality and safety of outpatient clinical visits.

Standard ACC.4.5

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

Standard ACC.4.5.1

The hospital has a process for the management of patients who leave the hospital against medical advice without notifying hospital staff.
Intent of ACC.4.5 and ACC.4.5.1
When a patient decides to leave the hospital after an examination has been completed and a treatment plan recommended, whether it is an inpatient or an outpatient, this is identified as “leaving against medical advice.” Inpatients and outpatients (including patients from the emergency department) have the right to refuse medical treatment and/or leave the hospital against medical advice. However, these patients may be at risk of inadequate treatment, which may result in permanent harm or death. When a competent inpatient or outpatient requests to leave the hospital without medical approval, the medical risks must be explained by the physician providing the treatment plan or his or her designee prior to discharge. Also, normal discharge procedures should be followed, if the patient allows. If the patient has a family physician who has not been involved, but is known to the hospital, the family physician must be notified of the patient’s decision. Efforts should be made to identify the reason the patient is choosing to leave against medical advice. Hospitals need to understand these reasons in order to be able to provide better communication to patients and/or families and identify potential process improvements.

When a patient leaves the hospital against medical advice without notifying anyone in the hospital, or an outpatient receiving complex or lifesaving treatment, such as chemotherapy or radiation therapy, does not return for treatment, the hospital must make an effort to contact the patient to inform him or her of potential risks. If the patient has a family physician who is known to the hospital, the hospital, in order to reduce the risk of harm, should notify that physician.

The hospital designs this process to be consistent with applicable laws and regulations. When applicable, the hospital reports cases of infectious disease and provides information regarding patients who may harm themselves or others to local and national health authorities as required.

Measurable Elements of ACC.4.5
- 1. There is a process for managing inpatients and outpatients who notify staff that they are leaving against medical advice.
- 2. The process includes informing the patient of the medical risks of inadequate treatment.
- 3. The patient should be discharged according to the hospital discharge process.
- 4. If the family physician of a patient leaving against medical advice is known and has not been involved in the process, the physician is notified.
- 5. The hospital has a process to try to identify the reasons for patients leaving against medical advice.
- 6. The process is consistent with applicable laws and regulations, including requirements for reporting cases of infectious disease and cases in which patients may be a threat to themselves or others.

Measurable Elements of ACC.4.5.1
- 1. There is a process for the management of inpatients and outpatients who leave the hospital against medical advice without notifying hospital staff.
- 2. There is a process for the management of outpatients receiving complex treatment who do not return for treatment.
- 3. If the family physician is known and has not been involved in the process, the physician is notified.
- 4. The process is consistent with applicable laws and regulations, including requirements for reporting cases of infectious disease and cases in which patients may be a threat to themselves or others.
Transfer of Patients

**Standard ACC.5**
Patients are transferred to other organizations based on status, the need to meet their continuing care needs, and the ability of the receiving organization to meet patients’ needs.

**Intent of ACC.5**
Transferring a patient to an outside organization is based on the patient’s status and need for continuing health care services. Transfer may be in response to a patient’s need for specialized consultation and treatment, urgent services, or less-intensive services, such as subacute care or longer-term rehabilitation. Criteria help to identify when a transfer is necessary in order to ensure that the patient’s needs are met.

When referring a patient to another organization, the referring hospital must determine if the receiving organization provides services to meet the patient’s needs and has the capacity to receive the patient. This determination is usually made in advance, and the willingness to receive patients and the transfer conditions are described in formal or informal affiliations or agreements. This advance determination ensures continuity of care and that the patient’s care needs will be met. Transfers may occur to other sources of specialized treatment or services without formal or informal transfer agreements.

**Measurable Elements of ACC.5**
- 1. Transfers of patients are based on criteria developed by the hospital to address patients’ needs for continuing care.
- 2. The referring hospital determines that the receiving organization can meet the needs of the patient to be transferred.
- 3. Formal or informal arrangements are in place with receiving organizations when patients are frequently transferred to the same organization(s).

**Standard ACC.5.1**
The referring hospital develops a transfer process to ensure that patients are transferred safely.

**Intent of ACC.5.1**
Transferring a patient directly to another health care organization may be a brief process with an alert and talking patient, or it may involve moving a comatose patient who needs continuous nursing or medical oversight. In either case, the patient requires monitoring and may need specialized medical technology, but the qualifications of the individual doing the monitoring and the type of medical technology needed are significantly different. Thus, the condition and status of the patient determine the qualifications of the staff member monitoring the patient and the type of medical technology needed during transfer.

A consistent process for how patients are transferred from one organization to another is required to ensure that patients are transferred safely. Such a process addresses:
- how responsibility is transferred between practitioners and settings;
- criteria for when transfer is necessary to meet the patient’s needs;
- who is responsible for the patient during transfer;
- what medications, supplies, and medical technology are required during transfer;
- a follow-up mechanism that provides the condition of the patient during transfer and upon arrival to the receiving organization; and
- what is done when transfer to another source of care is not possible.
The hospital evaluates the quality and safety of the transfer process to ensure that patients were transferred with qualified staff and the correct medical technology for the patient’s condition.

**Measurable Elements of ACC.5.1**

- 1. The hospital develops a transfer process that addresses how responsibility for continuing care is moved to another practitioner or setting.
- 2. The transfer process identifies who is responsible for monitoring the patient during transfer and the staff qualifications required for the type of patient being transferred.
- 3. The transfer process identifies the medications, supplies, and medical technology required during transport.
- 4. The transfer process addresses a follow-up mechanism that provides information about the patient’s condition upon arrival to the receiving organization.
- 5. The transfer process addresses the situations in which transfer is not possible.
- 6. There is a process to evaluate the quality and safety of the transfer process.

**Standard ACC.5.2**

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

**Intent of ACC.5.2**

To ensure continuity of care, patient information is transferred with the patient. A copy of the discharge summary or other written clinical summary is provided to the receiving organization with the patient. The summary includes the patient’s clinical condition or status, the procedures and other interventions provided, and the patient’s continuing needs.

**Measurable Elements of ACC.5.2**

- 1. A patient clinical summary document is transferred with the patient.
- 2. The clinical summary includes patient status.
- 3. The clinical summary includes procedures and other interventions provided.
- 4. The clinical summary includes the patient’s continuing care needs.

**Standard ACC.5.3**

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

**Intent of ACC.5.3**

The record of each patient transferred to another health care organization contains documentation of the transfer. The documentation includes the name of the organization and the name of the individual agreeing to receive the patient, the reason(s) for the transfer, and any special conditions for transfer (such as when space at the receiving organization is available, or the patient’s status). Also, it is noted if the patient’s condition or status changed during transfer (for example, the patient dies or requires resuscitation). Any other documentation required by hospital policy (for example, a signature of the receiving nurse or physician, the name of the individual who monitored the patient during transport) is included in the record.

**Measurable Elements of ACC.5.3**

- 1. The records of transferred patients note the name of the receiving health care organization and the name of the individual agreeing to receive the patient.
2. The records of transferred patients contain documentation or other notes as required by the policy of the transferring hospital.

3. The records of transferred patients note the reason(s) for transfer.

4. The records of transferred patients note any special conditions related to transfer.

Transportation

Standard ACC.6
The process for referring, transferring, or discharging patients, both inpatients and outpatients, includes planning to meet patients’ transportation needs.

Intent of ACC.6
The hospital’s process for referring, transferring, or discharging patients includes an understanding of the transportation needs of patients. For example, patients from long term care facilities or rehabilitative centers needing outpatient services or evaluation in the emergency department may arrive by ambulance or other medical vehicle. Upon completion of the service, the patient may require assistance with transportation back to his or her home or another facility. In other situations, patients may drive themselves to the hospital for a procedure that impairs their ability to drive themselves home (such as eye surgery, a procedure that requires sedation, and the like). Assessing the patient’s transportation needs and ensuring that the patient has safe transportation is the hospital’s responsibility. Depending on hospital policy and the laws and regulations of the region, the cost of the transportation may or may not be the responsibility of the hospital.

The type of transportation will vary and may be by ambulance or other vehicles owned by the hospital or by a source designated by the family, or the family and/or friends may provide the transportation. The transportation selected will depend on the patient’s condition and status.

When the transport vehicles are owned by the hospital, they need to be in compliance with all applicable laws and regulations related to their operation, condition, and maintenance. The hospital identifies the transportation situations that have a risk of infection and implements strategies to reduce infection risk. (Also see PCI.7; PCI.7.1; PCI.7.1.1; PCI.7.2; PCI.7.3; PCI.8, ME 1; and PCI.9) The required drugs, medications, and other supplies needed within the vehicle are based on the types of patients transported. For example, simply taking geriatric patients home from outpatient visits is very different than transferring an infectious disease or burn patient to another hospital.

If the hospital contracts for transport services, the hospital must be assured that the contractor meets similar standards for patient and vehicle safety. When transportation services are provided by the Ministry of Health, an insurance organization, or other entity not under the control or supervision of the hospital, reporting quality and safety issues to the responsible organization provides valuable feedback that can help in making quality decisions related to patient transports.

In all cases, the hospital evaluates the quality and safety of the transportation services. This includes the receipt of, evaluation of, and response to complaints regarding the transportation provided or arranged.

Measurable Elements of ACC.6
1. There is an assessment of transportation needs when any patient is referred to another source of care, transferred to another care setting, or ready to go home following an inpatient admission or outpatient visit.

2. The transportation provided or arranged is appropriate to the needs and condition of the patient.

3. Transport vehicles owned by the hospital meet relevant laws and regulations related to their operation, condition, and maintenance.
4. Transportation services, including contracted services, meet the hospital’s requirements for quality and safe transport.

5. All vehicles used for transportation, contracted or hospital owned, comply with the infection control program and have appropriate medical technology, supplies, and medications to meet the needs of the patient being transported.

6. There is a process in place to monitor the quality and safety of transportation provided or arranged by the hospital, including a complaint process.

References
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<table>
<thead>
<tr>
<th>Standard</th>
<th>Change</th>
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<td>Renumbered; Requirement change</td>
<td>Renumbers and combines requirements of PFR.1.1 and PFR.1.1.1 (4th edition); rewords standard and MEs to clarify requirements</td>
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Patient and Family Rights (PFR)

**Standard PFR.1**
The hospital is responsible for providing processes that support patients’ and families’ rights during care. *

**Intent of PFR.1**
The hospital leadership is primarily responsible for how a hospital will treat its patients. Thus, leadership needs to know and to understand patient and family rights and their hospital’s responsibilities as identified in laws and regulations. Leadership then provides direction to department/service leaders who ensure that staff throughout the hospital assume responsibility for protecting these rights. To effectively protect and to advance patient rights, leadership works and seeks to understand their responsibilities in relation to the community served by the hospital.

The hospital respects the right of patients, and in some circumstances the right of the patient’s family, to have the prerogative to determine what information regarding their care would be provided to family or others, and under what circumstances. For example, the patient may not wish to have a diagnosis shared with family.

Patient and family rights are a fundamental element of all contacts among a hospital, its staff, and patients and families. Thus, policies and procedures are developed and implemented to ensure that all staff members are aware of and respond to patient and family rights issues when they interact with and care for patients throughout the hospital. The hospital uses a collaborative and inclusive process to develop the policies and procedures, and includes patients and families in the process. (Also see COP.9)

**Measurable Elements of PFR.1**

1. Hospital leadership works to protect and to advance patient and family rights.
2. Hospital leadership understands patient and family rights as identified in laws and regulations and in relation to the cultural practices of the community or individual patients served.
3. The hospital respects the right of patients, and in some circumstances the right of the patient’s family, to have the prerogative to determine what information regarding their care would be provided to family or others, and under what circumstances.
4. All staff are knowledgeable about patient rights and can explain their responsibilities in protecting patient rights.
Standard PFR.1.1
The hospital seeks to reduce physical, language, cultural, and other barriers to access and delivery of services.

Intent of PFR.1.1
Hospitals frequently serve communities with a diverse population. Patients may be aged, have disabilities, speak multiple languages or dialects, be culturally diverse, or present other barriers that make the process of accessing and receiving care very difficult. The hospital has identified those barriers and has implemented processes to eliminate or to reduce them for patients seeking care. The hospital also takes action to reduce the impact of these barriers on the delivery of services. (*Also see COP.1, PFE.2.1, and GLD.12*)

Measurable Elements of PFR.1.1
- 1. The department/service leaders and staff of the hospital identify the most common barriers in its patient population.
- 2. The department/service leaders develop and implement a process to overcome or limit barriers for patients seeking care.
- 3. The department/service leaders develop and implement a process to limit the impact of barriers on the delivery of services.

Standard PFR.1.2
The hospital provides care that is respectful of the patient’s personal values and beliefs and responds to requests related to spiritual and religious beliefs.

Intent of PFR.1.2
Each patient brings his or her own set of values and beliefs to the care process. Some values and beliefs are commonly held by all patients and are frequently cultural and religious in origin. Other values and beliefs are those of the patient alone. All patients are encouraged to express their beliefs in ways that respect the beliefs of others.

Strongly held values and beliefs can shape the care process and how patients respond to care. Thus, each health care practitioner seeks to understand the care and services he or she provides within the context of the patient’s values and beliefs.

When a patient or family wishes to speak with someone related to religious or spiritual needs, the hospital has a process to respond to the request. The process may be carried out through on-site religious staff, local sources, or family-referred sources. The process to respond is more complex; for example, when the hospital or country does not officially “recognize” and/or have sources related to a religion or belief for which there may be a request.

Measurable Elements of PFR.1.2
- 1. Patients’ values and beliefs are identified.
- 2. Staff provide care that is respectful of the patient’s values and beliefs.
- 3. The hospital responds to routine as well as complex requests related to religious or spiritual support.

Standard PFR.1.3
The patient’s rights to privacy and confidentiality of care and information are respected.
Intent of PFR.1.3
Patient privacy, particularly during clinical interviews, examinations, procedures/treatments, and transport, is important. Patients may desire privacy from other staff, from other patients, and even from family members. Also, patients may not wish to be photographed, to be recorded, or to participate in accreditation survey interviews. Although there are some common approaches to providing privacy for all patients, individual patients may have different or additional privacy expectations and needs according to the situation, and these expectations and needs may change over time. Thus, as staff members provide care and services to patients, they inquire about the patient’s privacy needs and expectations related to the care or service. This communication between a staff member and his or her patient builds trust and open communication and does not need to be documented.

