REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
Accreditation Participation Rules				
APR 01.03.01	Does the organization notify The Joint Commission in writing within 30 days of a change in ownership, control, location, capacity, or services offered?	**Procedure**	30 days	Regulatory Director
APR.09.01.01	Does the organization **inform** the public it serves about how to contact its management to report concerns about patient safety and quality of care?	**Procedure**	Annually	Regulatory Director
APR 09.02.01	Does the organization **educate** its staff and medical staff that any employee, physician, or other individual who provides care, treatment, or services that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission?	**Procedure**	Annually	Regulatory Director
Environment of Care				
EC 01.01.01 EP 3	Library of information regarding inspection, testing, and maintenance of its equipment and systems? Note: This library includes manuals, and ***procedures*** provided by manufacturers, technical bulletins, and other information.	**Procedure**	As new items enter service	Facilities Director
EC.02.01.01 EP 9	Written ***Procedures*** for responding to security incidents, including infant abduction	**Procedure**	Annually	Safety / EOC Chair
EC 02.01.01 EP 10	When a security incident occurs, does the organization follow its identified ***procedures***?	**Procedure**	As needed	Risk Manager
EC.02.01.03 EP 1	Develop a written **policy** prohibiting smoking in all buildings with exceptions for patients in specific circumstances.	**Policy**	Annually	CEO / Regulatory
EC.02.01.03 EP6	Does the organization take action to maintain compliance with its smoking **policy**?	**Procedure**	As needed	Safety Officer
EC.02.02.01 EP1	Written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation.	**Procedure**	As needed	Safety Officer
EC.02.02.01 EP 3,	***Procedure*** – Use of Precautions and PPE for the handling hazardous materials, spills, waste, waste removal, labeling and exposures.	**Procedure**	Annually	Safety Officer
EC 02.02.01 EP 19	Does the hospital have ***procedures*** for the proper routine storage and prompt disposal of trash?	**Procedure**	Annually	EOC Committee
EC 02.03.01 EP 11	Written fire prevention and response ***procedures***, including safety precautions related to the use of flammable germicides or antiseptics, established?	**Procedure**	Annually	EOC Committee
EC.02.04.01 EP 4, 6, 9	***Procedures*** for maintaining, inspecting and medical equipment, for alternate equipment maintenance, and for equipment failure	**Procedure**	Annually	EOC Manager
EC.02.05.01 EP 9-13	***Procedure*** for utility failures and disruptions	**Procedure**	Annually	Facilities Director

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
EC 02.05.03 EP 14	Does the hospital implement a **policy** to provide emergency backup for essential medication dispensing equipment identified by the hospital	**Policy**	Annually	EOC Committee
EC 02.05.03 EP 15	Does the hospital implement a **policy** to provide emergency backup for essential refrigeration for medications identified by the hospital, such as designated refrigerators, and freezers?	**Policy**	Annually	EOC Committee
EC 02.05.09 EP 12	Management of Cylinders **policy and procedures**	**Policy Procedure**	As needed	Unspecified
EC.01.01.01 EP 4-9	Safety, Security, Hazardous Materials and Wastes, Fire Safety (Response Plan), Medical Equipment, Utilities	**Plan**	Annual	Governing Body
EC 02.01.001 EP 16	MRI and other ionizing energy sources – safety, maintenance, testing, monitoring	**Plan**	Annual	Governing Body
EC.02.03.01 EP 9	Fire response plan	**Plan**	Annual	Governing Body
EC.02.04.01 EP 4	Alternative Equipment Maintenance Program	**Program**	Annual	Governing Body
EC 02.05.02 EP 2-4	Water Management and Treatment plan	**Plan**	Annual	Governing Body
EC 02.05.01 EP 15	Critical Care areas – plan to control airborne contaminates	**Plan**	Annual	Governing Body
Emergency Management				
EM 09.01.01 EP1	Written comprehensive Emergency Management program that addresses: Leadership structure and program accountability - Hazard vulnerability analysis - Mitigation and preparedness activities - Emergency operations plan and policies and procedures - Education and training - Exercises and testing - Continuity of operations plan - Disaster recovery - Program evaluation	**Program**	Every 2 years or more frequent if needed	Governing Body
EM 09.01.01 EP2	If the organization is part of an integrated system approach to Emergency Management, the system program must contain sufficient detail regarding each individual organizational component.	Program	Every 2 years or more frequent if needed	Governing Body
EM 09.01.01 EP 3	If the hospital or system provides transplant services, the hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant program, and the organ procurement organization (OPO) for the donation service area where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency	Written Protocols or Waiver document	Annual Minimally	Governing Body
EM 11.01.01 EP 1-3	The hospital conducts a facility-based hazard vulnerability analysis (HVA) using an all-hazards approach. This HVA is documented. The components outlined with this standard are addressed individually within the HVA.	Written document	Every 2 years or more frequent if needed	Governing Body

