Standards Interpretation FAQs

Standards	Subject	Interpretation Question	Response
International Patient Safety Goals (IPSG)			
IPSG.1	More than two patient identifiers	Is there a "penalty" or disadvantage to using more than two patient identifiers?	IPSG.1, ME 1 states "patients are identified using two patient identifiers, not including the use of the patient's room number and location in the hospital." Therefore, only two identifiers are required by JCI, unless the hospital policy requires more than two identifiers, in which case the surveyors will score according to the hospital policy. Some disadvantages for using more than two patient identifiers include the time required for health care practitioners to complete the patient identifier process using all three identifiers with each intervention on every patient. This may unintentionally decrease compliance with hospital policy. Patients may also be less amenable to a longer identification process. It may be helpful to consider an approach that uses identifiers that are much more specific and unique (in many countries, they use their national ID number as one of the two) and limiting to two identifiers.
IPSG.1	Patient photograph as an identifier	Is a photograph of a patient's face an appropriate identifier?	Whether or not a photo may be used as one of the identifiers depends on the ability of the photo to be used in all situations requiring patient identification and for all patients. For example, if the hospital chooses to use a photo as one of the two identifiers, the photo must be used by all departments/services, such as diagnostic imaging, the operating theatre, GI laboratory, physical therapy, and so on. In addition, some countries or regions may consider the use of a photo as an identifier a violation of the patient's privacy. Therefore, it is important to check local and regional laws and regulations. Additionally, the patient's condition may influence how effective the photograph is as a patient identifier, for example, in trauma patients or during treatments that may alter the patient's appearance (oral-facial surgery, treatments resulting in edema, etc.).
IPSG.1	Patient identifiers in special circumstances	What identifiers can be used for patients who are confused, disoriented, demented, unconscious, or sedated?	The intent of IPSG.1 states that there are special circumstances in which a hospital may need to develop a specific process for patient identification such as in the case of a comatose or confused/disoriented patient who may arrive with no identification. IPSG.1, ME 3 requires the hospital to ensure the correct identification of patients in these types of special circumstances. The process considers the unique needs of the patients, and staff use the process for patient identification in these circumstances to prevent error. It is up to the hospital to determine the identification process for unknown, unconscious patients. Examples of what some hospitals do include assigning a generic name such as "John Doe"/"Jane Doe" or "Unknown Male"/"Unknown Female" and a unique hospital ID number that may be auto-generated or manually assigned. Two different patient identifiers are required in any circumstance involving patient interventions.
IPSG.1	Identifiers for newborns	What identifiers can be used for newborns or nonverbal children?	As required by IPSG.1, all patients are identified using two patient identifiers. Many hospitals choose to use patient's name and birth date as the two identifiers. The issue for newborns is that there may be multiple newborns with the same birth date and often, parents do not choose a name for the baby immediately following the birth. Thus, two babies born to different mothers on the same day with the same surname and of the same sex will have the same two identifiers. For example, Girl Patel born to Anupam Patel and Girl Patel born to Lakhpreet Patel on 1 March 2018. Both babies' identifiers would be "Girl Patel" and "1 March 2018."

Standards	Subject	Interpretation Question	Response
			Information in the literature provides several examples of naming patterns for newborns and all recommend that simply using the sex of the baby and the surname along with the birth date is not adequate. Some hospitals have chosen to incorporate the mother's name into newborn identification (e.g., Anupam Girl Patel, Lakhpreet Girl Patel, Rosana Boy Velazquez) along with the birthdate. This method is not required; however, whatever method is chosen, the hospital must evaluate the potential risks associated with the method chosen and use a process that ensures proper identification of newborns. The chosen method must be used consistently with all newborns in the hospital.
IPSG.2.2	Handover communication	Can hospitals determine what is included in a handover, when it should be done, and who needs to be involved?	It is up to the hospital to determine the content of the handover communication. Patient information and the process for sharing information may vary between the type of health care practitioner and level or type of patient care. The content of the handover communication is standardized for the type of handover and may be different between health care practitioners, between different levels of care in the same hospital, and from inpatient units to diagnostic or other treatment departments, among other examples. A handover occurs when the responsibility for a patient and the patient's care is transferred from one health care practitioner to another, or from a team of practitioners to another, and occurs throughout the health care continuum.
IPSG.2.2	Documentation of handovers	Does the handover need to be documented?	The standards do not require documentation of handovers in the medical record. However, a hospital may implement a process that requires health care practitioners to document in the medical record that the handover was completed—such as the time/date of the handover, to whom the practitioner endorsed care, and the practitioner's signature. As another example, a hospital may require documentation of handovers on a form or tool that is stored separately from the medical record. Documentation of handovers could facilitate tracking of adverse events.