Medical and other health information, when documented and collected, is important for understanding the patient and his or her needs and for providing care and services over time. This information may be in paper or electronic form or a combination of the two. The hospital respects such information as confidential and has implemented policies and procedures that protect such information from loss or misuse. The policies and procedures reflect information that is released as required by laws and regulations.

Staff respects patient privacy and confidentiality by not posting confidential information on the patient’s door or at the nursing station and by not holding patient-related discussions in public places. Staff are aware of laws and regulations governing the confidentiality of information and inform the patient about how the hospital respects their privacy and the confidentiality of information. Patients are also informed about when and under what circumstances information may be released and how their permission will be obtained.

The hospital has a policy that indicates if patients have access to their health information and the process to gain access when permitted.

Measurable Elements of PFR.1.3
1. Staff members identify patient expectations and needs for privacy during care and treatment.
2. A patient’s expressed need for privacy is respected for all clinical interviews, examinations, procedures/treatments, and transport.
3. Confidentiality of patient information is maintained according to laws and regulations. (Also see MOL.2 and MOL.7)
4. Patients are requested to grant permission for the release of information not covered by laws and regulations.

Standard PFR.1.4
The hospital takes measures to protect patients’ possessions from theft or loss.

Intent of PFR.1.4
The hospital communicates its responsibility, if any, for the patient’s possessions to patients and families. When the hospital takes responsibility for any or all of the patient’s personal possessions brought into the hospital, there is a process to account for the possessions and to ensure that they will not be lost or stolen. This process considers the possessions of emergency patients, same-day surgery patients, inpatients, those patients unable to make alternative safekeeping arrangements, and those incapable of making decisions regarding their possessions. (Also see FMS.4.1)

Measurable Elements of PFR.1.4
1. The hospital has determined its level of responsibility for patients’ possessions.
2. Patients receive information about the hospital’s responsibility for protecting personal belongings.
3. Patients’ possessions are safeguarded when the hospital assumes responsibility or when the patient is unable to assume responsibility.
Standard PFR.1.5
Patients are protected from physical assault, and populations at risk are identified and protected from additional vulnerabilities.

Intent of PFR.1.5
The hospital is responsible for protecting patients from physical assault by visitors, other patients, and staff. This responsibility is particularly relevant to infants and children, the elderly, and others unable to protect themselves or to signal for help. The hospital seeks to prevent assault through such processes as investigating individuals in the facility without identification, monitoring remote or isolated areas of the facility, and quickly responding to those thought to be in danger of assault.

Each hospital identifies its at-risk patient groups (such as children, disabled individuals, the elderly) and establishes processes to protect the rights of individuals in these groups. Vulnerable patient groups and the hospital’s responsibility may be identified in laws and regulations. Staff members understand their responsibilities in these processes. Children, disabled individuals, the elderly, and other identified populations at risk are protected. Comatose patients and individuals with mental or emotional disabilities are also included. Such protection extends beyond physical assault to other areas of safety, such as abuse, negligent care, withholding of services, or providing assistance in the event of a fire. (Also see FMS.4.1 and FMS.7)

Measurable Elements of PFR.1.5
- 1. The hospital develops and implements a process to protect all patients from assault.
- 2. Vulnerable populations that are at additional risks are identified.
- 3. The hospital develops and implements a process to protect vulnerable populations from other safety issues.
- 4. Remote or isolated areas of the facility are monitored.
- 5. Staff members understand their responsibilities in the protection processes.

Standard PFR.2
The hospital supports patients’ and families’ rights to participate in the care process.

Intent of PFR.2
Patients and families participate in the care process by making decisions about care, asking questions about care, requesting a second opinion, and even refusing diagnostic procedures and treatments. When a patient requests a second opinion, it is expected that the hospital will not prohibit, prevent, or obstruct a patient who is seeking a second opinion, but rather, the hospital will facilitate the second opinion by providing the patient with information about his or her condition, such as test results, diagnosis, recommendations for treatment, and the like. The hospital must not withhold this information if a patient requests it for a second opinion. The hospital is not expected to provide and pay for a second opinion when requested by the patient. Policies address the patient’s right to seek a second opinion without fear of compromise to their care within or outside the hospital.

The hospital supports and promotes patient and family involvement in all aspects of care. All staff members are trained on the policies and procedures and on their role in supporting patients’ and families’ rights to participate in the care process. (Also see COP.7.1, ME 5)

Measurable Elements of PFR.2
- 1. The hospital supports and promotes patient and family participation in care processes.
- 2. The hospital facilitates a patient’s request to seek a second opinion without fear of compromise to his or her care within or outside the hospital.
3. Staff members are trained on the policies and procedures and their role in supporting patient and family participation in care processes.

**Standard PFR.2.1**

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

**Intent of PFR.2.1**

For patients and families to participate in care decisions, they need basic information about the medical conditions found during assessment, including any confirmed diagnosis, and on the proposed care and treatment. During the care process patients also have a right to be told of the outcomes of the planned care and treatment. In addition, it is important that they be told of any unanticipated outcomes of the care and treatment, such as unanticipated events during surgery or with prescribed medications or other treatments.

Patients and families understand that they have a right to this information and who is responsible for telling them. Patients and families understand the type of decisions that must be made about care and how to participate in those decisions. In addition, patients and families need to understand the hospital's process to obtain consent and which care processes, tests, procedures, and treatments require their consent.

Although some patients may not wish to personally know a confirmed diagnosis or to participate in the decisions regarding their care, they are given the opportunity and can choose to participate through a family member, friend, or a surrogate decision maker.

For patients, it should be clear who will provide them with the information about their medical condition, care, treatment, outcomes, unanticipated events, and the like.

**Measurable Elements of PFR.2.1**

1. Patients are informed of their medical conditions and any confirmed diagnosis.
2. Patients are informed of the planned care and treatment(s).
3. Patients are told when informed consent will be required and the process used to give consent.
4. Patients are informed about the expected outcomes of care and treatment.
5. Patients are informed about any unanticipated outcomes of care and treatment.
6. Patients and families are informed about their right to participate in care decisions to the extent they wish.

**Standard PFR.2.2**

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

**Intent of PFR.2.2**

Patients, or those making decisions on their behalf, may decide not to proceed with the planned care or treatment or to continue care or treatment after it has been initiated. Some of the most difficult decisions related to refusing or withdrawing care are related to decisions about withholding resuscitative services or forgoing or withdrawing life-sustaining treatment. These decisions are difficult not only for patients and families, but for health care professionals and the hospital as well. No single process can anticipate all the situations in which such decisions must be made. For this reason, it is important for the hospital to develop a framework for making these difficult decisions. The framework

- helps the hospital identify its position on these issues;
ensures that the hospital’s position conforms to its community’s religious and cultural norms and to any legal or regulatory requirements, in particular when legal requirements for resuscitation are not consistent with the patient’s wishes;

addresses situations in which these decisions are modified during care; and

guides health professionals through the ethical and legal issues in carrying out such patient wishes.

To ensure that the decision-making process related to carrying out the patient’s wishes is applied consistently, the hospital develops policies and procedures through a process that includes many professionals and viewpoints. The policies and procedures identify lines of accountability and responsibility and how the process is documented in the patient’s record.

The hospital informs patients and families about their rights to make these decisions, the potential outcomes of these decisions, and the hospital’s responsibilities related to such decisions. Patients and families are informed about any care and treatment alternatives.

**Measurable Elements of PFR.2.2**

1. The hospital has identified its position on withholding resuscitative services and forgoing or withdrawing life-sustaining treatments.

2. The hospital’s position conforms to its community’s religious and cultural norms and any legal or regulatory requirements.

3. The hospital informs patients and families about their rights to refuse or to discontinue treatment and the hospital’s responsibilities related to such decisions.

4. The hospital informs patients about the consequences of their decisions.

5. The hospital informs patients about available care and treatment alternatives.

6. The hospital guides health professionals on the ethical and legal considerations in carrying out patient wishes regarding treatment alternatives.

**Standard PFR.2.3**

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

**Intent of PFR.2.3**

Pain is a common part of the patient experience, and unrelieved pain has adverse physical and psychological effects. A patient’s response to pain is frequently within the context of societal norms and cultural and religious traditions. Thus, patients are encouraged and supported in their reporting of pain.

Dying patients have unique needs that may also be influenced by cultural and religious traditions. Concern for the patient’s comfort and dignity guides all aspects of care during the final stages of life. To accomplish this, all staff members are made aware of patients’ unique needs at the end of life. These needs include treatment of primary and secondary symptoms; pain management; response to the patient’s and family’s psychological, social, emotional, religious, and cultural concerns; and involvement in care decisions.

The hospital’s care processes recognize and reflect the right of all patients to assessment and management of pain and the assessment and management of a patient’s unique needs at the end of life. (*Also see COP.7*)

**Measurable Elements of PFR.2.3**

1. The hospital respects and supports the patient’s right to assessment and management of pain.

2. The hospital respects and supports the patient’s right to assessment and management of the dying patient’s needs.
3. The hospital's staff understand the personal, cultural, and societal influences on the patient’s experiences with pain.

4. The hospital's staff understand the personal, cultural, and societal influences on the patient’s experiences with death and dying.

**Standard PFR.3**

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

**Intent of PFR.3**

Patients have a right to voice complaints about their care and to have those complaints reviewed and, when possible, resolved. Also, decisions regarding care sometimes present questions, conflicts, or other dilemmas for the hospital and the patient, family, or other decision makers. These dilemmas may arise from issues of access, treatment, or discharge. They can be particularly difficult to resolve when the issues involve, for example, withholding resuscitative services or forgoing or withdrawing life-sustaining treatment.

The hospital has established processes for seeking resolution of such dilemmas and complaints. The hospital identifies in policies and procedures those who need to be involved in the processes and how the patient and family participate. (Also see SQE.11)

**Measurable Elements of PFR.3**

1. Patients are informed about the process for voicing complaints, conflicts, and differences of opinion.

2. Complaints, conflicts, and differences of opinion are investigated by the hospital.

3. Complaints, conflicts, and differences of opinion that arise during the care process are resolved.

4. Patients and families participate in the resolution process.

**Standard PFR.4**

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

**Intent of PFR.4**

Admission as an inpatient or registration as an outpatient to a health care hospital can be frightening and confusing for patients, making it difficult for them to act on their rights and to understand their responsibilities in the care process. Thus, the hospital prepares a written statement of patient and family rights and responsibilities that is given to patients when they are admitted as inpatients or registered as outpatients to the hospital and is available each visit or throughout their stay. For example, the statement may be posted in the facility.

The statement is appropriate to the patient’s age, understanding, and language. When written communication is not effective or appropriate, the patient and family are informed of their rights and responsibilities in a language and manner they can understand.

**Measurable Elements of PFR.4**

1. Information about patient rights and responsibilities is provided in writing to each patient.

2. The statement of patient rights and responsibilities is posted or otherwise available from staff at all times.

3. The hospital has a process to inform patients of their rights and responsibilities when written communication is not effective or appropriate.
**General Consent**

**Standard PFR.5**
General consent for treatment, if obtained when a patient is admitted as an inpatient or is registered for the first time as an outpatient, is clear in its scope and limits.

**Intent of PFR.5**
Many hospitals obtain a general consent (rather than rely on implied consent) for treatment when the patient is admitted as an inpatient to the hospital or when the patient is registered for the first time as an outpatient. When a general consent is obtained, patients are given information on the scope of the general consent, such as which tests and treatments are included under the general consent. Patients are also given information about those tests and treatments for which a separate informed consent will be obtained. The general consent notes if it is likely that students and trainees will participate in care processes. The hospital defines how a general consent is documented in the patient’s record.

**Measurable Elements of PFR.5**
- 1. Patients and families are informed as to the scope of a general consent, when used by the hospital.
- 2. The hospital has defined how a general consent, when used, is documented in the patient record.
- 3. Patients and families are informed about which tests and treatments require informed consent. (*Also see PFR.5.1*)

**Informed Consent**

**Standard PFR.5.1**
Patient informed consent is obtained through a process defined by the hospital and carried out by trained staff in a manner and language the patient can understand.

**Intent of PFR.5.1**
One of the main ways that patients are involved in their care decisions is by granting informed consent. To consent, a patient must be informed of those factors related to the planned care required for an informed decision. Informed consent may be obtained at several points in the care process. For example, informed consent can be obtained when the patient is admitted for inpatient care in the hospital and before certain procedures or treatments for which the risk is high. The consent process is clearly defined by the hospital in policies and procedures. Relevant laws and regulations are incorporated into the policies and procedures.

Patients and families are informed as to which tests, procedures, and treatments require consent and how they can give consent (for example, given verbally, by signing a consent form, or through some other means). Education by hospital staff is provided to patients and families as part of the process of obtaining informed consent for treatment (for example, for surgery and anesthesia).

Patients and families understand who may, in addition to the patient, give consent. Designated staff members are trained to inform patients and to obtain and to document patient consent. (*Also see PFR.5, ME.3 and GLD.18*)

**Measurable Elements of PFR.5.1**
- 1. The hospital develops and implements a clearly defined informed consent process.
- 2. Designated staff are trained in the process.
3. Patients learn about the process for granting informed consent in a manner and language that the patient understands.

4. Patients give informed consent consistent with the process.

5. There is a uniform recording of informed consent.

**Standard PFR.5.2**

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

**Intent of PFR.5.2**

When the planned care includes surgical or invasive procedures, anesthesia, procedural sedation, use of blood and blood products, or other high-risk treatments or procedures, a separate consent is obtained (also see ASC.3, ASC.3.3, ASC.5.1, and ASC.7.1). This consent process provides the information identified in PFR.5.3 and documents the identity of the individual providing the information. (Also see COP.8.5 and COP.9.1)

Not all treatments and procedures require a specific, separate consent. Each hospital identifies those high-risk, problem-prone, or other procedures and treatments for which consent must be obtained. (Also see COP.3) The hospital lists these procedures and treatments and educates staff to ensure that the process to obtain consent is consistent. The list is developed collaboratively by those physicians and others who provide the treatments or perform the procedures. The list includes procedures and treatments provided on an outpatient basis and inpatient basis.