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
EM 12.01.01 EP 1	The hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff, volunteers, physicians, and other licensed practitioners on actions to take during emergency or disaster incidents. The plan and policies address the specific aspects included within this standard. • The EOP identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event. • Written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, patients, and volunteers. • written procedures for how the hospital will provide essential needs for its staff and patients, whether they shelter in place or evacuate, that includes, but is not limited to, the following: - Food and other nutritional supplies - Medications and related supplies - Medical/surgical supplies - Medical oxygen and supplies - Potable or bottled water • The hospital's incident command structure is defined within the EOP, describes the overall incident command operations, including specific incident command roles and responsibilities. • The EOP includes a defined process for cooperating and collaborating with other health care facilities; health care coalitions; and local, tribal, regional, state, and federal emergency preparedness officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident.	Plan	Every 2 years or more frequent if needed	Governing Body
EM 12.01.01 EP 9	Emergency preparedness policies and procedures that address the role of the hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Social Security Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Applicable only to organizations that receive reimbursement from Medicare, Medicaid or Children's Health Insurance Program (CHIP)	Policy	Every 2 years or more frequent if needed	Governing Body

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
EM 12.02.01 EP 1	A contact list of individuals and entities that are to be notified in response to an emergency. The list includes: - Staff - Physicians and other licensed practitioners – Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions)	Document	Every 2 years or more frequent as needed	Leadership

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
EM 12.02.01 EP 2-6	There is a written communications plan that: • describes how it will establish and maintain communications in order to deliver coordinated messages and information during an emergency or disaster incident to the following individuals: Staff, licensed practitioners, and volunteers (including individuals providing care at alternate sites) - Patients and family members, including people with disabilities and other access and functional needs - Community partners (such as fire department, emergency medical services, police, public health department) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Media and other stakeholders • describes how the hospital will communicate with and report information about its organizational needs, available occupancy, and ability to provide assistance to relevant authorities. • identifies the hospital's warning and notification alerts specific to emergency and disaster events and the procedures to follow when an emergency or disaster incident occurs • includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: - Patient's family, representative, or others involved in the care of the patient - Disaster relief organizations and relevant authorities - Other health care providers • identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: - How and when alternate/backup communication methods are used - Verifying that its communications systems are compatible with those of community partners and relevant authorities the hospital plans to communicate with - Testing the functionality of the hospital's alternate/backup communication systems or equipment	Plan	Every 2 years or more frequent as needed	Governing Body