IPSG.3	High-alert/high-risk and look alike/sound alike (LASA) medications	Does a hospital need to have separate processes for LASA and high-alert medications?	Hospitals need to institute risk management strategies to enhance patient safety and minimize adverse events related to medications. A hospital can have a process for managing high-alert medications that is different from the process for managing look-alike/sound-alike medications. While the two processes may be different, each of these processes must be used the same throughout the hospital, wherever medications are stored. For example, if the process is to use red stickers to identify high-alert medications in the pharmacy, then red stickers must be used to identify high-alert medications on any wards where those medications are stored. If the process for look-alike/sound-alike medications is to use tall-man lettering in the pharmacy, then tall-man lettering must be used to identify look-alike/sound-alike medications on any wards where those medications are stored.
IPSG.3	List of look-alike/sound-alike (LASA) medications	How should we create our look-alike/sound-alike (LASA) list?	IPSG.3 states that the hospital uses its own internal data related to medication use, including near misses, medication errors, adverse events, and other relevant information when developing its list(s) of high-alert medications and LASA medications. The Ministry of Health may have a list of medications to include on the LASA list. In addition, the Institute for Safe Medication Practices (ISMP) publishes information about LASA medications. If a hospital has already identified LASA medications, the hospital may consider reviewing MOH and ISMP resources as well as analyzing hospital data to identify if additions to the list are necessary.
IPSG.3	Labeling high-alert medications	Does every individual dose of high-alert medication need to be labeled?	It is not recommended that each vial or dosage unit of a high-alert medication be individually labeled with a high-alert label. These medications should be stored in a way that reduces the likelihood of inadvertent administration. Labeling of each individual unit of a high-alert medication may result in dangerous, unintended consequences if the label covers

Standards	Subject	Interpretation Question	Response
			the name of the medication and/or the dose on the package. Such labeling may not only result in covering up the medication name and dose, but also may potentially create a "look alike" phenomenon that could create another opportunity for mix-up with other similarly shaped and labeled dosage forms and medications. If a hospital chooses to place the high-alert label on the box, bin, shelf, or drawer of high-alert medications, when a dose or vial is removed, the individual dose or vial must be labeled as high-alert. For example, a vial is removed from a labeled box in the pharmacy to be sent to the floor. It is placed in a plastic bag that has a high-alert label.
IPSG.3.1	Concentrated electrolytes in patient care areas	If a hospital determines that it is important to have a small supply of concentrated electrolytes in a patient care area (for example, operating theaters or intensive care units), is it permitted?	The literature identifies very few conditions that require treatment with concentrated electrolytes, and the standards require that hospitals use the literature to determine the areas in the hospital where concentrated electrolytes are required in their concentrated form (see IPSG.3.1, ME 2). In addition, the standards require that when concentrated electrolytes are stored in patient care areas, the electrolytes are clearly labeled and stored in a manner that restricts access and promotes safe use (IPSG.3.1, ME 3). The standards do not specify precisely how to store these drugs, but rather allow the hospital to determine the best storage method that would meet the requirements of the standard and prevent patient harm or death.
IPSG.4	Surgical site marking	Does every procedure require the surgical site to be marked, including cardiac catheterization procedures, spinal epidurals, and laparoscopic surgeries?	As identified in the intent of IPSG.4, surgical site marking is done in all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine). Thus, site marking is not required for insertion of central lines or for procedures where the insertion site is not the surgical site, such as in cardiac catheterization or some interventional radiology procedures. However, when the insertion of a catheter is for the purpose of performing a procedure on a right vs. left organ, such as in interventional radiology when the procedure is for a right or left kidney, there must be some method of marking the correct kidney, for example, on a diagram or a digital image. Site marking for dental procedures would be required for procedures that could pose irreversible damage, such as a tooth extraction.
IPSG.4	Preoperative checklist/verification process	What needs to be included in the preoperative verification process and does the process need to be documented all at one time?	The expectation is that prior to starting the surgical or invasive procedure, all requirements of the verification process have been completed and documented. The various elements of the preoperative verification process may be completed at different times and do not need to be documented at the same time. For example, informed consent may be obtained and documented in an office visit two weeks prior to surgery and all relevant images may be properly labeled and displayed in the operating theater prior to surgery. As identified in IPSG.4, ME 3 – the hospital uses a checklist or other process to document the preoperative verification.
IPSG.4.1	Time-out	What needs to be included in the time out and when should the time out be completed?	The components of the time-out process include ensuring the correct patient identification, correct site, agreement of the procedure to be done and confirmation that all aspects of the verification process have been completed. The hospital may choose how the time-out process is documented, either as an independent process or as part of the preoperative verification process. Regardless, all the components of the time-out must be documented, including the time that the time-out occurred. Per ME 1, the full team participates in the time-out, and the time-out is conducted immediately before starting the procedure.