**Measurable Elements of PFR.5.2**

1. Consent is obtained before surgical or invasive procedures.

2. Consent is obtained before anesthesia and procedural sedation.

3. Consent is obtained before the use of blood and blood products.

4. The hospital has listed those additional procedures and treatments that require separate consent.

5. Consent is obtained before the additional and/or other high-risk procedures and treatments.

6. The identity of the individual providing the information to the patient and family is noted in the patient’s record.

**Standard PFR.5.3**

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

**Intent of PFR.5.3**

Staff members clearly explain any proposed treatment(s) or procedures to the patient and the family. The information provided includes

- the patient's condition;
- the proposed treatment(s);
- the name of the person providing the treatment;
- potential benefits and drawbacks;
- possible alternatives;
- the likelihood of success;
- possible problems related to recovery; and
- possible results of nontreatment. (Also see PFR.5.2)
Staff members also inform the patient of the name of the physician or other practitioner who has primary responsibility for the patient’s care or who is authorized to perform procedures or treatment(s). Frequently, patients have questions about their primary care practitioners’ experience, length of time with the hospital, and the like. The hospital needs to have a process to respond when patients request additional information about their primary care practitioners.

**Measurable Elements of PFR.5.3**

- 1. Patients are informed of elements a) through h) in the intent as relevant to their condition and planned treatment.
- 2. Patients know the identities of the physicians or other practitioners responsible for their care.
- 3. The hospital develops and implements a process to respond to a patient’s request for additional information on the practitioner responsible for his or her care.

**Standard PFR.5.4**
The hospital establishes a process, within the context of existing law and culture, for when others can grant consent.

**Intent of PFR.5.4**
Informed consent for care sometimes requires that people other than (or in addition to) the patient be involved in decisions about the patient’s care. This is particularly true when the patient does not have the mental or physical capacity to make care decisions, when culture or custom requires that others make care decisions, or when the patient is a child. When the patient cannot make decisions about his or her care, a surrogate decision maker is identified. When someone other than the patient gives consent, that individual is noted in the patient’s record.

**Measurable Elements of PFR.5.4**

- 1. The hospital develops and implements a process for when others can grant informed consent.
- 2. The process respects law, culture, and custom.
- 3. Individuals, other than the patient, granting consent are noted in the patient’s record.

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**Organ Donation**

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

**Standard PFR.6**
The hospital informs patients and families about how to choose to donate organs and other tissues.

**Standard PFR.6.1**
The hospital provides oversight for the process of organ and tissue procurement.
Intent of PFR.6 and PFR.6.1
The shortage of available organs for transplant has encouraged many countries to develop procedures and systems to increase that supply. In some countries, laws determine that everyone is a donor unless specified otherwise (which is considered presumed consent). In other countries, explicit consent for organ donation is required. The hospital is responsible for defining the process of obtaining and recording consent for cell, tissue, and organ donation in relation to international ethical standards and the manner in which organ procurement is organized in their country. The hospital has a responsibility to ensure that adequate controls are in place to prevent patients from feeling pressured to donate.

The hospital supports the choice of patients and families to donate organs and other tissues for research or transplantation. Information is provided to patients and families on the donation process and the manner in which organ procurement is organized for the community, region, or nation (such as a national or regional organ procurement agency or network).

The shortage of organs for transplant has resulted in questionable practices in the procurement and transplantation of organs. The practice of inducing vulnerable individuals or groups (such as illiterate and impoverished persons, undocumented immigrants, prisoners, and political or economic refugees) to become living donors, organ trafficking (the buying and selling of organs over black market trade), the harvesting of organs without consent from executed prisoners or dead patients, and transplant tourism are inconsistent with ensuring organ donor and recipient safety.

Oversight for the process of organ and tissue procurement includes defining the donation process that is consistent with laws and regulations, respecting the community’s religious and cultural values, ensuring ethical practices, and identifying requirements for consent. Hospital staff are trained on the donation process that supports patient and family choices. Staff are also trained in the contemporary concerns and issues related to organ donation and availability of transplants. The hospital cooperates with other hospitals and agencies in the community responsible for all or a portion of the procurement, banking, transportation, or transplantation process. (Also see COP.9)

Measurable Elements of PFR.6
- 1. The hospital supports patient and family choices to donate organs and other tissues.
- 2. The hospital provides information to patients and families on the donation process.
- 3. The hospital provides information to the patient and family on the manner in which organ procurement is organized.
- 4. The hospital ensures that adequate controls are in place to prevent patients from feeling pressured to donate.

Measurable Elements of PFR.6.1
- 1. The hospital defines the organ- and tissue-donation processes and ensures that the process is consistent with the region’s laws and regulations and its religious and cultural values.
- 2. The hospital identifies consent requirements and develops a consent process consistent with those requirements.
- 3. Staff are trained in the contemporary issues and concerns related to organ donation and the availability of transplants.
- 4. The hospital cooperates with relevant hospitals and agencies in the community to respect and to implement choices to donate.
## Assessment of Patients (AOP)

### Changes to the AOP Chapter

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<tr>
<td>AOP.1.1</td>
<td>Renumbered; No significant change</td>
<td>Moves requirement from AOP.1.2 (4th edition) and adds text to intent to emphasize the need for health professionals to work together for effective patient assessment</td>
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<td>Standard</td>
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<tr>
<td>AOP.2</td>
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<td>Adds text to intent to clarify and add examples of non-acute patients who may not need daily physician assessments; combines ME 1 and ME 2 (4th edition)</td>
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<td>AOP.4</td>
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<td>Incorporates standard AOP.4.1 (4th edition) to consolidate similar requirements and eliminates AOP.4.1, ME 2 (4th edition)</td>
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<td>AOP.5</td>
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<td>Incorporates standard AOP.5.11 (4th edition) and adds ME 4 regarding the hospital’s ability to identify and contact experts in specialized diagnostic areas; combines ME 3 (4th edition) with ME 2 and clarifies expectation</td>
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<tr>
<td>AOP.5.1</td>
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<td>Rewords standard, intent, and MEs to emphasize the need for all laboratory staff members to have the required education, training, qualifications, and experience; revises MEs to clarify requirements, including the need for a staffing plan to provide laboratory staffing during all hours of operation and during emergencies</td>
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<td>AOP.5.3</td>
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<td>Moves requirement from AOP.5.1 (4th edition) and revises standard, intent, and MEs to make a more direct association between the laboratory safety program and compliance with facility management and infection control programs</td>
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<tr>
<td>AOP.5.3.1</td>
<td>New standard</td>
<td>Establishes a new standard to emphasize the need to reduce special risks for laboratory staff related to infection control and biohazards</td>
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<td>AOP.5.4</td>
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<tr>
<td>AOP.5.5</td>
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<tr>
<td>AOP.5.6</td>
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<td>Moves requirement from AOP.5.5 (4th edition)</td>
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<tr>
<td>AOP.5.7</td>
<td>Renumbered; No significant change</td>
<td>Renumbers AOP.5.6 (4th edition) and inserts language specifically calling for “established and implemented” procedures for collecting, identifying, handling, transporting, and disposing of specimens</td>
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<td>AOP.5.8</td>
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<tr>
<td>AOP.5.9 and AOP.5.9.1</td>
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<td>Revises MEs to consolidate and clarify expectations; introduces a new ME 2 in AOP.5.9.1 regarding satisfactory performance of the laboratory’s proficiency testing results in accordance with laws and regulations</td>
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<td>AOP.5.10 and AOP.5.10.1</td>
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<tr>
<td>AOP.5.11</td>
<td>New standard</td>
<td>Introduces a new standard specific to blood bank and transfusion services</td>
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### Standards, Intents, and Measurable Elements

#### Standard AOP.1

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

#### Intent of AOP.1

An effective patient-assessment process results in decisions about the patient’s immediate and continuing treatment needs for emergency, elective, or planned care, even when the patient’s condition changes. Patient assessment is an ongoing, dynamic process that takes place in many inpatient and outpatient settings and departments and clinics. Patient assessment consists of three primary processes:

1. Collecting information and data on the patient’s physical, psychological, and social status, and his or her health history
2. Analyzing the data and information, including the results of laboratory and imaging diagnostic tests, to identify the patient’s health care needs
3. Developing a plan of care to meet the patient’s identified needs

When a patient has been registered or admitted to a hospital for inpatient or outpatient care/treatment, a complete assessment needs to be performed related to the reason(s) the patient has come for care. The specific
information the hospital requires at this stage, and the procedures for getting it, depend on the patient’s needs and the setting in which care is being provided (for example, inpatient or outpatient care). Hospital policies and procedures define how this process functions and what information needs to be gathered and documented. (Also see ACC.1)

To consistently assess patient needs, the hospital defines, in policies, the minimum content of assessments to be performed by physicians, nurses, and other clinical disciplines. Assessments are performed by each discipline within its scope of practice, licensure, applicable laws and regulations, or certification. Only qualified individuals conduct the assessments. Any assessment forms used for assessments reflect this policy. The hospital defines assessment activities in both inpatient and outpatient settings in which care is provided. (Also see ASC.3.2, ME 1 and ASC.4, ME 1) The hospital defines those elements common to all assessments and defines any differences, when permitted, in the scope of general medical and specialty services assessments. The assessment defined in policy may be completed by more than one qualified individual and at different points in time. All the content must be available when treatment is initiated. (Also see AOP.1.2 and AOP.1.2.1)

**Measurable Elements of AOP.1**

| 1. | The minimum content of assessments for inpatients is defined for each clinical discipline that performs assessments and specifies the required elements of the history and physical examination. |
| 2. | The minimum content of assessments for outpatients is defined for each clinical discipline that performs assessments and specifies the required elements of the history and physical examination. |
| 3. | Only qualified individuals permitted by licensure, applicable laws and regulations, or certification perform the assessment. (Also see SQE.10) |
| 4. | The hospital identifies the information to be documented for the assessments. |

**Standard AOP.1.1**

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

**Intent of AOP.1.1**

The initial assessment of a patient, outpatient or inpatient, is critical to identifying his or her needs and starting the care process. The initial assessment provides information to
- understand the care the patient is seeking;
- select the best care setting for the patient;
- form an initial diagnosis; and
- understand the patient’s response to any previous care.

To provide this information, the initial assessment includes an evaluation of the patient’s medical status through a physical examination and health history. The psychological assessment determines the patient’s emotional status (for example, if he or she is depressed, fearful, or belligerent and may harm him- or herself or others). Gathering social information on a patient is not intended to “classify” patients. Rather, a patient’s social, cultural, family, and economic contexts are important factors that can influence his or her response to illness and treatment. Families can be very helpful in these areas of assessment and in understanding the patient’s wishes and preferences in the assessment process. Economic factors are assessed as part of the social assessment or assessed separately when the patient and his or her family will be responsible for the cost of all or a portion of the care while an inpatient or following discharge. Many different qualified individuals may be involved in the assessment of a patient. The most important factors are that the assessments are complete and available (also see ACC.3, ME 2) to those caring for the patient.

Patient assessment is most beneficial when it considers the patient’s condition, age, and health needs, as well as his or her requests or preferences. These processes are most effectively carried out when the various health
professionals responsible for the patient work together. (*Also see* COP.8.4; COP.8.7; COP.9.2; and MOI.10, ME 2)

**Measurable Elements of AOP.1.1**

- 1. All inpatients and outpatients have an initial assessment that includes a health history and physical examination consistent with the requirements defined in hospital policy.
- 2. Each patient receives an initial psychological assessment as indicated by his or her needs.
- 3. Each patient receives an initial social and economic assessment as indicated by his or her needs.
- 4. The initial assessment results in an initial diagnosis.

**Standard AOP.1.2**

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

**Standard AOP.1.2.1**

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

**Intent of AOP.1.2 and AOP.1.2.1**

The primary outcome from the patient’s initial assessments is an understanding of the patient’s medical and nursing needs so care and treatment can begin. To accomplish this, the hospital determines the minimum content of the initial medical and nursing and other assessments (*also see* AOP.1), the time frame for completion of assessments, and the documentation requirements for assessments (*also see* AOP.1.3). Although the medical and nursing assessments are primary to the initiation of care, there may be additional assessments by other health care practitioners, including special assessments (*also see* AOP.1.4 and AOP.1.5) and individualized assessments (*also see* AOP.1.6). These assessments must be integrated and the most urgent care needs identified (*also see* AOP.4).

The initial medical and nursing assessments are completed within 24 hours of admission to the hospital and available for use by all those caring for the patient. When the patient’s condition indicates, the initial medical and/or nursing assessment are conducted and available earlier. Thus, emergency patients are assessed immediately, and policy may define that certain other patient groups are assessed sooner than 24 hours.

In an emergency, the initial medical and nursing assessments may be limited to the patient’s apparent needs and condition. Also, when there is no time to record the complete history and physical examination of an emergency patient requiring surgery, a brief note and the preoperative diagnosis are recorded before surgery. (*Also see* MOI.10.1, ME 3)

**Measurable Elements of AOP.1.2**

- 1. The initial medical assessment, including health history, physical exam, and other assessments required by the patient’s condition, is performed and documented within the first 24 hours of admission as an inpatient or sooner as required by patient condition.
- 2. The initial medical assessment results in a list of specific medical diagnoses that includes primary and associated conditions requiring treatment and monitoring.
- 3. The initial nursing assessment is performed and documented within the first 24 hours of admission as an inpatient or sooner as required by patient condition.
- 4. The initial nursing assessment results in a list of specific patient nursing needs or conditions that require nursing care, interventions, or monitoring.
Measurable Elements of AOP.1.2.1
- 1. The medical assessment of emergency patients is based on their needs and condition and documented in the patient record.
- 2. The nursing assessment of emergency patients is based on their needs and condition and documented in the patient record.
- 3. Before surgery is performed, there is a brief note and preoperative diagnosis documented for emergency patients requiring emergency surgery. (Also see ASC.7)

Standard AOP.1.3
The hospital has a process for accepting initial medical assessments conducted in a physician’s private office or other outpatient setting prior to admission or outpatient procedure.

Intent of AOP.1.3
When the initial medical assessment is conducted in a physician’s private office or other outpatient setting prior to care in the hospital as an inpatient, it must be within the previous 30 days. If at the time of admission as an inpatient the medical assessment is greater than 30 days old, the medical history must be updated and the physical examination repeated. For medical assessments performed and documented 30 days or less prior to admission, any significant changes in the patient’s condition since the assessment are noted at admission. This updating and/or reexamination can be accomplished by any qualified individual. (Also see AOP.1.2 and AOP.1.2.1 regarding the time frame and documentation requirements for initial assessments conducted in the hospital).