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
EM 12.02.03. EP 2-6	• A documented staffing plan for managing all staff and volunteers to meet patient care needs during the duration of an emergency or disaster incident or during a patient surge. The plan includes the following: - Methods for contacting off-duty staff, physicians, and other licensed practitioners - Acquiring staff, physicians, and other licensed practitioners from its other health care facilities - Use of volunteer staffing, such as staffing agencies, health care coalition support, and those deployed as part of the disaster medical assistance teams- staffing plan addresses the management of all staff and volunteers as follows: - Reporting processes - Roles and responsibilities for essential functions - Integrating staffing agencies, volunteer staffing, or deployed medical assistance teams into assigned roles and responsibilities • The staffing plan describes how it will manage volunteer licensed practitioners when the emergency operations plan has been activated and the hospital is unable to meet its patient needs. The hospital does the following: - Verifies and documents the identity of all volunteer licensed practitioners - Completes primary source verification of licensure as soon as the immediate situation is under control or within 72 hours from the time the volunteer licensed practitioner presents to the organization - Provides oversight of the care, treatment, and services provided by volunteer licensed practitioners • The plan describes how it will provide employee assistance and support, which includes the following: - Staff support needs (for example, housing or transportation) - Family support needs of staff (for example, childcare, elder care) - Mental health and wellness needs	Plan	Annual Minimally	Leadership
EM 12.02.05 EP 1-2	• The hospital's Emergency Operations plan for providing patient care and clinical support includes written procedures and arrangements with other hospitals and providers for how it will share patient care information and medical documentation and how it will transfer patients to other health care facilities to maintain continuity of care. • The plan addresses managing individuals that may present during a disaster or emergency that are not in need of medical care (such as visitors).	Plan	Every 2 years or more frequent if needed	Governing Body

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
EM 12.02.07 EP 1	• There is a plan for safety and security measures. The plan describes the roles that community security agencies (for example, police, sheriff, National Guard) will have in the event of an emergency and how the hospital will coordinate security activities with these agencies. • The plan includes a system to track the location of its on-duty staff and patients when sheltered in place, relocated, or evacuated. If on-duty staff and patients are relocated during an emergency, the hospital documents the specific name and location of the receiving facility or evacuation location.	Plan	Annual	Governing Body
EM 12.02.09 EP1-3	• The emergency operations plan describes in writing how it will document, track, monitor, and locate the following resources (on-site and off-site inventories) and assets during and after an emergency or disaster incident:- Medications and related supplies- Medical/surgical supplies- Medical gases including oxygen and supplies- Potable or bottled water and nutrition- Non-potable water- Laboratory equipment and supplies- Personal protective equipment- Fuel for operations- Equipment and nonmedical supplies to sustain operations • The plan describes how it will obtain, allocate, mobilize, replenish, and conserve its resources and assets during and after an emergency or disaster incident, including the following:- If part of a health care system, coordinating within the system to request resources- Coordinating with local supply chains or vendors- Coordinating with local, state, or federal agencies for additional resources- Coordinating with regional health care coalitions for additional resources- Managing donations (such as food, water, equipment, materials) • The plan describes in writing the actions the hospital will take to sustain the needs of the hospital for up to 96 hours based on calculations of current resource consumptions.	Plan	Every 2 years or more frequent as needed	Governing Body

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
EM 12.02.11 EP 1-4	• The Utility Management Plan describes in writing the utility systems that it considers as essential or critical to provide care, treatment, and services. • describes in writing how it will continue to maintain essential or critical utility systems if one or more are impacted during an emergency or disaster incident. • describes in writing alternative means for providing essential or critical utilities, such as water supply, emergency power supply systems, fuel storage tanks, and emergency generators • the plan includes alternate sources for maintaining energy to the following: - Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions - Emergency lighting - Fire detection, extinguishing, and alarm systems- Sewage and waste disposal	Plan	Annual	Governing Body
EM 13.01.01 EP 1-2	• There is a written continuity of operations plan (COOP) • The continuity of operations plan identifies in writing how and where it will continue to provide its essential business functions when the existing functional space is not available	Plan	Every 2 years or more frequent if needed	Governing Body
EM 13.01.01 EP 3-4	• There is a written order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties. • There is a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the hospital for specified purposes and to carry out specific duties.	Plan	Annual	Governing Body
EM 14.01.01 EP 1-2	• There is a disaster recovery plan that describes in writing its strategies for when and how it will do the following: - Conduct hospital wide damage assessments - Restore critical systems and essential services - Return to full operations • The disaster recovery plan describes in writing how the hospital will address family reunification and coordinate with its local community partners to help locate and assist with the identification of adults and unaccompanied children.	Plan	Every 2 years or more frequent if needed	Governing Body