IPSG.6.1	Fall risk screening for outpatients	What constitutes a fall risk screening and do all	The standards manual glossary defines screening as "a set of standardized rules or tests applied to patient groups on which to base a preliminary judgment that further evaluation or interventions are warranted." Fall risk screening often

Standards	Subject	Interpretation Question	Response
		outpatients need to be screened for fall risk?	involves a screening tool, which may be comprised of a few yes/no questions or questions that get assigned a numerical score depending upon the answers received. The answers or score may indicate a potential fall risk. According to IPSG.6.1, a hospital determines the "outpatients whose condition, diagnosis, situation, or location may put them at risk for falls." A hospital may identify specific groups/populations of patients that are at-risk for falls regardless of performing individual screenings and implement fall-risk preventive measures without performing screening for these groups. Hospitals may consider other types of patients that could be at-risk for falls but are not in the groups identified, and the process for identifying those patients and determining their fall risk. Fall-risk screening and preventive interventions are documented for outpatients identified to be at risk for falls. Evidence-based tools for fall risk screening are available in the literature. Tools should be selected that are appropriate for the hospital's patient population.
Access to Care and Continuity of Care (ACC)			
ACC.4.3, ACC.4.3.1	Discharge instructions	What information and instructions should patients receive at time of discharge?	As identified in ACC.4.3, the complete, printed discharge summary is prepared for all patients. The expectation is that whether the patient stays for one day or multiple days, a discharge summary is completed for all inpatients. The summary may be very brief for patients who stay one day and experience no complications, or it may be quite detailed and extensive for patients who have stayed multiple days and/or experienced complications. Per ACC.4.3.1, discharged patients should receive discharge instructions in a language he or she understands. Unlike the discharge summary which must be printed, the discharge instructions may be provided in writing, verbally, or in another form (ME 2). The instructions include information the patient will need for any care/treatment needed at home. For example, medications to be taken, wound care (if needed), when to return for scheduled or unanticipated follow-up care, and when to obtain urgent care (ME 3 and ME 4).
Patient and Family Rights (PFR)			
PFR.5	General consent	Is a written general consent required when the patient is admitted as an inpatient or during the first visit as an outpatient?	PFR.5 does not require a written documentation of general consent. However, there is information that must be provided to the patient at the time of admission or during the first visit as an outpatient whether or not a general consent is used or not used. The information includes informing patients about what tests, procedures, treatments, interventions, etc. will require informed consent, as well as informing patients when any trainees and/or students (such as medical trainees, nursing students, physical therapy students, and the like) may be providing some of the care to the patient (ME 3 and ME 4). If a general consent is not used, the hospital will be asked to provide evidence on how this information is provided to patients/families.
PFR.5.1	Uniform process for obtaining and	The intent of PFR.5.1 discusses how patients can give consent (verbally, signing	The standard states that the hospital must develop a uniform process for obtaining informed consent that is carried out by staff who are trained to do it in a manner and language that the patient understands. The standard does not require a written process; however, the standard does require that there is uniform documentation of the process for obtaining

Standards	Subject	Interpretation Question	Response
	documentation of informed consent	a consent form, or through other means). Does that mean the patient can agree verbally and does not need to sign the consent form?	informed consent in the patient medical record. Many hospitals choose to use a written process which clearly demonstrates the information provided to patients, the patient's permission as evidenced by a signature, and a uniform recording of the process.
Assessment of Patients (AOP)			
AOP.1.4	Nutritional screening	Does the nutritional screening apply to outpatients?	Patients in both inpatient and outpatient settings should be screened for nutritional and functional status. There may be underlying issues not evident from simply looking at the patient; therefore, the screening would be part of the initial assessment. There may be situations in which an outpatient does not require a medical or nursing assessment during their visit; for example, a patient who comes to the outpatient clinic to obtain a diagnostic test and does not receive a medical/nursing assessment. This may be a situation in which screening for nutritional and functional status is not necessary in the outpatient setting.
AOP.1.5	Pain screening	Should all patients be screened for pain, even if they are an outpatient or cared for by a specialty service such as psychiatry?	The expectation is that all patients who are receiving care in the hospital are screened for pain, regardless of the patient's condition, inpatient versus outpatient status, or the service being provided.
AOP.5.1.1	Oversight of point-of-care-testing (POCT)	Who can oversee the POCT program?	According to the intent of AOP.5.1.1, POCT programs must be overseen and supervised "by the individual responsible for managing the laboratory services or a designee." The individual responsible for the POCT program must be able to show evidence of their training and competency specific to providing oversight for all tests that are provided outside of the laboratory as part of the POCT program.
AOP.5.10, AOP.5.10.1 **(Also see GLD.6.2)**	Reference Lab services (Contracted Lab)	If lab specimens are sent out, is primary source verification of the lab and each lab personnel's certifications and licensures required?	There are two standards that should be reviewed when a hospital or the hospital laboratory uses the services of a reference (contracted) laboratory—whether for select tests or to provide all laboratory services; standard AOP.5.10 and standard GLD.6.2. As identified from the standards, 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 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)
AOP.6.3	Radiation safety training	Do hospitals need to implement radiation safety	Education on radiation safety is primarily directed at staff. However, education for staff needs to address the impact that radiation exposure has on patients. AOP.6.3, ME 2 refers to staff education about radiation dosing. As stated in the intent of the standard, radiation exposure can pose potential risk of long- term damage, depending on the dose of

Standards	Subject	Interpretation Question	Response
		education for patients and staff?	radiation delivered and the number of tests performed on any one person. The higher the dose as well as the cumulative effect of repeated doses, the greater the risk for long- term damage. Health care practitioners need to be cognizant of the risks of overexposure to radiation and the measures necessary to avoid unnecessary exposure to themselves and their patients.