When an assessment is partially or entirely completed outside the hospital (for example, in a consultant surgeon’s office), the findings are reviewed and/or verified at admission as an inpatient, as appropriate to the time between the outside assessment and admission, the critical nature of the findings, the complexity of the patient, and the planned care and treatment (for example, the review confirms the clarity of the diagnosis and any planned procedures or treatments; the presence of radiographs needed in surgery; and any changes[s] in the patient’s condition, such as control of blood sugar; it also identifies any critical lab tests that may need repeating). (Also see AOP.4)

Measurable Elements of AOP.1.3
- 1. Initial medical assessments conducted prior to admission to inpatient status or prior to an outpatient procedure in the hospital are less than or equal to 30 days old.
- 2. For assessments less than or equal to 30 days old, any significant changes in the patient’s condition since the assessment are documented in the patient’s record at the time of admission as an inpatient or prior to an outpatient procedure.
- 3. If the medical assessment is greater than 30 days old at the time of admission as an inpatient or prior to an outpatient procedure, the medical history must be updated and the physical examination repeated.
- 4. The findings of all assessments performed outside the hospital are reviewed and/or verified at the time of admission to inpatient status.

Standard AOP.1.3.1
A preoperative assessment is documented before anesthesia or surgical treatment and includes the patient’s medical, physical, psychological, and spiritual/cultural needs.

Intent of AOP.1.3.1
The preoperative assessment is a clinical risk assessment that assesses the health of a patient to determine if the patient is safe to undergo the anesthesia and surgery.
The initial preoperative assessment includes the patient’s medical, physical, psychological, and spiritual/cultural needs prior to surgery. In addition, assessing the patient for any care needs following discharge is a valuable component of the preoperative assessment. (Also see ASC.7)

Results of the medical assessment and of any diagnostic tests, along with potential patient needs following discharge, are recorded in the patient's record before anesthesia or surgery.

**Measurable Elements of AOP.1.3.1**

- 1. Patients for whom surgery is planned have a preoperative assessment performed before the surgery.
- 2. The preoperative assessment includes the patient’s medical, physical, psychological, spiritual/cultural, and discharge needs.
- 3. The preoperative assessment of surgical patients is documented in the patient record before surgery.

**Standard AOP.1.4**

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

**Intent of AOP.1.4**

The information gathered at the initial medical and/or nursing assessment, through the application of screening criteria, may indicate that the patient needs further or more in-depth assessment of nutritional status or functional status, including a fall-risk assessment (also see IPSG.6). The more in-depth assessment may be necessary to identify those patients in need of nutritional interventions and patients in need of rehabilitation services or other services related to their ability to function independently or at their greatest potential.

The most effective way to identify patients with nutritional or functional needs is through screening criteria. Screening generally involves performing a very simple, high-level evaluation of a patient to determine if the patient exhibits a risk that might indicate the need for a more in-depth assessment. For example, the initial nursing assessment form may contain basic criteria for a nutritional screen, such as five or six simple questions with a numerical score relating to recent decline in food intake, weight loss during the past three months, mobility, and the like. The patient’s total score would then identify a patient at nutritional risk requiring a more in-depth nutritional assessment.

In each case, the screening criteria are developed by qualified individuals able to further assess and, if necessary, to provide any required patient treatment. For example, screening criteria for nutritional risk may be developed by nurses who will apply the criteria, dietitians who will supply the recommended dietary intervention, and nutritionists able to integrate nutritional needs with the other needs of the patient. (Also see COP.4 and COP.5)

The information gathered at the initial medical and/or nursing assessment may also identify a need for other assessments, such as dental, hearing, vision, and so on. (Also see AOP.1.2 and AOP.1.2.1) The hospital refers the patient for further assessments within the hospital when available, or through the community following discharge.

**Measurable Elements of AOP.1.4**

- 1. Qualified individuals develop and implement criteria to identify patients who require further nutritional assessment.
- 2. Patients at risk for nutritional problems receive a nutritional assessment.
- 3. Qualified individuals develop and implement criteria to identify patients who require further functional assessment.
- 4. Patients in need of a functional assessment are referred for such an assessment.
- 5. When the need for additional specialized assessments is identified, patients are referred within the hospital or outside the hospital.
6. Specialized assessments conducted within the hospital are completed and documented in the patient’s record.

Standard AOP.1.5
All inpatients and outpatients are screened for pain and assessed when pain is present.

Intent of AOP.1.5
During the initial assessment and during any reassessments, a screening procedure is used to identify patients with pain. Examples of questions that may be used in a screening exam include the following:
- Are you having pain right now?
- Does pain keep you from sleeping at night?
- Does pain keep you from participating in activities?
- Do you experience pain every day?

Positive answers to questions such as these indicate the need for a more in-depth assessment of the patient’s pain. When pain is identified in the outpatient setting, the patient may be more thoroughly assessed and treated in the hospital or provided with a referral for further assessment and treatment. The scope of treatment is based on the care setting and services provided. (Also see COP.6)

When the patient is an inpatient in the hospital, a more comprehensive assessment is performed as soon as pain is identified. This assessment is appropriate to the patient’s age and measures pain intensity and quality, such as pain character, frequency, location, and duration. Additional information may include pain history, what makes pain better or worse, what are the patient’s goals for pain relief, and the like. This assessment is recorded in a way that facilitates regular reassessment and follow-up according to criteria developed by the hospital and the patient’s needs. (Also see AOP.1.2 and AOP.1.2.1)

Measurable Elements of AOP.1.5
1. Patients are screened for pain.
2. When pain is identified from the initial screening exam, a comprehensive assessment of the patient’s pain is performed.
3. The assessment is recorded in a way that facilitates regular reassessment and follow-up according to criteria developed by the hospital and the patient’s needs.

Standard AOP.1.6
The hospital conducts individualized initial assessments for special populations cared for by the hospital.

Intent of AOP.1.6
The initial assessment of certain types of patients or certain patient populations requires that the assessment process be modified. Such modification is based on the unique characteristics or needs of each patient population. Each hospital identifies those special patient groups and populations and modifies the assessment process to meet their special needs. In particular, when the hospital serves one or more of the special-needs patients or populations listed below, the hospital conducts individualized assessments of the following:
- Children
- Adolescents
- Frail elderly
- Terminally ill/dying patient
- Patients with intense or chronic pain
- Women in labor
- Women experiencing terminations in pregnancy
Assessment of Patients (AOP)

- Patients with emotional or psychiatric disorders
- Patients suspected of drug and/or alcohol dependency
- Victims of abuse and neglect
- Patients with infectious or communicable diseases
- Patients receiving chemotherapy or radiation therapy
- Patients whose immune systems are compromised

The assessment of patients suspected of drug and/or alcohol dependency and the assessment of victims of abuse and neglect are shaped by the culture of the patient population. These assessments are not intended to be proactive case-finding processes. Rather, the assessment of these patients responds to their needs and condition in a culturally acceptable and confidential manner. The assessment process is modified to be consistent with local laws and regulations and professional standards related to such populations and situations and to involve the family when appropriate or necessary. (Also see AOP.1.2 and AOP.1.2.1)

**Measurable Elements of AOP.1.6**

- 1. The hospital identifies, in writing, those special patient groups and populations it serves that require modifications to its assessment.
- 2. The assessment process for special-needs patient populations is modified to reflect their needs.
- 3. The modified assessment process is consistent with local laws and regulations and incorporates professional standards related to such populations.

**Standard AOP.1.7**

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

**Intent of AOP.1.7**

Assessments and reassessments need to be individualized to meet patients’ and families’ needs when patients are at the end of life. Assessments and reassessments should evaluate, as indicated by the patient’s condition,

- a) such symptoms as nausea and respiratory distress;
- b) factors that alleviate or exacerbate physical symptoms;
- c) current symptom management and the patient’s response;
- d) patient and family spiritual orientation and, as appropriate, any involvement in a religious group;
- e) patient and family spiritual concerns or needs, such as despair, suffering, guilt, or forgiveness;
- f) patient and family psychosocial status, such as family relationships, the adequacy of the home environment if care is provided there, coping mechanisms, and the patient’s and family’s reactions to illness;
- g) the need for support or respite services for the patient, family, or other caregivers;
- h) the need for an alternative setting or level of care; and
- i) survivor risk factors, such as family coping mechanisms and the potential for pathological grief reactions.

**Measurable Elements of AOP.1.7**

- 1. Dying patients and their families are assessed and reassessed for those elements in a) through i) of the intent, according to their identified needs.
- 2. Assessment findings guide the care and services provided. (Also see AOP.2, ME 2)
- 3. Assessment findings are documented in the patient record.

**Standard AOP.1.8**

The initial assessment includes determining the need for discharge planning.
Intent of AOP.1.8
Continuity of care requires special preparation and considerations for some patients, such as for discharge planning. The hospital develops a mechanism, such as a list of criteria, to identify those patients for whom discharge planning is critical due to age, lack of mobility, continuing medical and nursing needs, or assistance with activities of daily living, among others. As arrangements for discharge may take some time, the assessment process and planning process are initiated as soon as possible after admission as an inpatient. (Also see ACC.4)

Discharge planning includes any special education the patient may require related to continuing care outside of the hospital. For example, a newly diagnosed Type 1 diabetic patient will need education related to diet and nutrition, as well as instruction on administration of insulin injections. A patient admitted for an acute myocardial infarction may need cardiac rehabilitation following discharge, as well as nutritional instruction. Successful discharges depend on effective planning.

Measurable Elements of AOP.1.8
- 1. There is a process to identify those patients for whom discharge planning is critical.
- 2. Planning for discharge for these patients begins soon after admission as inpatients.
- 3. Discharge planning includes identifying special educational needs and developing and implementing a plan to address those needs.

Standard AOP.2
All patients are reassessed at intervals based on their condition and treatment to determine their response to treatment and to plan for continued treatment or discharge.

Intent of AOP.2
Reassessment by all the patient’s health care practitioners is key to understanding whether care decisions are appropriate and effective. Patients are reassessed throughout the care process at intervals based on their needs and plan of care or as defined in hospital policies and procedures. The results of these reassessments are noted in the patient’s record for the information and use of all those caring for the patient. (Also see ACC.3)

Reassessment by a physician is integral to ongoing patient care. A physician assesses an acute care patient at least daily, including weekends, and when there has been a significant change in the patient’s condition.

Reassessments are conducted and results are entered in the patient’s record:
- at regular intervals during care (for example, nursing staff periodically record vital signs, pain assessment, and lung and heart sounds, as needed based on the patient’s condition);
- daily by a physician for acute care patients;
- in response to a significant change in the patient’s condition;
- if the patient’s diagnosis has changed and the care needs require revised planning; and
- to determine if medications and other treatments have been successful and the patient can be transferred or discharged.

Some non-acute patients may not need daily physician assessments; for example, a stable psychiatric patient receiving group therapy sessions, or a patient who is past the acute phase of illness or surgery and who is receiving only rehabilitative treatment. The hospital identifies, in writing, those patients who do not require daily assessments.

Measurable Elements of AOP.2
- 1. Patients are reassessed to determine their response to treatment and plan for continued treatment and/or discharge. (Also see COP.5, ME 3; ASC.6.1; and MMU.7, ME 1)
- 2. Patients are reassessed at intervals based on their condition and when there has been a significant change in their condition, plan of care, or individual needs. (Also see AOP.1.7, ME 2)
3. A physician reassesses patients at least daily, including weekends, during the acute phase of their care and treatment.

4. For non-acute patients, the hospital defines, in writing, the circumstances in which, and the types of patients or patient populations for which, a physician’s assessment may be less than daily and identifies the minimum reassessment interval for these patients.

5. Reassessments are documented in the patient record.

**Standard AOP.3**

Qualified individuals conduct the assessments and reassessments.

**Intent of AOP.3**

The assessment and reassessment of patients are critical processes that require special education, training, knowledge, and skills. Thus, for each type of assessment, those individuals qualified to perform the assessment are identified and their responsibilities defined in writing. In particular, those individuals qualified to conduct emergency assessments or assessments of nursing needs are clearly identified. Assessments are performed by each discipline within its scope of practice, licensure, applicable laws and regulations, or certification.

**Measurable Elements of AOP.3**

1. Individuals qualified to conduct patient assessments and reassessments are identified and have their responsibilities defined in writing. *(Also see SQE.1.1, ME 2)*

2. Only those individuals permitted by licensure, applicable laws and regulations, or certification perform patient assessments.

3. Emergency assessments are conducted by individuals qualified to do so.

4. Nursing assessments are conducted by individuals qualified to do so.

**Standard AOP.4**

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

**Intent of AOP.4**

A patient may undergo many kinds of assessments outside and inside the hospital by many different departments and services. As a result, there may be a variety of information, test results, and other data in the patient’s record *(also see AOP.1.3)*. A patient benefits most when the staff responsible for the patient work together to analyze the assessment findings and combine this information into a comprehensive picture of the patient’s condition. From this collaboration, the patient’s needs are identified, the order of their importance is established, and care decisions are made. Integration of findings at this point will facilitate the coordination of care provision. *(Also see AOP.1.2, and AOP.1.2.1, and COP.2)*

The process for working together is simple and informal when the patient’s needs are not complex. Formal treatment team meetings, patient conferences, and clinical rounds may be needed for patients with complex or unclear needs. The patient, his or her family, and others who make decisions on the patient’s behalf are included in the decision process when it is needed.

**Measurable Elements of AOP.4**

1. Patient assessment data and information are analyzed and integrated.

2. Those responsible for the patient’s care participate in the process.

3. Patient needs are prioritized based on assessment results.
Laboratory Services

**Standard AOP.5**
Laboratory services are available to meet patient needs, and all such services meet applicable local and national standards, laws, and regulations.

**Intent of AOP.5**
The hospital has a system for providing laboratory services, including clinical pathology services, required by its patient population, clinical services offered, and health care practitioner needs. The laboratory services are organized and provided in a manner that meets applicable local and national standards, laws, and regulations.

Laboratory services, including those required for emergencies, may be provided within the hospital, by agreement with another organization, or both. Laboratory services are available after normal hours for emergencies. In addition, the hospital is able to identify and to contact experts in specialized diagnostic areas, such as parasitology, virology, or toxicology, when needed.

Outside sources are convenient for the patient to access. The hospital selects outside sources based on the recommendation of the laboratory’s leader or other individual responsible for laboratory services. Outside sources of laboratory services meet applicable laws and regulations and have an acceptable record of accurate, timely services. Patients are informed when an outside source of laboratory services is owned by the referring physician.

