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This fourth edition of the Joint Commission International Accreditation Standards for Hospitals contains all the standards, intent statements, measurable elements of standards, accreditation policies and procedures, and a glossary of key terms. This Introduction is designed to provide you with information on the following topics:

- The benefits of accreditation
- Joint Commission International (JCI) and its relationship to The Joint Commission (U.S.A.)
- The international accreditation initiatives of JCI
- The origin of the standards and how they are organized
- How to use this standards manual
- What is new in this fourth edition of the manual

If, after reading this publication, you have questions about the standards or the accreditation process, please contact JCI. Contact information is located in the Foreword (preceding this section).

What is accreditation?

Accreditation is a process in which an entity, separate and distinct from the health care organization, usually nongovernmental, assesses the health care organization to determine if it meets a set of requirements (standards) designed to improve the safety and quality of care. Accreditation is usually voluntary. Accreditation standards are usually regarded as optimal and achievable. Accreditation provides a visible commitment by an organization to improve the safety and quality of patient care, to ensure a safe care environment, and to continually work to reduce risks to patients and staff. Accreditation has gained worldwide attention as an effective quality evaluation and management tool.

What are the benefits of accreditation?

The accreditation process is designed to create a culture of safety and quality within an organization that strives to continually improve patient care processes and results. In doing so, organizations

- improve public trust that the organization is concerned for patient safety and the quality of care;
- provide a safe and efficient work environment that contributes to worker satisfaction;
- negotiate with sources of payment for care with data on the quality of care;
- listen to patients and their families, respect their rights, and involve them in the care process as partners;
- create a culture that is open to learning from the timely reporting of adverse events and safety concerns; and
- establish collaborative leadership that sets priorities for and continuous leadership for quality and patient safety at all levels.
What is JCI’s relationship to The Joint Commission?

JCI is the international arm of The Joint Commission (U.S.A.); JCI’s mission is to improve the quality and safety of health care in the international community.

For more than 75 years, The Joint Commission (U.S.A.) and its predecessor organization have been dedicated to improving the quality and safety of health care services. Today, The Joint Commission is the largest accreditor of health care organizations in the United States—it surveys nearly 16,000 health care programs through a voluntary accreditation process. The Joint Commission and JCI are both nongovernmental, not-for-profit United States corporations.

What are the purpose and the goal of JCI accreditation initiatives?

JCI accreditation is a variety of initiatives designed to respond to a growing demand around the world for standards-based evaluation in health care. The purpose is to offer the international community standards-based, objective processes for evaluating health care organizations. The goal of the program is to stimulate demonstration of continuous, sustained improvement in health care organizations by applying international consensus standards, International Patient Safety Goals, and data measurement support. In addition to the standards for hospitals contained in this fourth edition, JCI has developed standards and accreditation programs for the following:

- Ambulatory Care
- Clinical Laboratories
- Primary Care Centers
- The Care Continuum (home care, assisted living, long term care, hospice care)
- Medical Transport Organizations

JCI also offers certification of clinical care programs, such as programs for stroke care, cardiac care, or joint replacement. JCI accreditation programs are based on an international framework of standards adaptable to local needs.

All the JCI accreditation and certification programs are characterized by the following:

- International consensus standards, developed and maintained by an international task force, and approved by an international Board, are the basis of the accreditation program.
- The underlying philosophy of the standards is based on principles of quality management and continuous quality improvement.
- The accreditation process is designed to accommodate the legal, religious, and/or cultural factors within a country. Although the standards set uniform, high expectations for the safety and quality of patient care, country-specific considerations related to compliance with those expectations are part of the accreditation process.
- The on-site survey team and agenda will vary depending on the organization’s size and type of services provided. For example, a large multispecialty organization may require a four- or five-day survey by a physician, a nurse, and an administrator, while a 50-bed, single-specialty hospital may require a shorter survey by a smaller team.
- JCI accreditation is designed to be valid, reliable, and objective. Based on the analysis of the survey findings, final accreditation decisions are made by an international accreditation committee.
How were the standards initially developed and refined for this fourth edition?

A 12-member International Standards Subcommittee, composed of experienced physicians, nurses, administrators, and public policy experts, guides the development and revision process of the JCI accreditation standards. The subcommittee consists of members from six major world regions: Latin America and the Caribbean, Asia and the Pacific Rim, the Middle East, Central and Eastern Europe, Western Europe, and Africa. The work of the subcommittee is refined based on an international field review of the standards and the input from experts and others with unique content knowledge.

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 those functions related to providing patient care and those related to providing a safe, effective, and well-managed organization. These functions 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.

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 Web site for consideration of adapting them to the needs of individual countries. The translation and use of the standards as published by JCI requires permission.

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

When standard compliance is related to a laws and regulations, whichever sets the higher or stricter requirement applies.

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;
Overview

This chapter addresses the International Patient Safety Goals (IPSG), as required for implementation as of 1 January 2011 in all organizations accredited by Joint Commission International (JCI) under the International Standards for Hospitals.

The purpose of the IPSG is to promote specific improvements in patient safety. The goals highlight problematic areas in health care and describe evidence- and expert-based consensus solutions to these problems. Recognizing that sound system design is intrinsic to the delivery of safe, high-quality health care, the goals generally focus on systemwide solutions, wherever possible.