AOP.6.3	Radiation dosing	How do hospitals determine maximum doses of radiation for each study?	There may be some tests that have very specific guidelines for conducting the tests, such as nuclear medicine. Often, staff performing these tests require special training and certification. A more detailed protocol would likely be required for these tests. There are some diagnostic imaging tests that are simple, such as x-ray, and may not necessarily have a defined and elaborate protocol. However, there are guidelines for how much radiation is necessary to obtain the best image. For example, there are industry standards for how to perform a digital image of the chest; it is expected that the test follows industry and hospital guidelines. It may be that the hospital has a chart that identifies the appropriate dose of radiation for the less complicated tests.
Care of Patients (COP)			
COP.2.2	Texting platform	What are the requirements for a secure texting platform for texting of patient orders and information?	Hospitals are not required to implement text messaging for patient orders; however, if they choose to allow text messaging, the expectation is that the hospital meet the requirements of standard COP.2.2. The goal is to ensure patient safety and maintain patient confidentiality. There are various vendors that provide secure messaging solutions. A hospital may want to conduct a comparative assessment of the vendors in their market and the functionality offered by each. It is important to look at whether a product meets the hospital's needs, including the needs of its health care practitioners and patients. Other factors to consider that may influence a hospital's decision related to a text messaging product include: • the hospital's current/baseline technology infrastructure • the ability/need for integration with the hospital's existing systems or need for a stand-alone system • any local legal or regulatory requirements The requirements in a) through g) of the intent of COP.2.2 might be addressed within the vendor's software, by the messaging application used, by a third-party application or software add-on, etc.
COP.3	Violence and neglect screenings	Which patient groups are required to have a violence/neglect screening?	Standard COP.3 states that the care of high-risk patients and the provision of high-risk services are guided by professional practice guidelines, laws, and regulations. The intent of the standard further elaborates what patients are considered high risk due to age, condition, or the critical nature of their needs. Hospital leadership in collaboration with appropriate department/service leaders as well as the community agencies and resources are responsible for identifying the patients considered high risk in the hospital; such as vulnerable patient populations at risk for abuse and/or neglect. When developing policies, procedures, and processes, such as screening for abuse/neglect, they must be tailored to the high-risk patient populations to be effective in reducing the related risk.

Standards	Subject	Interpretation Question	Response
COP.3.2	Resuscitation services	How does a hospital determine and test the availability of resuscitation teams and equipment, including the number and location of emergency carts?	Standard COP.3.2 requires that basic life support (BLS) be implemented immediately upon recognition of cardiac or respiratory arrest, and advanced life support be implemented within 5 minutes of recognition of cardiac or respiratory arrest. Many hospitals have teams that are trained in advanced life support (ALS) and their process requires the teams to respond to a respiratory/cardiac arrest. To ensure that the teams can respond from their location to the patient experiencing a respiratory/cardiac arrest in less than 5 minutes, it would be important to test response times, including arriving with necessary resuscitation equipment such as an emergency cart. An example of testing response times might include activating a mock code call and timing how long it takes the team to respond with the necessary equipment. It would be important to identify response times in different areas of the hospital and during different times of day or night. It would also be acceptable to time response times to actual codes. For example, the hospital may choose to review code documentation to identify the time the code was called and the time that ALS was available.
COP.3.2	Pediatric resuscitation	Please provide clarification on the requirements for pediatric resuscitation and PALS training.	As identified in COP.3.2, ME 2, availability of technology and medications for basic and advanced life support are based on the needs of the population. Thus, if the hospital has pediatric patients, technology and equipment specific for pediatric patients must be available. ME 3 identifies that advanced life support, or pediatric advanced life support as identified by patient needs, is available within 5 minutes. Standard SQE.8.1 identifies that all staff who provide patient care are trained in resuscitation, and ME 2 states that the appropriate level of training is provided with sufficient frequency to meet staff needs. This means that if there are pediatric patients, staff must be trained in pediatric resuscitation. When there is a pediatric respiratory or cardiac arrest, at the very least, the person leading the resuscitation team is required to have pediatric advanced life support training; others require, at minimum, pediatric basic life support training. Ideally, others on the team should have pediatric advanced life support training as well but it is not required for everyone on the team to be trained in pediatric advanced life support.