**Measurable Elements of AOP.5**
- 1. Laboratory services meet applicable local and national standards, laws, and regulations.
- 2. Laboratory services are available to meet the needs related to the hospital’s mission and patient population, the community’s health care needs, and emergency needs, including after normal hours.
- 3. Experts in specialized diagnostic areas are contacted when needed.
- 4. Outside sources are selected based on an acceptable record and compliance with laws and regulations.
- 5. Patients are informed about any relationships between the referring physician and outside sources of laboratory services. (Also see GLD.12.1, ME 1)

**Standard AOP.5.1**
A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service.

**Intent of AOP.5.1**
Clinical laboratory services are under the direction of an individual who is qualified by virtue of documented training, expertise, and experience, consistent with applicable laws and regulations. This individual assumes professional responsibility for the laboratory facility and the services provided in the laboratory as well as tests performed outside the laboratory, such as the testing performed at bedside (point-of-care testing). The oversight of services outside the laboratory includes ensuring consistent hospitalwide policies and practices, such as training and supply management, among others. It does not include daily supervision of those activities. Daily supervision remains the responsibility of the leaders of the department or unit in which the testing is conducted.

When this individual provides clinical consultation or medical opinion, he or she is a physician, preferably a pathologist. Specialty and subspecialty laboratory services are under the direction of appropriately qualified individuals. Responsibilities of the laboratory leader include
- developing, implementing, and maintaining policies and procedures;
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- administrative oversight;
- maintaining any necessary quality control program;
- recommending outside sources of laboratory services; and
- monitoring and reviewing all laboratory services.

**Measurable Elements of AOP.5.1**

- 1. The clinical laboratory, and other laboratory services throughout the hospital, are under the direction and oversight of one or more qualified individuals. *Also see GLD.9, ME 1*
- 2. Responsibilities for developing, implementing, and maintaining policies and procedures are defined and carried out.
- 3. Responsibilities for administrative oversight are defined and carried out.
- 4. Responsibilities for maintaining quality control programs are defined and carried out.
- 5. Responsibilities for recommending reference (contract) laboratory services are defined and carried out. *Also see GLD.6, ME 4 and GLD.6.1, ME 3*
- 6. Responsibilities for monitoring and reviewing all laboratory services within and outside the laboratory are defined and carried out.

**Standard AOP.5.2**

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

**Intent of AOP.5.2**

The hospital identifies the education, training, qualifications, and experience of laboratory staff members performing and interpreting laboratory tests, those who are approved to perform point-of-care screening tests at the bedside, and those who direct or supervise staff who perform testing. Supervisory staff and technical staff are oriented to their work. Technical staff are given work assignments consistent with their training and experience. In addition, the laboratory implements a staffing program that allows staff to perform tests promptly and to ensure laboratory staffing during all hours of operation and for emergencies. *Also see SQE.4*

**Measurable Elements of AOP.5.2**

- 1. All laboratory staff have the required credentials to administer, perform, and interpret tests.
- 2. Staff performing point-of-care testing have the required qualifications and training to administer point-of-care tests.
- 3. A staffing program is implemented that allows staff to perform tests promptly and to provide staffing during all hours of operation and during emergencies.
- 4. Laboratory supervisory staff are identified and have the proper qualifications and experience.

**Standard AOP.5.3**

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

**Intent of AOP.5.3**

The laboratory has an active safety program to the degree required by the risks and hazards encountered in the laboratory. The program addresses safety practices and prevention measures *for example*, eye-wash stations,
spill kits, and the like) for laboratory staff, other staff, and patients when present. The laboratory program is coordinated with the hospital’s facility management and infection control programs.

The laboratory safety management program includes:
- compliance with standards addressing facility management and infection control programs;
- compliance with local and regional laws and regulations;
- availability of safety devices appropriate to the laboratory’s practices and hazards encountered;
- the orientation of all laboratory staff to safety procedures and practices; and
- in-service education for new procedures and newly acquired or recognized hazardous materials. (Also see PCI.5, FMS.4, FMS.4.1, and FMS.5)

**Measurable Elements of AOP.5.3**

- 1. A laboratory safety program addresses potential safety risks in the laboratory and other areas outside the laboratory where laboratory services are provided.
- 2. The program is part of the hospital’s facility management and infection control programs and reports to the hospital safety structure at least annually and when any safety events occur.
- 3. Identified safety risks are addressed by specific processes and/or devices to reduce the safety risks.
- 4. Laboratory staff are oriented to safety procedures and practices and receive ongoing education and training for new practices and procedures. (Also see FMS.11, ME 1; GLD.9, ME 4; and SQE.8, MEs 3 and 4)

**Standard AOP.5.3.1**

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

**Intent of AOP.5.3.1**

There are policies, procedures, and practices implemented to reduce the hazards of exposure to biohazardous materials. Infections acquired in the laboratory are reported internally and, when appropriate, to public health agencies. The following biosafety hazards and practices are addressed in written procedures, and the requirements of the procedures are followed:

- a) Exposures to aerosols and droplets are controlled (for example, when mixing, sonicating, centrifuging, and flaming inoculating loops).
- b) Laboratory coats, gowns, or uniforms are worn to protect street clothes and prevent contamination.
- c) Biosafety cabinets are used when required.
- d) Rules govern how to handle laboratory exposure to infectious agents, accidental cuts, needlestick injuries, accidental ingestion, and contact of potentially infectious agents with mucus membranes. These rules include decontamination procedures, whom to contact for emergency treatment, and the location and use of safety equipment.
- e) There are written procedures defining safe collection, transport, and handling of all specimens. The procedure includes prohibiting anyone in laboratory technical areas from eating, drinking, smoking, applying cosmetics, manipulating contact lenses, and mouth pipetting.
- f) When relevant to their jobs, personnel have received training about precautionary measures, modes of transmission, and prevention of blood-borne pathogens.
- g) The laboratory also has a procedure to control exposure to tuberculosis.

When problems with practice are identified, or accidents occur, corrective actions are taken, documented, and reviewed. (Also see PCI.7.2)

**Measurable Elements of AOP.5.3.1**

- 1. The laboratory has a defined process for reducing the risks of infection.
2. Infections acquired in the laboratory are reported, as defined in the policy, and in compliance with applicable laws and regulations.

3. The laboratory follows biosafety rules for relevant practices addressed in elements a) through g) in the intent.

4. When problems with practice are identified, or accidents occur, corrective actions are taken, documented, and reviewed.

**Standard AOP.5.4**
Laboratory results are available in a timely way as defined by the hospital.

**Intent of AOP.5.4**
The hospital defines the time period for reporting laboratory test results. Results are reported within a time frame based on patient needs, services offered, and clinical staff needs. Emergency tests and after-hours and weekend testing needs are included. Results from urgent tests, such as those from the emergency department, operating theatres, and intensive care units, are given special attention in the quality measurement process. In addition, when laboratory services are by contract with an outside organization, the reports are also timely, as set forth by hospital policy or the contract. *(Also see IPSG.2.1)*

**Measurable Elements of AOP.5.4**

- 1. The hospital has established the expected report time for results.
- 2. The timeliness of reporting of urgent/emergency tests is measured.
- 3. Laboratory results are reported within a time frame to meet patient needs. *(Also see ASC.7, ME 1)*

**Standard AOP.5.5**
All equipment and medical technology used for laboratory testing is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.

**Intent of AOP.5.5**
Laboratory staff work to ensure that all equipment and medical technology, including medical devices used for point-of-care testing, function at acceptable levels and in a manner that is safe to the operator(s). The laboratory develops and implements a program to manage equipment and medical technology that provides for

- selecting and acquiring laboratory equipment and medical technology;
- identifying and taking inventory of laboratory equipment and medical technology;
- assessing laboratory equipment and medical technology use through inspection, testing, calibration, and maintenance;
- monitoring and acting on laboratory equipment and medical technology hazard notices, recalls, reportable incidents, problems, and failures; and
- documenting the management program.

Testing, maintenance, and calibration frequency are related to the laboratory’s use of its equipment and medical technology and its documented history of service. *(Also see FMS.8 and FMS.8.1)*

**Measurable Elements of AOP.5.5**

- 1. The laboratory develops, implements, and documents a program to manage laboratory equipment and medical technology.
- 2. The program identifies how laboratory equipment and medical technology are selected and acquired.
- 3. There is a documented inventory of all laboratory equipment and medical technology.
4. Laboratory equipment and medical technology are inspected and tested when new and according to age, use, and manufacturers' recommendations thereafter and the inspections are documented.

5. Laboratory equipment and medical technology are calibrated and maintained according to manufacturers' recommendations, and the calibration and maintenance are documented.

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

Standard AOP.5.6

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

Intent of AOP.5.6

The hospital has identified those reagents and supplies necessary to regularly provide laboratory services to its patients. A process to order or to secure those essential reagents and other supplies is effective. All reagents are stored and dispensed according to defined procedures. The evaluation of all reagents ensures accuracy and precision of results. Written guidelines ensure the complete and accurate labeling of reagents and solutions and the accuracy and precision of all results. (Also see AOP.5.9 and FMS.5)

Measurable Elements of AOP.5.6

1. Essential reagents and supplies are identified.

2. Essential reagents and supplies are available, and there is a process to address when reagents are not available.

3. All reagents are stored and dispensed according to manufacturers' directives or packaging instructions.

4. The laboratory has and follows written guidelines for evaluation of all reagents to provide for accuracy and precision of results.

5. All reagents and solutions are completely and accurately labeled.

Standard AOP.5.7

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

Intent of AOP.5.7

Procedures are established and implemented for

- ordering tests;
- collecting and identifying specimens;
- transporting, storing, and preserving specimens; and
- receiving, logging in, and tracking specimens.

These procedures are observed for specimens sent to reference (contract) laboratory services for testing.

Measurable Elements of AOP.5.7

1. Procedures are established and implemented for the ordering of tests.

2. Procedures are established and implemented for the collection and identification of specimens. (Also see IPSG.1, ME 3)

3. Procedures are established and implemented for the transport, storage, and preservation of specimens.
4. Procedures are established and implemented for the receipt and tracking of specimens.
5. The procedures are followed when reference (contract) laboratory services are used.

**Standard AOP.5.8**

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

**Intent of AOP.5.8**

The laboratory establishes reference intervals or “normal” ranges for each test performed. The range is included in the clinical record, either as part of the report or by including a current listing of such values approved by the laboratory leader. Ranges are furnished when a reference (contract) laboratory service performs the test. The reference ranges are appropriate to the hospital’s geography and demographics and are reviewed and updated when methods change.

**Measurable Elements of AOP.5.8**

- 1. The laboratory has established reference ranges for each test performed.
- 2. The range is included in the clinical record at the time test results are reported.
- 3. Ranges are furnished when tests are performed by reference (contract) laboratory services.
- 4. Ranges are appropriate to the hospital’s geography and demographics.
- 5. Ranges are reviewed and updated as needed.

**Standard AOP.5.9**

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

**Standard AOP.5.9.1**

There is a process for proficiency testing of laboratory services.

**Intent of AOP.5.9 and AOP.5.9.1**

Well-designed quality control systems are essential to providing excellent pathology and clinical laboratory services. Quality control procedures include

- validation of the test methods used for accuracy, precision, and reportable range;
- daily surveillance of results by qualified laboratory staff;
- testing of reagents (also see AOP.5.6);
- rapid corrective action when a deficiency is identified; and
- documentation of results and corrective actions.

Proficiency testing determines how well an individual laboratory’s results compare with other laboratories that use the same methodologies. Such testing can identify performance problems not recognized by internal mechanisms. Thus, the laboratory participates in an approved proficiency-testing program when available. Alternatively, when approved programs are not available, the laboratory exchanges samples with a laboratory in another organization for purposes of peer comparison testing. The laboratory maintains a cumulative record of participation in a proficiency-testing process. Proficiency testing, or an alternative, is carried out for all specialty laboratory programs when available. (Also see AOP.5.10 and GLD.11)

**Measurable Elements of AOP.5.9**

- 1. The hospital establishes and implements a quality control program for the clinical laboratory.
- 2. The program includes the validation of test methods.
3. The program includes the daily surveillance and documentation of test results.
4. The program includes testing of reagents.
5. The program includes rapid correction and documentation of deficiencies.

**Measurable Elements of AOP.5.9.1**

1. The laboratory participates in a proficiency-testing program, or an alternative, for all specialty laboratory services and tests.
2. For each specialty, subspecialty, analyte, or test, the laboratory’s proficiency testing results meet satisfactory performance criteria in accordance with laws and regulations.
3. The laboratory maintains records of its participation in a proficiency-testing program.

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**Standard AOP.5.10**

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

**Standard AOP.5.10.1**

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

**Intent of AOP.5.10 and AOP.5.10.1**

When the hospital uses the services of a reference laboratory (also known as a contract laboratory)—whether for select tests or to provide all laboratory services—the following information is required:

- a) A copy of a license from a recognized licensing authority
- b) A copy of the certificate or letter of accreditation or certification from a recognized laboratory accreditation or certification program*
- c) Documentation that the reference (contract) laboratory participates in an outside proficiency-testing program (Also see AOP.5.9.1)

In addition, the hospital identifies measures for monitoring the quality of the services provided by all reference (contract) laboratories—for example, turnaround times for tests, critical results reporting, and problems with specimens such as missing identifiers or specimen rejections. Qualified individuals review and act on the results of the quality monitoring. (Also see GLD.6.1)

* A recognized laboratory accreditation or certification program is one that has been reviewed and endorsed by a laboratory professional society or governmental or private agency.

**Measurable Elements of AOP.5.10**

1. The hospital maintains a copy of the license, from a recognized licensing authority, for all reference laboratories used by the hospital.
2. The hospital maintains a copy of the certificate or letter of accreditation or certification, from a recognized laboratory accreditation or certification program, for all reference laboratories used by the hospital.
3. The hospital maintains documentation that any reference laboratory used by the hospital participates in an outside proficiency-testing program.

**Measurable Elements of AOP.5.10.1**

1. The frequency and type of performance expectation data from reference laboratories are determined by the hospital.
2. The qualified individual responsible for the laboratory or a qualified designee reviews the performance expectation data from reference laboratories.

3. The responsible individual or qualified designee takes action based on the results.

4. An annual report of the data from reference laboratories is provided to hospital leadership to facilitate management of contracts and contract renewals.

Blood Bank and/or Transfusion Services

Standard AOP.5.11
A qualified individual is responsible for blood bank and/or transfusion services and ensures that services adhere to laws and regulations and recognized standards of practice.

Intent of AOP.5.11
Blood bank and/or transfusion services, when provided by the hospital, are under the direction of an individual who is qualified by virtue of documented training, expertise, and experience, consistent with applicable laws and regulations. This individual assumes professional responsibility for all aspects of blood bank services provided in the hospital. The oversight of services includes establishment, implementation, and documentation of the processes for
   a) blood donor selection;
   b) blood collection;
   c) blood storage;
   d) compatibility testing; and
   e) blood distribution.