The goals are structured in the same manner as the other standards, including a standard (goal statement), an intent statement, and measurable elements. The goals are scored similar to other standards as “met,” “partially met,” or “not met.” The Accreditation Decision Rules include compliance with the IPSG as a separate decision rule.

Goals

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

- **IPSG.1** Identify Patients Correctly
- **IPSG.2** Improve Effective Communication
- **IPSG.3** Improve the Safety of High-Alert Medications
- **IPSG.4** Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery
- **IPSG.5** Reduce the Risk of Health Care–Associated Infections
- **IPSG.6** Reduce the Risk of Patient Harm Resulting from Falls
Goals, Standards, Intents, and Measurable Elements

**Goal 1: Identify Patients Correctly**

**Standard IPSG.1**
The organization develops an approach 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, or not fully alert; may change beds, rooms, or locations within the hospital; may have sensory disabilities; 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.

Policies and/or procedures are collaboratively developed to improve identification processes, in particular, the processes used to identify a patient when giving medications, blood, or blood products; taking blood and other specimens for clinical testing; or providing any other treatments or procedures. The policies and/or procedures require at least two ways 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. The policies and/or procedures clarify the use of two different identifiers in different locations within the organization, such as in ambulatory care or other outpatient services, the emergency department, or operating theatre. Identification of the comatose patient with no identification is also included. A collaborative process is used to develop the policies and/or procedures to ensure they address all possible identification situations.

**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 administering medications, blood, or blood products.
- 3. Patients are identified before taking blood and other specimens for clinical testing. *(Also see AOP:5.6, ME 2)*
- 4. Patients are identified before providing treatments and procedures.
- 5. Policies and procedures support consistent practice in all situations and locations.

**Goal 2: Improve Effective Communication**

**Standard IPSG.2**
The organization develops an approach to improve the effectiveness of communication among caregivers.

**Intent of IPSG.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. The most error-prone communications are patient care orders given verbally and those given over the telephone, when permitted under local laws and regulations. Another error-prone communication is the report back of critical test results, such as the clinical laboratory telephoning the patient care unit to report the results of a STAT test.
Overview

A health care organization’s main purpose is patient care. Providing the most appropriate care in a setting that supports and responds to each patient’s unique needs requires a high level of planning and coordination. Certain activities are basic to patient care. For all disciplines that care for patients, these activities include

- planning and delivering care to each patient;
- monitoring the patient to understand the results of the care;
- modifying care when necessary;
- completing the care; and
- planning the follow-up.

Many physicians, nurses, pharmacists, rehabilitation therapists, and other types of health care practitioners may carry out these activities. Each practitioner has a clear role in patient care. That role is determined by licensure; credentials; certification; laws and regulations; an individual’s particular skills, knowledge, and experience; and organization policies or job descriptions. Some care may be carried out by the patient, his or her family, or other trained caregivers.

The Assessment of Patients (AOP) standards (also see pages 75–100) describe the basis for care delivery—a plan for each patient based on an assessment of his or her needs. That care may be preventive, palliative, curative, or rehabilitative and may include anesthesia, surgery, medication, supportive therapies, or a combination of these. A plan of care is not sufficient to achieve optimal outcomes. The delivery of the services must be coordinated and integrated by all individuals caring for the patient.

Standards

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

Care Delivery for All Patients

COP.1 Policies and procedures and applicable laws and regulations guide the uniform care of all patients.

COP.2 There is a process to integrate and to coordinate the care provided to each patient.
COP.2.1 The care provided to each patient is planned and written in the patient’s record.

COP.2.2 Those permitted to write patient orders write the order in the patient record in a uniform location.

COP.2.3 Procedures performed are written into the patient’s record.

COP.2.4 Patients and families are informed about the outcomes of care and treatment, including unanticipated outcomes.

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

COP.3 Policies and procedures guide the care of high-risk patients and the provision of high-risk services.

COP.3.1 Policies and procedures guide the care of emergency patients.

COP.3.2 Policies and procedures guide the use of resuscitation services throughout the organization.

COP.3.3 Policies and procedures guide the handling, use, and administration of blood and blood products.

COP.3.4 Policies and procedures guide the care of patients on life support or who are comatose. (Also see PFR.1.5)

COP.3.5 Policies and procedures guide the care of patients with communicable diseases and immune-suppressed patients.

COP.3.6 Policies and procedures guide the care of patients on dialysis.

COP.3.7 Policies and procedures guide use of restraint and the care of patients in restraint.

COP.3.8 Policies and procedures guide the care of elderly patients, disabled individuals, children, and populations at risk for abuse.

COP.3.9 Policies and procedures guide the care of patients receiving chemotherapy or other high-risk medications.

Food and Nutrition Therapy

COP.4 A variety of food choices, appropriate for the patient’s nutritional status and consistent with his or her clinical care, is regularly available.

COP.4.1 Food preparation, handling, storage, and distribution are safe and comply with laws, regulations, and current acceptable practices.

COP.5 Patients at nutrition risk receive nutrition therapy.

Pain Management

COP.6 Patients are supported in managing pain effectively.

End-of-Life Care

COP.7 The organization addresses end-of-life care.

COP.7.1 Care of the dying patient optimizes his or her comfort and dignity.