COP.4	Patient/family supplied food	Can families bring food for patients, and how should the food be stored?	As identified in COP.4, ME 5, "When families provide food, they are educated about the patient's diet limitations." The standard allows for families to provide food; however, it must be according to the dietary restrictions of the patient. Therefore, if a patient is on a sodium-restricted diet, the family must ensure that the food they bring for the patient is low sodium. The food that families prepare and provide is considered part of the patient's care and treatment, so the refrigerators in which the food is stored must be monitored for temperature control to ensure the food does not spoil. In addition, it is important to identify the date when the food was prepared to ensure the food is consumed in a timely manner.
COP.8, COP.9	Transplant services	What organs and tissues are included under the Transplant Standards and do all standards following COP.8 and COP.9 apply to all transplants?	The transplant standards apply to any organs or tissues that are considered an allograft transplant – that is between two genetically non-identical members of the same species. Tissues include bones, tendons, cornea, skin, heart valves, nerves, and veins. In addition, stem cells and bone marrow are often considered a transplant. Some of the COP.8 and COP.9 standards may not apply to all tissue donation/transplants. For example, when stem cells are collected in the same manner as blood is collected, standard COP.9.2 may not be applicable.
Anesthesia and Surgical Care (ASC)			

Standards	Subject	Interpretation Question	Response
ASC.3	Procedural sedation	What do the MEs mean when they require emergency equipment and a member of staff trained in advanced life support to be 'immediately available' during administration of procedural sedation?	Standard ASC.3 requires that resuscitation equipment and staff trained in advanced life support are immediately available when procedural sedation is performed. Immediately available means someone with advanced life support training is present in the room during the sedation procedure. It may be the nurse who is monitoring the patient, the physician performing the procedure, or another health care practitioner within the immediate vicinity. The person with advanced life support training must be permitted to perform advanced life support if needed. Immediate availability of equipment requires the equipment to be either at the bedside or in the department/area in which sedation is performed.
ASC.7.4	Implantable devices	What is the JCI definition of "implantable device"?	An implantable medical device is defined as "a device that is permanently placed into a surgically or naturally formed cavity of the body to continuously assist, restore, or replace a function or structure of the body throughout the useful life of the device." In this context, JCI defines "permanent" to be "throughout the useful life of the device." Some implantable devices may not last for the life of the patient, depending on the type of device, when it was implanted in the patient, and the age, health status, and life expectancy of the patient.
Medication Management and Use (MMU)			
MMU.3	Medication storage	What are the JCI recommendations for measuring room temperature and humidity for medication storage areas?	MMU.3 requires hospitals to determine the conditions under which medications maintain stability and ensure storage conditions are suitable. However, JCI standards do not make specific recommendations for temperature, humidity, or frequency of monitoring medication storage conditions. Hospitals may obtain this information from product inserts, communications with pharmaceutical manufacturers, industry standards, or from evidence in the literature. Thus, if the recommendation is for a product to be stored at a particular temperature and/or not to exceed a certain humidity level, the hospital would be expected to provide those storage conditions and ensure those conditions are maintained wherever the product is stored. JCI does not recommend or endorse any particular thermometer or humidity measuring device to accomplish this.
MMU.3.1	Labeling medications	Does the pharmacy need to label large bottles of medication with the opened date?	The hospital is not required to write the date a staff person opens a medication on the container; however, the date of expiration (shelf life) should be written on the medication container after opening. This date would be based on the manufacturer's guidelines for shelf life of the medication.
MMU.4.1	PRN medication orders	Do orders for PRN medications require an indication as part of the order?	Hospitals need to have a process to identify whether or when indications for use are required on medication orders, particularly those that are considered PRN orders. The expectation is that when a PRN medication is ordered, there is an indication for when the medication is to be given, the dose, the route, and how often. The orders are expected to be specific; for example, an order that says, "Morphine sulfate 2-6 mg. every 4-6 hours PRN pain" is an incomplete order. A complete order states, "Morphine sulfate, 2 mg. every 4 hours, PRN for pain greater than 6/10."
MMU.5	Medication preparation	What is the definition of a functionally separate area for medication preparation?	A functionally separate area refers to a designated area established by the hospital and/or pharmacy that allows for accurate and safe preparation and dispensing of medications. This area would not be near an open high-traffic area, a busy nursing station, a crowded entrance or waiting room, or similar location, as these areas have the potential to be noisy with distractions that can interfere with the process of preparing and/or dispensing medications and instructions

Standards	Subject	Interpretation Question	Response
			to staff and patients. This area should be clean, uncluttered, and compliant with laws, regulations, and professional standards of practice. For example, if standards of practice require a mask or a laminar airflow hood in preparation of a medication, the medication preparation area should allow for this practice.