Quality control processes for all blood bank services are established, implemented, and documented to ensure the safety of blood bank and transfusion services. Blood donor and transfusion services are guided by laws and regulations and recognized standards of practice.

Measurable Elements of AOP.5.11
1. A qualified individual is responsible for blood bank and/or transfusion services. (Also see COP.3.3, ME 1 and GLD.9, ME 1)
2. The blood bank has established, implemented, and documented processes for a) through e) of the intent. (Also see COP.3.3, ME 2)
3. Quality control measures are in place for all blood bank and transfusion services and are established, implemented, and documented.
4. The blood bank and transfusion services comply with applicable laws and regulations and recognized standards of practice.

Radiology and Diagnostic Imaging Services

Standard AOP.6
Radiology and diagnostic imaging services are available to meet patient needs, and all such services meet applicable local and national standards, laws, and regulations.
Intent of AOP.6
The hospital has a system for providing radiology and diagnostic imaging services required by its patient population, clinical services offered, and health care practitioner needs. Radiology and diagnostic imaging services meet all applicable local and national standards, laws, and regulations.

Radiology and diagnostic imaging services, including those required for emergencies, may be provided within the hospital, by agreement with another organization, or both. Radiology and diagnostic imaging services are available after normal hours for emergencies. In addition, the hospital can identify and contact experts in specialized diagnostic areas, such as radiation physics, radiation oncology, or nuclear medicine, when necessary. The hospital maintains a roster of such experts.

Outside sources are convenient for the patient to access, and reports are received in a timely way that supports continuity of care. The hospital selects outside sources based on the recommendation of the laboratory’s leader or other individual responsible for radiology and diagnostic imaging services. Outside sources of radiology and diagnostic imaging services meet applicable laws and regulations and have an acceptable record of accurate, timely services. Patients are informed when an outside source of services is owned by the referring physician.

Measurable Elements of AOP.6

1. Radiology and diagnostic imaging services meet applicable local and national standards, laws, and regulations.
2. Adequate, regular, and convenient radiology and diagnostic imaging services are available to meet the needs related to the hospital’s mission and patient population, the community’s health care needs, and emergency needs, including after normal hours.
3. The hospital contacts experts in specialized diagnostic areas when needed.
4. Outside sources are selected based on recommendations of the laboratory leader and an acceptable record of timely performance and compliance with applicable laws and regulations.
5. Patients are informed about any relationships between the referring physician and outside sources of radiology and/or diagnostic imaging services. (Also see GLD.12.1, ME 1)

Standard AOP.6.1
A qualified individual(s) is responsible for managing the radiology and diagnostic imaging services.

Intent of AOP.6.1
Radiology and diagnostic imaging services, provided at any location in the hospital, are under the direction of an individual who is qualified by documented education, training, expertise, and experience, consistent with applicable laws and regulations. This individual assumes professional responsibility for the radiology and diagnostic imaging facility and the services provided. When this individual provides clinical consultation or medical opinion, he or she is a physician, preferably a radiologist. When radiation therapy or other special services are provided, they are under the direction of appropriately qualified individuals.

The radiology and diagnostic imaging leader’s responsibilities include
- developing, implementing, and maintaining policies and procedures;
- administrative oversight;
- maintaining any necessary quality control program;
- recommending outside sources of radiology and diagnostic imaging services; and
- monitoring and reviewing all radiology and diagnostic imaging services. (Also see GLD.9)

Measurable Elements of AOP.6.1

1. Radiology and diagnostic imaging services are under the direction of one or more qualified individuals.
2. Responsibilities for developing, implementing, and maintaining policies and procedures are defined and carried out.

3. Responsibilities for administrative oversight are defined and carried out.

4. Responsibilities for maintaining quality control programs are defined and carried out.

5. Responsibilities for recommending outside sources of radiology and diagnostic imaging services are defined and carried out. (Also see GLD.6, ME 4)

6. Responsibilities for monitoring and reviewing all radiology and diagnostic imaging services are defined and carried out.

**Standard AOP.6.2**

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

**Intent of AOP.6.2**

The hospital identifies which radiology and diagnostic imaging staff members perform diagnostic and imaging studies, those who are approved to perform point-of-care tests at the bedside, those who are qualified to interpret the results or to verify and report results, and those who direct or supervise the processes. Supervisory staff and technical staff have appropriate and adequate training, experience, and skills and are oriented to their work. Technical staff members are given work assignments consistent with their training and experience. In addition, there is a sufficient number of staff to perform, to interpret, and to report studies promptly and to provide necessary staffing during all hours of operation and for emergencies. (Also see SQE.4)

**Measurable Elements of AOP.6.2**

1. Those individuals who perform diagnostic and imaging studies or direct or supervise the studies are identified.

2. Staff with proper qualifications and experience perform diagnostic and imaging studies.

3. Staff with proper qualifications and experience interpret study results.

4. Properly qualified staff verify and report the results of studies.

5. There is an adequate number of staff to meet patient needs. (Also see GLD.9, ME 2 and SQE.6, ME 2)

6. Supervisory staff have proper qualifications and experience.

**Standard AOP.6.3**

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

**Intent of AOP.6.3**

The hospital has an active radiation safety program that includes all components of the hospital’s radiology and diagnostic imaging services, including radiation oncology and the cardiac catheterization laboratory. The radiation safety program reflects the risks and hazards encountered. The program addresses safety practices and prevention measures for radiology and diagnostic imaging staff, other staff, and patients. The program is coordinated with the hospital’s safety management program.

The radiation safety management program includes

- compliance with applicable standards, laws, and regulations;
- compliance with standards addressing facility management and infection control programs;
- availability of safety protective devices appropriate to the practices and hazards encountered;
the orientation of all radiology and diagnostic imaging staff to safety procedures and practices; and
in-service education for new procedures and newly acquired or recognized hazardous materials. (Also see
FMS.4, FMS.4.1, and FMS.5)

Measurable Elements of AOP.6.3

- 1. A radiation safety program is in place that addresses potential safety risks and hazards encountered
   within or outside the department.
- 2. The safety program is part of the hospital’s facility management and infection control programs, and
   the program provides reports to the hospital safety structure at least annually and when any safety
   events occur.
- 3. Identified radiation safety risks are addressed by specific processes or devices that reduce safety risks
   (such as lead aprons, radiation badges, and the like).
- 4. Radiology and diagnostic imaging staff are oriented to safety procedures and practices and receive
   ongoing education and training for new procedures, equipment, and medical technology. (Also see
   FMS.11.1, ME 1; GLD.9, ME 4; and SQE.8, MEs 3 and 4)

Standard AOP.6.4

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

Intent of AOP.6.4

The hospital defines the time period for reporting diagnostic radiology and diagnostic imaging study results.
Results are reported within a time frame based on patient needs, services offered, and the clinical staff’s needs.
Emergency tests and after-hours and weekend testing needs are included. Results from urgent radiology and
diagnostic imaging studies, such as those from the emergency department, operating theatres, and intensive care
units, are given special attention in the quality measurement process. Radiology and diagnostic imaging studies
performed by outside contractors of services are reported according to hospital policy or contract requirement.

Measurable Elements of AOP.6.4

- 1. The hospital has established the expected report time for results.
- 2. The timeliness of reporting of urgent/emergency studies is measured.
- 3. Radiology and diagnostic imaging study results are reported within a time frame to meet patient needs.
   (Also see ASC.7, ME 1)

Standard AOP.6.5

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

Intent of AOP.6.5

Radiology and diagnostic imaging staff work to ensure that all equipment and medical technology function at
acceptable levels and in a manner that is safe to the operator(s). Radiology and diagnostic imaging develops and
implements a program to manage equipment and medical technology that provides for
- selecting and acquiring equipment and medical technology;
- identifying and inventorying equipment and medical technology;
- assessing equipment and medical technology use through inspection, testing, calibration, and
  maintenance;
- monitoring and acting on equipment and medical technology hazard notices, recalls, reportable
  incidents, problems, and failures; and
documenting the management program.

Testing, maintenance, and calibration frequency are related to the use of the equipment and medical technology and its documented history of service. (Also see FMS.8 and FMS.8.1)

**Measurable Elements of AOP.6.5**

- 1. Radiology and diagnostic imaging develops, implements, and documents a program to manage equipment and medical technology.
- 2. The program identifies how radiology equipment and medical technology are selected and acquired.
- 3. There is a documented inventory of all radiology equipment and medical technology.
- 4. Radiology equipment and medical technology are inspected and tested when new and according to age, use, and manufacturers’ recommendations.
- 5. Radiology equipment and medical technology are calibrated and maintained according to manufacturers’ recommendations.
- 6. The hospital has a system in place for monitoring and acting on radiology equipment and medical technology hazard notices, recalls, reportable incidents, problems, and failures.

**Standard AOP.6.6**

X-ray film and other supplies are regularly available.

**Intent of AOP.6.6**

The hospital has identified the film, reagents, and supplies necessary to regularly provide radiology and diagnostic imaging services to its patients. A process to order or to secure essential film, reagents, and other supplies is effective. All supplies are stored and dispensed according to defined procedures that incorporate the manufacturers’ recommendations. The periodic evaluation of reagents according to manufacturers’ recommendations ensures accuracy and precision of results. (Also see AOP.6.8 and FMS.5)

**Measurable Elements of AOP.6.6**

- 1. Essential x-ray film, reagents, and supplies are identified.
- 2. Essential x-ray film, reagents, and supplies are available.
- 3. All supplies are stored and dispensed according to guidelines.
- 4. All supplies are periodically evaluated for accuracy and results.
- 5. All supplies are completely and accurately labeled.

**Standard AOP.6.7**

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

**Intent of AOP.6.7**

Sound quality control systems are essential to providing excellent radiology and diagnostic imaging services. (Also see GLD.11) Quality control procedures include:

- validation of the test methods used for accuracy and precision;
- daily surveillance of imaging results by qualified radiology staff;
- rapid corrective action when a deficiency is identified;
- testing of reagents and solutions; and
- documentation of results and corrective actions.
Measurable Elements of AOP.6.7

1. The hospital establishes and implements a quality control program for the radiology and diagnostic imaging services.
2. Quality control includes validating test methods.
3. Quality control includes daily surveillance and documentation of imaging results.
4. Quality control includes testing reagents and solutions and documenting test results.
5. Quality control includes rapid correction and documentation when a deficiency is identified.

Standard AOP.6.8
The hospital regularly reviews quality control results for all outside sources of diagnostic services.

Intent of AOP.6.8
When the hospital uses outside sources of radiology and diagnostic imaging services, it regularly receives and reviews the quality control results for those outside sources. Qualified individuals review the quality control results. When diagnostic imaging quality control of outside sources is difficult to obtain, the department/service leader develops an alternative approach for quality oversight. (Also see AOP.6.6)

Measurable Elements of AOP.6.8

1. The frequency and type of quality control data from outside sources are determined by the hospital.
2. The qualified individual responsible for the radiology quality control or qualified designee reviews the quality control results from the outside source.
3. The responsible individual or qualified designee takes action based on the quality control results.
4. An annual report of the quality control data from the outside source is provided to hospital leadership to facilitate management of contracts and contract renewal.

References

เพื่อศึกษามาตรฐาน ที่กลุ่มชลบุรีเท่านั้น
## Care of Patients (COP)

### Changes to the COP Chapter

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<tr>
<th>Standard</th>
<th>Change</th>
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<tbody>
<tr>
<td>COP.1</td>
<td>No significant change</td>
<td>Rewords standard and MEs minimally for clarity</td>
</tr>
<tr>
<td>COP.2.1</td>
<td>Requirement change</td>
<td>Revises text of standard and intent and adds examples of measurable goals to intent; revises MEs to clarify expectations, including removing ME 3 and ME 5 (4th edition), combining ME 6 and ME 7 (4th edition), and adding new ME 4 and ME 5</td>
</tr>
<tr>
<td>COP.2.2</td>
<td>Requirement change</td>
<td>Rewrites standard and adds text to intent for clarity; revises ME 1 to emphasize the need for a uniform process for prescribing patient orders</td>
</tr>
<tr>
<td>COP.2.3</td>
<td>Requirement change</td>
<td>Adds text to standard, intent, and MEs for clarity; adds new ME 2 to require that the person requesting, and the reason for requesting, the procedure or treatment are documented in the patient’s record</td>
</tr>
<tr>
<td>COP.3</td>
<td>Requirement change</td>
<td>Eliminates multiple, individual standards by incorporating the following standards from the 4th edition: COP.3.1, COP.3.2, COP.3.4, COP.3.5, COP.3.6, COP.3.7, COP.3.8, and COP.3.9; rewrites ME 2 and adds MEs 4 and 5 to more clearly identify expectations for the care of high-risk patients in the hospital</td>
</tr>
<tr>
<td>COP.3.1</td>
<td>New standard</td>
<td>Introduces new requirement for staff training to recognize and respond to changes in a patient’s condition</td>
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<tr>
<td>COP.3.2</td>
<td>New standard</td>
<td>Adds new requirement to emphasize the need for resuscitation services to be available and consistent throughout the hospital</td>
</tr>
<tr>
<td>COP.3.3</td>
<td>Requirement change</td>
<td>Revises intent and MEs to emphasize the need for a qualified individual and clinical guidelines and procedures to guide the safe and consistent handling, use, and administration of blood and blood products</td>
</tr>
<tr>
<td>COP.4</td>
<td>Requirement change</td>
<td>Adds ME 4 from COP.4.1 (4th edition) to emphasize the need for timely distribution of food and honoring special requests</td>
</tr>
<tr>
<td>COP.5</td>
<td>No significant change</td>
<td>Adds minimal text to intent for clarity; incorporates ME 4 (4th edition) into ME 3</td>
</tr>
<tr>
<td>COP.6</td>
<td>Requirement change</td>
<td>Adds text to intent to clarify expectations; adds ME 2 on communication with patients regarding potential pain from planned treatments, procedures, or examinations</td>
</tr>
</tbody>
</table>
### Standards, Intents, and Measurable Elements

#### Care Delivery for All Patients

**Standard COP.1**

Uniform care of all patients is provided and follows applicable laws and regulations. ![icon]

**Intent of COP.1**

Patients with the same health problems and care needs have a right to receive the same quality of care throughout the hospital. To carry out the principle of “one level of quality of care requires that the department/service leaders plan and coordinate patient care.” In particular, services provided to similar patient populations in multiple departments or settings are guided by policies and procedures that result in their uniform delivery. In addition, the department/service leaders ensure that the same level of care is available each day of the week, and all work shifts each day. Those policies and procedures respect applicable laws and regulations that shape the care process and are best developed collaboratively. Uniform patient care is reflected in the following:

a) Access to and appropriateness of care and treatment do not depend on the patient’s ability to pay or the source of payment.

b) Access to appropriate care and treatment by qualified practitioners does not depend on the day of the week or time of day.

c) Acuity of the patient’s condition determines the resources allocated to meet the patient’s needs.

d) The level of care provided to patients *(for example, anesthesia care)* is the same throughout the hospital.

e) Patients with the same nursing care needs receive comparable levels of nursing care throughout the hospital.