MMU.5.2	Medication distribution	What does "most ready to administer form" mean?	The most ready-to-administer form means once it is dispensed, the medication is ready for administration to the patient without further steps, such as diluting, mixing, drawing up, etc. When possible, medications are obtained in the most ready-to-administer form available from the manufacturer (e.g., unit dose packaging). As defined by the Institute for Safe Medication Practices (ISMP), a unit dose is a single package that contains one dose of a medication intended for one patient. For example, a package with one tablet, one single-use vial, and so on. ISMP also provides a definition for an injectable medication/solution in the most ready-to-administer form-- "An injectable product containing the active drug in solution at the required concentration and volume, presented in the final container (syringe, infusion bag, or elastomeric device), and ready to be administered to the patient."
Patient and Family Education (PFE)			
PFE.2	Education/learner assessment	Is there a need to assess language, barriers to learn, beliefs/value that impact response to the illness and health literacy in all outpatients coming to clinics and ambulatory areas?	While an in-depth assessment of the patient and family education needs, readiness and willingness to learn, and health care literacy may not be practical in an outpatient or ambulatory settings, there are elements of each of these areas that must be considered when providing education to patients and family members. It is important to address the patient's individualized needs and to consider the necessary information the patient requires during admission and for discharge. In addition, performing a quick assessment of whether the patient has physical, mental or emotional impairments can help identify what type of impact this may have on his or her ability to learn. Learning barriers may include visual or hearing impairments, language barriers, or the shock of learning a critical diagnosis. These barriers have a potential to impact patient/family learning and much of this can be identified quickly during the initial assessment. Documentation of any barriers to learning may be important to have available throughout the continuum of care and during follow-up visits.
Quality Improvement and Patient Safety (QPS)			
QPS.7, QPS.9	Data analysis and sentinel events	Do we have to use the Root Cause Analysis (RCA) tool when conducting an analysis following a sentinel event?	A credible root cause analysis needs to be performed following a sentinel event. However, the intent of QPS.7 does not require the use of a specific tool. The goal is for the hospital to better understand the origins of the event. There are different types of tools that can be found in the literature that may help hospitals achieve this goal. Whatever tool is used, the results of the analysis must identify the origins of the event which will lead to system improvements and other actions that can prevent or reduce the risk of similar sentinel events occurring.
Prevention and Control of Infections (PCI)			
PCI.7	Sterilization of hinged instruments	Do all hinged instruments need to be packed in an open position to ensure effective sterilization?	Guidelines published by the Association for the Advancement of Medical Instrumentation (AAMI) and other organizations identify that all hinged instruments should be unlocked and in an open position when cleaned and sterilized. This is to ensure that blood and/or body fluids are not trapped in the hinges. When cleaning and sterilization processes do not follow current professional guidelines, the surgical and other instruments can pose an infection risk for patients.

Standards	Subject	Interpretation Question	Response
PCI.7.1	Single-use devices	Can single-use devices be reused?	PCI7.1 requires hospitals to identify and implement a process for managing the reuse of single-use devices consistent with regional and local laws and regulations as well as professional standards. If the hospital permits the reuse of single-use devices, the hospital must have a policy that guides such reuse. There are specific elements that the policy must address, and these are detailed in the standard. In addition, the hospital is expected to track adverse events related to reused devices and materials to identify and implement improvements.
PCI.7.1	Tracking reusable devices	What methods are appropriate for tracking reusable devices?	There are several methods for tracking instruments and devices that allow for traceability to the patient. These range from barcode systems with tracking software to more manual, paper-based processes. When appropriate, devices and instruments can be marked with etchings, engravings, identification tape, and other means. For example, identification of a device is matched with the device's most-recent sterilization process, and then recorded in the patient's medical record for the procedure performed. This allows for tracing the reusable device to the patient on whom it was used.
PCI.8	Negative pressure rooms, temporary isolation	If the hospital does not have either a designated negative pressure room or a HEPA filtrated room, would a policy to cover short term management of a suspected case be appropriate?	The standards do not explicitly state that a hospital must have a negative pressure room to treat patients with airborne infections. However, the intent of PCI.8. states that the preferred placement for a patient with an airborne infection is in a negative-pressure room, and if not available, temporary precautions must be in place. When negative-pressure rooms and TNPI systems, such as HEPA filtration, are not available, hospitals must have a process, including policies and procedures, to manage patients with airborne infections for short periods of time. Hospitals must also have a process to manage an influx of patients with contagious infections.
PCI.9	Personal protective equipment (PPE)	What are the expectations for use of PPE when handling specimens and/or drawing blood? In some countries it is not required to wear gloves in the laboratory and/or blood bank.	The use of gloves is the recommended practice anytime staff may contact blood or body fluids. The "WHO guidelines on drawing blood: best practices in phlebotomy" state the "availability of appropriate supplies and protective equipment [and] procurement of supplies is the direct responsibility of the administrative (management) structures responsible for setting up phlebotomy services." These supplies include "hand-hygiene materials (soap and water or alcohol rub), well-fitting non-sterile gloves, single-use disposable needles, and syringes or lancing devices in sufficient numbers to ensure that each patient has a sterile needle and syringe or equivalent for each blood sampling." While local/regional laws and regulations may not require the use of gloves for phlebotomy, as identified in the introduction of the standards manual, JCI surveys to whichever is the higher or stricter standard.
Governance, Leadership, and Direction (GLD)			
GLD.6.2	Contracted Independent Practitioners	Are contracted independent practitioners required to have primary source verification and privileging?	The standards require that independent practitioners, even if they do not come inside the building to provide patient care services to patients, must meet the same requirements for credentialing and privileging as all other physicians providing patient care/services. When the service provided determines the course of care for the patient, the practitioner must be credentialed and privileged. In addition, independent practitioners must be evaluated as all other physicians and the quality of services provided by the independent practitioners must be monitored as part of the hospital's quality improvement program.

Standards	Subject	Interpretation Question	Response
GLD.7.1	At risk medications, supplies, and equipment	How does the hospital determine which medications and pieces of equipment are considered “at risk”?	The standards do not specify what medications, supplies, products, etc. should be included as "at risk." The hospital will determine which medications, supplies, and products are “at risk” based on its services and circumstances. The risk to medications, supplies, and products may be affected by environmental, legal, regional, and other factors; therefore, different hospitals may have different lists depending on their location, circumstance, supplier, etc. For example, in countries where the average temperature is usually above 30 degrees centigrade, the hospital may decide that medications required to be frozen (such as vaccines) or those required to be kept at 0 degrees centigrade are most “at risk” of losing stability. Another country may have issues associated with very expensive implantable devices being "at risk" for being stolen and replaced with counterfeit items.
GLD.14	Student credentials	What documentation is required for students in the hospital?	For each student, the hospital maintains documentation of the enrollment status, license if required, certifications achieved (for example, certification in a medical or surgical specialty, certification in advanced life support), the academic classification of the student or trainee (for example, 1st year medical trainee, 2nd year nursing student), the level of supervision required, and documentation of orientation to the hospital and the hospitals programs (such as infection control, quality and patient safety, fire safety).
GLD.13, GLD.13.1	Culture of safety	What is required of the hospital’s “culture of safety” program?	The culture of safety program encourages an environment in which individuals report errors and near misses without fear of reprimand or punishment. Hospital leadership further encourages a culture of safety by emphasizing teamwork and creating structures, processes, and programs that allow trust, respect, and a positive culture to flourish among and between all levels of the hospital, from staff through leadership. Hospital leadership evaluates the culture on a regular basis using a variety of methods, such as formal surveys, focus groups, staff interviews, and data analysis. In addition, hospital leadership uses measures to evaluate and monitor the safety culture within the hospital and implement improvements identified from measurement and evaluation. As part of the program for risk management, risk analysis may include evaluation of near misses (related to medication and other adverse events, including non-clinical near misses), which may identify areas and/or systems issues related to the culture of safety. Thus, improvements to the safety culture can be implemented to prevent near misses and increase patient safety.
Facility Management and Safety (FMS)			
FMS.6	Structural integrity of patient care areas	How can hospital leadership evaluate structural integrity?	The hospital will need to provide information from the process of evaluating their facilities as they relate to the likelihood and consequences of hazards, threats, and events. For example, in areas where hurricanes or earthquakes are possible disasters, a hospital will want to look at their buildings to determine whether they can survive the direct impact of a hurricane or withstand the vibration/shaking an earthquake. During a disaster, health care organizations are a critical resource to the communities and others that may be impacted. Therefore, it is essential that they be able to structurally withstand the disaster, so they can continue to care for their patients and support the community. The intent of this requirement is for hospitals to know their own structural limitations and then to begin plans to mitigate these issues over time so that they can continue to operate and be available to serve communities during a disaster. The World Health Organization provides an assessment form that may be helpful to hospitals looking to assess the structural, non-structural, and operational integrity of their hospital. The form is titled “Hospital Safety Index;

Standards	Subject	Interpretation Question	Response
			Evaluation Forms for Safe Hospitals." Sections 2 and 3 of this form address the structural and non-structural integrity. Non-structural integrity refers mostly to utilities.
Staff Qualifications and Education (SQE)			
SQE.5, SQE.9	Primary source verification	Does a hospital have to conduct primary source verification for a new staff member coming from another JCI accredited hospital?	When a hospital grants privileges to a licensed independent practitioner or hires a licensed healthcare professional that is from a JCI accredited hospital, primary source verification is not required as long as the JCI accredited hospital that performed the primary source verification is willing to share their most recent survey findings report indicating that there were no findings related to the SQE standards that address primary source verification. The intent of SQE.9 through SQE.9.2 identifies 3 acceptable substitutions for performing primary source verification of credentials. Number 2 states: *"Applicable to all hospitals, an affiliated hospital that has already conducted primary source verification of the medical staff applicant, is acceptable as long as the affiliated hospital has current Joint Commission International (JCI) accreditation (this would also include TJC accreditation) with 'full compliance' on its verification process found in SQE.9.1, MEs 1 and 2. Full compliance means the organization's Official Survey Findings Report indicates that all measurable elements are fully met, or any not met or partially met measurable element required to be addressed by Strategic Improvement Plan (SIP) actions have been addressed and are now in full compliance*." The hospital hiring the practitioner from an accredited JCI hospital would be required to perform privileging of the practitioner and maintain a personnel file for the new hire that includes all documentation for education, training, and privileges, as well as the other information described in SQE.5.