Uniform patient care results in the efficient use of resources and permits the evaluation of outcomes of similar care throughout the hospital. *(Also see PFR.1.1 and GLD.12)*

**Measurable Elements of COP.1**

- 1. The hospital’s department/service leaders collaborate to provide uniform care processes.

- 2. The provision of uniform care reflects local and regional laws and regulations.

- 3. Uniform care is provided that meets requirements a) through c) in the intent.

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<tr>
<th>Standard</th>
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<tr>
<td>COP.8—COP.9.3</td>
<td>New standards</td>
<td>Introduces several standards to emphasize the need for safety and quality of organ and tissue transplant services</td>
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</table>

**Note:** This table lists changes to requirements in this chapter only. Requirements that were in this chapter in the 4th edition of this manual and are now contained either in their entirety or in part in another chapter of this 5th edition are listed in that chapter’s “Changes” table.

The following standard appeared in this chapter of the 4th edition standards but was deleted from this edition (listed with 4th edition numbers): COP.2.4.

**Note:** Some standards require the hospital to have a written policy or procedure for specific processes. Those standards are indicated by a ![icon] icon after the standard text.
Standard COP.2
There is a process to integrate and to coordinate the care provided to each patient.

Intent of COP.2
The patient care process is dynamic and involves many health care practitioners and can involve multiple care settings and departments and services. The integration and coordination of patient care activities are goals that result in efficient care processes, more effective use of human and other resources, and the likelihood of better patient outcomes. Thus, department/service leaders use tools and techniques to better integrate and to coordinate care for their patients (for example, team-delivered care, multidepartmental patient rounds, combined care planning forms, integrated patient record, case managers).

The patient’s record facilitates and reflects the integration and coordination of care. In particular, each practitioner records observations and treatments in the patient’s record. Also, any results or conclusions from collaborative patient care team meetings or similar patient discussions are written in the patient’s record. (Also see AOP.4)

Measurable Elements of COP.2

1. Care planning is integrated and coordinated among settings, departments, and services.
2. Care delivery is integrated and coordinated among settings, departments, and services.
3. The results or conclusions of any patient care team meetings or other collaborative discussions are documented in the patient’s record.

Standard COP.2.1
An individualized plan of care is developed and documented for each patient.

Intent of COP.2.1
The plan of care outlines care and treatment to be provided to an individual patient. The plan of care identifies a set of actions that the health care team will implement to resolve or support the diagnosis identified by assessment. The overall goal of a plan of care is to achieve optimal clinical outcomes.

The planning process is collaborative and uses the data from the initial assessment and from periodic reassessments performed by physicians, nurses, and other health care practitioners to identify and to prioritize the treatments, procedures, nursing care, and other care to meet the patient’s needs. The patient and family are involved in the planning process with the health care team. The plan of care is developed within 24 hours of admission as an inpatient. Based on the reassessment of the patient performed by the patient’s health care practitioners, the plan of care is updated as appropriate to reflect the evolving condition of the patient. The plan of care is documented in the patient’s record.

The plan of care for a patient must be related to his or her identified needs. Those needs may change as the result of clinical improvement or new information from a routine reassessment (for example, abnormal laboratory or radiography results), or they may be evident from a sudden change in the patient’s condition (for example, loss of consciousness) (also see COP.8.7 and COP.9.3). The plan of care is revised based on these changes and is documented in the record as notes to the initial plan, or they may result in a new plan of care.

One method of developing care plans is to identify and establish measurable goals. Measurable goals can be selected by the responsible physician in collaboration with the nurse and other health care practitioners. Measurable goals are observable, achievable targets related to patient care and expected clinical outcomes. They must be realistic, specific to the patient, and time-based to provide a means for measuring progress and outcomes related to the plan of care. Examples of measurable, realistic goals include the following:

- The patient will resume and maintain an adequate cardiac output as indicated by a heart rate, rhythm, and blood pressure that are within normal limits.
The patient will demonstrate proper self-administration of insulin injections prior to hospital discharge. The patient will be able to walk from his bed to the visitor lounge with a standard walker, bearing weight as tolerated on the affected leg.

**Note:** A single, integrated plan of care that identifies measurable goals expected by each health care practitioner is preferable. It is good practice for the plan of care to reflect individualized, objective, and measurable goals to facilitate reassessment and revision of the plan of care. *(Also see PFE.4)*

### Measurable Elements of COP.2.1

1. The care for each patient is planned by the responsible physician, nurse, and other health care practitioners within 24 hours of admission as an inpatient.

2. The plan of care is individualized based on the patient’s initial assessment data and identified needs.

3. The plan of care is updated or revised and reviewed by the multidisciplinary team based on the reassessment of the patient by the health care practitioners.

4. The initial plan of care and any revisions to the plan of care are documented in the patient’s record.

5. The plan of care for each patient is reviewed when initially developed and when revised based on changes in the patient’s condition by the multidisciplinary team and documented in the patient’s record.

6. The planned care is provided for each patient and documented in the patient’s record by the health professional providing the care. *(Also see COP.2.3; ASC.3; ASC.5; and MOI.10.1, ME 4)*

### Standard COP.2.2

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

**Intent of COP.2.2**

Many patient care activities require a qualified individual to prescribe an order for that activity that must be documented in the patient record. Such activities may include, for example, orders for laboratory testing, administration of medications, specific nursing care, nutrition therapy, rehabilitative therapy, and the like. Patient care activities requiring orders are ordered by individuals qualified to do so. Such orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the carrying out of orders. Documented orders help staff understand the specifics of an order, when the order is to be carried out, and who is to carry out the order. Orders can be written on an order sheet that is transferred to the patient’s record periodically or at discharge, or a computerized order entry system may be used in hospitals that are using electronic patient records.

Each hospital decides

- which orders must be written/documented rather than verbal;
- which diagnostic imaging and clinical laboratory test orders must provide a clinical indication/rationale;
- any exceptions in specialized settings, such as emergency departments and intensive care units;
- who is permitted to prescribe orders; and
- where orders are to be located in the patient record. *(Also see IPSG.2, MMU.4, MMU.4.1, MMU.4.2, MMU.4.3, MOI.10, and MOI.11)*

### Measurable Elements of COP.2.2

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

2. Diagnostic imaging and clinical laboratory test orders include a clinical indication/rationale when required for interpretation.

3. Orders are prescribed only by those qualified to do so.

4. Orders are found in a uniform location in patient records.
Standard COP.2.3
Clinical and diagnostic procedures and treatments performed, and the results or outcomes, are documented in the patient’s record.

Intent of COP.2.3
Clinical and diagnostic procedures and treatments performed, and the results or outcomes, are documented in the patient’s record. Examples of such procedures and treatments include endoscopies, cardiac catheterization, radiation treatment, computed tomography (CT) exams, and other invasive and noninvasive diagnostic procedures and treatments. Information about who requested the procedure or treatment and the reason for the procedure or treatment are included in the documentation. (Also see COP.2.1 and ASC.7.2)

Measurable Elements of COP.2.3
- 1. Procedures and treatments performed are documented in the patient’s record.
- 2. The person requesting, and the reason for requesting, the procedure or treatment are documented in the patient’s record.
- 3. The results of procedures and treatments performed are documented in the patient’s record.

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

Standard COP.3
The care of high-risk patients and the provision of high-risk services are guided by professional practice guidelines, laws, and regulations.

Intent of COP.3
Hospitals care for patients with a variety of health care needs. Some patients are considered high risk because of their age, their condition, or the critical nature of their needs. Children and the elderly are commonly placed in this group, as they frequently cannot speak for themselves, do not understand the care process, and cannot participate in decisions regarding their care. Similarly, the frightened, confused, comatose, or emergency patient is unable to understand the care process when care needs to be provided efficiently and rapidly.

Hospitals also provide a variety of services, some of which are considered high risk because of the complex medical technology needed to treat a life-threatening condition (dialysis patients), the nature of the treatment (patients on life support), the potential for harm to the patient (restraint), or toxic effects of certain high-risk medications (for example, chemotherapy).

Policies, guidelines, and procedures for managing the care of these patients are important tools for staff to understand and respond in a thorough, competent, and uniform manner. Hospital leadership is responsible for
- identifying the patients and services considered high risk in the hospital;
- using a collaborative process to develop guidelines and procedures for care; and
- training staff in implementing the guidelines and procedures.

Policies, guidelines, and procedures for care must be tailored to the particular at-risk patient population or high-risk service to be appropriate and effective in reducing the related risk. It is particularly important that the procedure identify
- how planning will occur, including the identification of differences between adult and pediatric populations, or other special considerations;
the documentation required for the care team to work and to communicate effectively;
- special consent considerations, if appropriate;
- patient-monitoring requirements;
- special qualifications or skills of staff involved in the care process; and
- the availability and use of specialized medical technology.

When serving any of the high-risk patients or providing any of the high-risk services identified below, the hospital establishes and implements guidelines and procedures for the services provided for and the patients served. (Also see PCI.8 and PCI.8.1) The high-risk services are for
- a) emergency patients;
- b) comatose patients;
- c) patients on life support;
- d) care of patients with a communicable disease;
- e) care of immunosuppressed patients;
- f) care of patients receiving dialysis;
- g) care of patients in restraints;
- h) care of patients receiving chemotherapy; and
- i) care of vulnerable patient populations, including frail elderly, dependent children, and patients at risk for abuse and/or neglect.

Additional patients and services are included when they are represented in the hospital’s patient population and in the services it offers.

Hospital leadership also identifies additional risk as the result of any procedures or plan of care (for example, the need to prevent deep vein thrombosis, decubitus ulcers, and ventilator-associated infections in patients on life support; neurological and circulatory injury in restrained patients; blood exposure in dialysis patients; central line infections; and falls). Such risks, when present, need to be addressed and prevented by educating staff and developing appropriate policies, guidelines, and procedures. (Also see PFR.5.2.) The hospital uses measurement information to evaluate the services provided to high-risk patients and integrates that information into the hospital’s overall quality improvement program.

**Measurable Elements of COP.3**

1. Hospital leadership has identified the high-risk patients and services.
2. When high-risk services are provided by the hospital, leadership establishes and implements guidelines and procedures for those services and for the care of high-risk patients, for at least a) through i) of the intent. (Also see MOI.10.1, ME 4)
3. Staff have been trained and use the guidelines and procedures for care.
4. Hospital leadership identifies additional risks that may affect high-risk patients and services.
5. Evaluation of the high-risk services is included in the hospital’s quality improvement program.

**Recognition of Changes to Patient Condition**

**Standard COP.3.1**
Clinical staff are trained to recognize and respond to changes in a patient’s condition.

**Intent of COP.3.1**
Staff who do not work in critical care areas may not have adequate knowledge and training to assess and monitor patients with critical conditions. However, a significant number of patients outside of critical care areas experience critical inpatient events. Often, a patient will exhibit early warning signs (for example, a worsening of
vital signs or a subtle change in neurological status) shortly before experiencing significant clinical decline, resulting in a major event. The literature identifies physiological criteria that can assist staff in early detection of deteriorating patients.\textsuperscript{6–11} A majority of patients who experience cardiopulmonary or respiratory arrest demonstrate clinical deterioration prior to arrest. When staff are able to identify these patients early and request additional assistance from specially trained individuals, clinical outcomes improve.

All clinical staff require education and training to provide the knowledge and skills to recognize and intervene when patient assessments identify physiological signs that are outside of the normal range, indicating a potential for patient deterioration. Early response to changes in a patient’s condition is critical to potentially preventing further deterioration. Hospitals that develop a systematic approach to early recognition and intervention of patients whose condition is deteriorating may reduce cardiopulmonary arrests and patient mortality. (\textit{Also see SQE.3})

**Measurable Elements of COP.3.1**

- 1. The hospital develops and implements a systematic process for staff recognition of and response to a patient whose condition appears to be worsening.
- 2. The hospital develops and implements documented criteria describing early warning signs of a change or deterioration in a patient’s condition and when to seek further assistance.
- 3. Based on the hospital’s early warning criteria, staff seek additional assistance when they have concerns about a patient’s condition.
- 4. The hospital informs the patient and family how to seek assistance when they have concerns about a patient’s condition.

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**Resuscitation Services**

**Standard COP.3.2**

Resuscitation services are available throughout the hospital.

**Intent of COP.3.2**

Resuscitation services can be defined as clinical interventions for the emergent care of patients experiencing a critical, life-threatening event, such as cardiac or respiratory arrest. When a cardiac or respiratory arrest occurs, the immediate initiation of chest compressions or respiratory support may mean the difference between life and death or, at the very least, may help avoid potentially serious brain damage.

Successful resuscitation of patients in cardiopulmonary arrest is dependent on critical interventions, such as early defibrillation and accurate implementation of advanced life support.\textsuperscript{11–14} These services must be available to all patients, 24 hours a day, every day. Essential to providing these critical interventions is the quick availability of standardized medical technology, medications for resuscitation, and staff properly trained in resuscitation.\textsuperscript{14} Basic life support must be implemented immediately upon recognition of cardiac or respiratory arrest, and a process must be in place for providing advanced life support in fewer than 5 minutes. This could include reviews of actual in-hospital resuscitations as well as mock cardiac arrest response training. Resuscitation services available within the hospital, including medical technology and properly trained staff, must be based on clinical evidence and the population served (\textit{for example}, if the hospital has a pediatric population, medical technology for pediatric resuscitation must be available). (\textit{Also see} ASC.3, ME 4; SQE.8.1; GLD.9, ME 2; and FMS.8)

**Note:** All areas of the hospital includes any areas where treatment and services are provided, including treatment or diagnostic areas in separate buildings on the hospital campus.
Measurable Elements of COP.3.2

1. Resuscitation services are available and provided to all patients 24 hours a day, every day, throughout all areas of the hospital.