SQE.8.1	Resuscitation training	Who is required to receive BLS/ALS resuscitation training?	Staff members who provide patient care are to be trained in resuscitative techniques and the level of training appropriate to their role. Level of training refers to either basic life support training or advanced life support training. Everyone providing patient care is required to have at a minimum, basic life support training. Based on the type of services provided, the hospital identifies those persons providing patient care who require advanced life support training. For example, staff who are part of the resuscitation team, staff who provide or monitor patients receiving procedural sedation, and perhaps staff who work in the emergency department or the intensive care units are examples of staff who may require advanced life support training.
SQE.11	Independent practitioner privileges	Does SQE.11 involve nurse practitioners and other practitioners, such as psychologists, who can act with a level of independence?	The process for privileging nurse practitioners and other independent health care practitioners would be dependent on the laws and regulations and the hospital policy. If they function independently, without job descriptions, their process would be the same as the process for physicians - or any other clinical staff practicing independently, without a job description.
Management of Information (MOI)			
MOI.4	Abbreviations	Does JCI have a list of abbreviations hospitals can use?	If a hospital chooses to allow abbreviations in its organization, JCI standards require hospitals to implement a process for the uniform use of approved abbreviations, such as a list of abbreviations that are approved for use. Each abbreviation used in the hospital should have only one meaning. JCI does not have a list of approved abbreviations.

Standards	Subject	Interpretation Question	Response
			If the hospital chooses to allow approved abbreviations, there must also be a do-not-use list of abbreviations. Abbreviations are not used on informed consent and patient rights documents, discharge instructions, discharge summaries, and other documents patients and families receive from the hospital about the patient's care.
MOI.9	Electronic vs. paper medical record	How will transitioning from paper to electronic medical records affect our survey?	Each hospital determines how patient medical records will be organized and maintained. It is allowable for any, all, or parts of the medical record to be electronic or paper copy, printed or hand-written, provided the format is 'uniform'. When adopting an EMR, there may be a transition period during which patient medical records are not all in the same format, meaning some may be electronic while others are still in paper format. Therefore, it is acceptable to have some patient medical records in electronic format and some in paper format for the look-back period during your survey. It is also acceptable to have parts of a patient's medical record available electronically while other parts of the patient's record are in paper format.
MOI.8, MOI.8.1	Policies and procedures	How can a hospital ensure staff education on policies and procedures and perform monitoring that will provide evidence of full implementation?	In the intent of standard MOI 8.1, it states that a tracking system would allow each document to be identified by title, date of issue, edition and/or current revision date, number of pages, who authorized issue and/or reviewed the document, and database identification. The intent states that there is a process to ensure that staff members have read and are familiar with policies, procedures, and plans relevant to their work. Examples of education include providing a review of relevant policies and procedures during staff orientation and scheduling groupwide education sessions for applicable staff on any new policies/procedures developed. Monitoring of full implementation can be performed as part of the quality improvement and patient safety program. For example, when a hospital implements a new policy related to antibiotic stewardship, appropriate staff (such as the pharmacist) can monitor physician staff adherence to adopted guidelines on proper use of antibiotics. Another example would be staff compliance with hospital requirements for using approved abbreviations and not using abbreviations from the "do not use" list in the patient medical record. This would be monitored through the medical record review process.
Human Subjects Research Programs (HRP)			
HRP.1	Human subjects protection	As an AMC hospital, what is required to demonstrate that hospital leadership verbally communicates within the hospital their commitment to protect human subjects research participants?	A commitment to human subjects research is not separate from the commitment to patient care. Commitment is integrated at all levels of the organization. Thus, ethical considerations, good communication, responsible leaders of departments and services, regulatory compliance, and financial and nonfinancial resources are components of this commitment. This commitment is further identified with the organization having adequate indemnity insurance to compensate patients for adverse events due to the research protocol. The hospital leadership is knowledgeable about and complies with regulation and professional standards such as the International Conference on Harmonization (ICH), World Health Organization (WHO), and Good Clinical Practice (GCP) regarding human research subjects. In addition, the following standards in the GLD chapter are some of the other requirements for leadership to ensure support and commitment to the hospital's patients. GLD.12, 12.1, 12.2 refer to ethical business decisions, establishing a culture of ethical practice, and ethical decision making. GLD.12.1, MEs 1 through 3, refer to the hospital's ownership and any conflicts of interest; honest portrayal of services to patients; and ensuring financial incentives and payment arrangements do not compromise patient care.