2. Medical technology for resuscitation and medications for basic and advanced life support are standardized and available for use based on the needs of the population served.

3. In all areas of the hospital, basic life support is implemented immediately upon recognition of cardiac or respiratory arrest, and advanced life support is implemented in fewer than 5 minutes.

Standard COP.3.3

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

Intent of COP.3.3

Blood must be administered in accordance with standards of practice and in a consistent manner in order to ensure the safety of the recipient. Therefore, clinical guidelines and procedures describe the process for:

a) procurement of blood from the blood bank or blood storage area;
b) patient identification;
c) blood administration;
d) monitoring of the patient; and

e) identification and response to signs of potential transfusion reactions.

An individual with the education, knowledge, and expertise to oversee the blood and blood products administration ensures that processes, procedures, and clinical guidelines for transfusions are defined and implemented.15–18 (Also see QPS.8, ME 2)

Measurable Elements of COP.3.3

1. An individual with education, knowledge, and expertise oversees the administration of blood and blood products. (Also see AOP.5.11, ME 1)

2. Clinical guidelines and procedures are established and implemented for the handling, use, and administration of blood and blood products. (Also see AOP.5.11, ME 2)

3. Clinical guidelines and procedures address the processes for a) through e) in the intent.

Food and Nutrition Therapy

Standard COP.4

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

Intent of COP.4

Appropriate food and nutrition are important to patients’ well-being and recovery. Food choices take into consideration the patient’s age, cultural and dietary preferences, and planned care, which may include special dietary needs such as low cholesterol, diabetic diet, and clear liquids, depending on the patient’s diagnosis. The patient participates in planning and selecting foods, and the patient’s family may, when appropriate, participate in providing food, consistent with cultural, religious, and other traditions and practices and compatible with the patient’s diagnosis. Based on the patient’s assessed needs and plan of care, the patient’s physician or other qualified caregiver orders food or other nutrients for the patient. When the patient’s family or others provide food to the patient, they are educated about foods that are contraindicated according to the patient’s care needs.
and plans, including information about any medications associated with food interactions. When possible, patients are offered a variety of food choices consistent with their nutritional status. (Also see AOP.1.4)

**Measurable Elements of COP.4**
- 1. A variety of food choices or nutrition, consistent with the patient’s condition, care, and needs, is regularly available.
- 2. Prior to patients being fed, all inpatients have orders for food in their records.
- 3. The order is based on the patient’s nutritional status and needs.
- 4. The distribution of food is timely, and special requests are met.
- 5. When families provide food, they are educated about the patients’ diet limitations.

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**Standard COP.5**
Patients at nutrition risk receive nutrition therapy.

**Intent of COP.5**
On initial assessment, patients are screened to identify those patients who may be at nutritional risk. These patients are referred to a nutritionist for further assessment. When it is determined that a patient is at nutritional risk, a plan for nutrition therapy is developed and carried out. The patient’s progress is monitored and recorded in his or her record. Physicians, nurses, the dietetics service, and, when appropriate, the patient’s family, collaborate to plan and to provide nutrition therapy. (Also see AOP.1.4)

**Measurable Elements of COP.5**
- 1. Patients assessed at nutrition risk receive nutrition therapy.
- 2. A collaborative process is used to plan, to deliver, and to monitor nutrition therapy.
- 3. The patient’s response to nutrition therapy is monitored and documented in the patient record. (Also see AOP.2, ME 1)

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**Pain Management**

**Standard COP.6**
Patients are supported in managing pain effectively.

**Intent of COP.6**
Pain can be a common part of the patient experience and may be associated with the condition or illness for which the patient is being treated. Pain may also be an expected part of certain treatments, procedures, or examinations. As part of care planning, patients are informed about the likelihood of pain when it is an anticipated effect from treatments, procedures, or examinations and what options for pain management are available. Whatever the origin of pain, unrelieved pain has adverse physical and psychological effects. Thus, patients in pain have the right to appropriate assessment and management of pain. (Also see PFR.2.3 and AOP.1.5)

Based on the scope of services provided, the hospital has processes to assess and to manage pain appropriately, including
- identifying patients with pain during initial assessment and reassessments;
- providing information to patients about pain that may be an expected result of treatments, procedures, or examinations;
c) providing management of pain, regardless of the origin of pain, according to guidelines or protocols and in conjunction with patient goals for pain management;
d) communicating with and educating patients and families about pain and symptom management in the context of their personal, cultural, and religious beliefs; and
e) educating health care practitioners about pain assessment and management.

Measurable Elements of COP.6

1. Based on the scope of services provided, the hospital has processes to identify patients in pain.
2. When pain is an expected result of planned treatments, procedures, or examinations, patients are informed about the likelihood of pain and options for pain management.
3. Patients in pain receive care according to pain management guidelines and according to patient goals for pain management.
4. Based on the scope of services provided, the hospital has processes to communicate with and to educate patients and families about pain.
5. Based on the scope of services provided, the hospital has processes to educate staff about pain.

End-of-Life Care

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

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

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

Standard COP.7

The hospital addresses end-of-life care.

Intent of COP.7

Patients who are dying have unique needs for respectful, compassionate care. To accomplish this, all staff are made aware of the unique needs of patients at the end of life. Concern for the patient’s comfort and dignity should guide all aspects of care during the final stages of life. End-of-life care provided by the hospital includes:

a) providing appropriate treatment for any symptoms according to the wishes of the patient and family;
b) sensitively addressing such issues as autopsy and organ donation;
c) respecting the patient’s values, religion, and cultural preferences;
d) involving the patient and family in all aspects of care; and
e) responding to the psychological, emotional, spiritual, and cultural concerns of the patient and family.
To accomplish these goals, all staff are educated about the unique needs of patients and their families at the end of life. The hospital evaluates the quality of the end-of-life care provided by evaluating family and staff perceptions of the care provided. (*Also see* PFR.2.3)

**Measurable Elements of COP.7**

- 1. Staff are educated about the unique needs of patients and their families at the end of life.
- 2. End-of-life care provided by the hospital addresses dying patients’ needs, at least including evaluation of elements a) through e) in the intent.
- 3. The quality of the end-of-life care is evaluated by family and staff.

**Standard COP.7.1**

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

**Intent of COP.7.1**

The hospital ensures appropriate care of those in pain or dying by:

- taking interventions to manage pain and primary or secondary symptoms;
- preventing symptoms and complications to the extent reasonably possible;
- taking interventions that address patient and family psychosocial, emotional, and spiritual needs regarding dying and grieving;
- taking interventions that address patient and family religious and cultural concerns; and
- involving the patient and family in care decisions.

**Measurable Elements of COP.7.1**

- 1. Interventions are taken to manage pain and primary or secondary symptoms.
- 2. Symptoms and complications are prevented to the extent reasonably possible.
- 3. Interventions address patient and family psychosocial, emotional, and spiritual needs regarding dying and grieving.
- 4. Interventions address patient and family religious and cultural concerns.
- 5. The patient and family are involved in care decisions. (*Also see* PFR.2)

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**Hospitals Providing Organ and/or Tissue Transplant Services**

**Note:** The following standards are intended to be used during those times when patients and/or families request information about organ and tissue donation and/or when organ/tissue procurement is performed. For hospitals providing organ and/or tissue transplant services, standards COP.8 through COP.9.3 apply. Please contact the JCI Accreditation Office with inquiries.

Transplantation of organs is often a lifesaving procedure, and organ and tissue transplants are sometimes the only options for treatment of a wide range of diseases. Recent advances in transplantation have led to a greater success rate for transplanted organs and tissues. However, transplantation is not free from risk. Transmission of infections from the donor to the recipient is a well-documented safety concern. Diseases with documented transmission from infected donors subsequent to transplant include, to name a few, HIV, hepatitis B and C, and Creutzfeldt-Jakob disease (CJD). Recipients may also contract bacterial or fungal infections through contamination during transportation, storage, or handling.
Leadership’s commitment to creating a culture conducive to organ and tissue donation can have significant impact on the overall success of the hospital’s organ and tissue procurement efforts. These standards address the hospital’s organizationwide responsibilities for organ and tissue donation and procurement. This includes any individual who has been determined medically suitable for donation by the organ-procurement organization. If the hospital has the necessary resources to support the recovery of organs and tissues after cardiac death, non–heart-beating donors are included in the organ procurement effort.

**Standard COP.8**
The hospital’s leadership provides resources to support the organ/tissue transplant program.

**Intent of COP.8**
The organ/tissue transplant program requires staff with specialized education and training and other resources in order to provide safe, high-quality care. Staff education and training must be specific to the responsibilities and requirements of organ/tissue transplant. Other essential resources include supplies, patient rooms with ventilation required for the type of transplant procedure (for example, positive pressure ventilation), required pharmaceuticals for the type of transplant procedure, laboratory testing to ensure that tissue/organs are not contaminated, and other resources as identified by the program service leader. In addition, resources related to information management systems are necessary to assist with the collection of data associated with risks, outcomes, and other information that support the quality of the transplant program. (Also see GLD.1.1, ME 3; GLD.7; and GLD.9, ME 2)

**Measurable Elements of COP.8**
- Trained staff are available to provide safe, high-quality care to the organ/tissue transplant program.
- The hospital’s leadership allocates resources for the organ/tissue transplant program.
- Information management systems are used to support the quality of the organ/tissue transplant program.

**Standard COP.8.1**
A qualified transplant program leader is responsible for the transplant program.

**Intent of COP.8.1**
The responsibility of a hospital offering organ and tissue transplant services is to provide safe, high-quality care to transplant donors and recipients. At the core of this responsibility is an infrastructure capable of supporting all transplant program activities. A key element of the infrastructure is an individual(s) responsible for oversight of the organ/tissue transplant program. Acting on a full-time or part-time basis, this individual(s) provides that oversight as part of his or her assigned responsibilities or job description. This individual(s) is qualified in transplant management through education, training, experience, licensure, and/or certification. The required qualifications depend on the activities carried out. (Also see GLD.9, ME 1)

**Measurable Elements of COP.8.1**
- One or more individuals oversees the organ/tissue transplant program.
- The individual(s) is qualified for the program’s scope and complexity.
- The individual(s) fulfills the program’s oversight responsibilities as defined by the transplant program.

**Standard COP.8.2**
The transplant program includes a multidisciplinary team that consists of people with expertise in the relevant organ-specific transplant programs.
**Intent of COP.8.2**

The success of a transplant program and positive outcomes for transplant recipients and living donors as well are dependent on a team of health care providers who have clinical knowledge and expertise in organ-specific transplantation. The nursing, psychological, pharmacological, and nutritional needs of an organ recipient and a living organ donor are unique. As related to the type of transplant, a multidisciplinary team consists of individuals from:

- medicine;
- nursing;
- nutrition;
- pharmacology;
- social services; and
- psychological services.

This team should have the qualifications, training, and experience to provide care and services to transplant recipients and living donors. *(Also see GLD.9, ME 3)*

**Measurable Elements of COP.8.2**

- 1. The transplant program documents the composition of the tissue/organ-specific transplant team.
- 2. The transplant program documents the team members’ responsibilities.
- 3. Based on the services provided by the transplant team, the team includes individuals experienced in medicine, nursing, nutrition, pharmacology, social services, psychological services, and transplant coordination.
- 4. The transplant program evaluates team members for qualifications, training, and experience at the time each individual is being considered for the transplant team.

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**Standard COP.8.3**

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

**Intent of COP.8.3**

Transplant services carry unique and critical risks to organ/tissue recipients and, in the cases of living donors, to the donor as well. An important component in ensuring safe, high-quality care through all phases of the donor/recipient process is identifying an individual with overall responsibility for coordination and continuity of the live donor’s and recipient’s care. This individual may be a physician, registered nurse, or other qualified health care professional. *(Also see ACC.3)*

**Measurable Elements of COP.8.3**

- 1. The individual responsible for the coordination of the live donor’s and transplant recipient’s care is identified and available through all phases of transplant care.
- 2. The clinical transplant coordinator facilitates continuity of care for transplant patients (candidates and recipients) through the pre-transplant, transplant, and discharge phases of transplantation.
- 3. The clinical transplant coordinator facilitates continuity of care for living donors during evaluation, donation, and discharge phases of donation.
- 4. The coordination of organ/transplant activities is communicated to all staff involved in the transplant program activities.
Standard COP.8.4
The transplant program uses organ-specific transplant clinical eligibility, psychological, and social suitability criteria for transplant candidates.

Intent of COP.8.4
There are multiple areas for consideration when a decision needs to be made about allocating organs to recipients. Consideration may be given to the imminent need of the patient for a transplant, the benefit the patient may gain from the transplant, the availability of alternative treatments, the expected improvement in the patient’s quality of life, and the amount of resources required for successful treatment.

Because human organs and tissues available for transplant are limited, criteria for recipient selection are developed. Criteria for transplant recipient selection helps identify the most appropriate patient and limits the potential for bias. Thus, criteria for access to organs and tissues are defined in a transparent manner, based on an objective evaluation of medical needs.

In addition, there are organ-specific criteria that must be taken into account in the decision for allocating an organ. For example, the viability of an organ outside of the body varies from organ to organ. Thus consideration must be given to the length of time it may take for an organ to reach the recipient. (Also see AOP.1.1)

Measurable Elements of COP.8.4
1. The transplant program documents organ-specific candidate selection criteria.
2. The results of a medical evaluation are included in the determination of suitability for transplantation.
3. The transplant program documents organ compatibility confirmation in the transplant candidate’s medical record.

Standard COP.8.5
The transplant program obtains informed consent specific to organ transplantation from the transplant candidate.

Intent of COP.8.5
To consent, a patient must be informed of those factors related to the planned care required for an informed decision. Factors that could affect the success of the graft or the candidate’s health as a recipient include, but are not limited to,

a) the donor’s history;
b) condition of the organ(s) used;
c) age of the organ(s); and
d) the potential risk of contracting infectious disease(s) if disease(s) cannot be detected in an infected donor.

In addition, there may be psychological, ethical, financial, and other factors that are unique to the transplant patient than for other patients, such as the need for immunosuppressive medications and the projected survival rate. The patient needs to be informed of all special considerations as part of the consent process. The transplant program also follows the hospital’s policy for informed consent as well as local and regional laws and regulations. (Also see PFR.5.2)

Measurable Elements of COP.8.5
1. The transplant program follows the hospital’s policy when obtaining informed consent from transplant candidates.