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
EM 15.01.01 EP 1-4	• There is a written education and training program in emergency management that is based on the hospital's prioritized risks identified as part of its hazard vulnerability analysis, the emergency operations plan, communication plan, and policies and procedures. • The initial education and training is documented and includes the following: - Activation and deactivation of the emergency operations plan - Communications plan - Emergency response policies and procedures - Evacuation, shelter-in-place, lockdown, and surge procedures - Where and how to obtain resources and supplies for emergencies (such as procedures manuals or equipment) • There is a process for ongoing education and training to all staff, volunteers, physicians, and other licensed practitioners that is consistent with their roles and responsibilities in an emergency: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training • The hospital requires that incident command staff participate in education and training specific to their duties and responsibilities in the incident command structure. This education/training is documented.	Program Procedure Procedure Procedure	Every 2 years or more frequent if needed	EM Committee
EM 16.01.01 EP 1-3	• There is a written plan for when and how the organization will conduct annual testing of its emergency operations plan. The planned exercises are based on the following: - Likely emergencies or disaster scenarios - Emergency operations plan and policies and procedures - After-action reports (AAR) and improvement plans - The six critical areas (communications, resources and assets, staffing, patient care activities, utilities, safety and security) • The hospital is required to conduct two exercises per year to test the emergency operations plan. These exercises are documented. • Each accredited freestanding outpatient care building that provides patient care, treatment, and services is required to conduct at least one operations-based or discussion-based exercise per year unless included in hospital drill. This test is documented.	Plan Procedure Procedure	Every 2 years or more frequent if needed	EM Committee

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
EM. 17.01.01 EP 1 & 3	• There is a documented review of all after-action reports and improvement plans. • The emergency management program is reviewed and updated as needed based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan- Continuity of operations plan - Education and training program - Testing program	Procedure	Upon completion. Every 2 years or more frequent as needed	EM Committee
Human Resources				
HR 01.01.01 EP3	Define and Verify Staff Qualifications (education, experience – job responsibilities)	Policy	Upon Hire	HR Director
HR 01.01.01 EP4	Does the hospital obtain a criminal background check	Policy Procedure	Upon Hire or as needed	HR Director
HR.01.02.05 EP 5	Staff comply with health screening policies if present	Policy	As needed	HR
HR 01.02.01 EP 2	Physician Assistant/Advance Practice Nurse credentialing/privileging process	Procedure	Every 2 years	Medical Staff office
HR 01.04.01 EP 1	Does Hospital staff orient staff to key safety content before care is provided?	Policy	Upon Hire	HR
HR 01.04.01 EP 3	Does Hospital orient staff (hospital policies/procedures, Cultural diversity, Patient Rights, Ethical aspects of care, etc.)	Policy	Upon Hire	HR
HR 01.05.03 EP 25	Does hospital provide ongoing education on Safe MRI practices to Technologist?	Procedure	Annually	Imaging Director
HR.01.06.01 EP 1, 6	Define and identify frequency of competency assessment	Policy	3 years	HR Director
HR.01.07.01 EP 2	Performance Evaluations and Frequency	Policy	Annually	HR / Department Director
HR 01.07.01 EP 5	LIP brings non-employee into organization – is that individual's competency reviewed?	Procedure	As Needed	Medical Staff Office / HR
Infection Control				
IC.01.01.01 EP 4	Development of policies governing control of infectious and communicable diseases	Policy	2 years	Governing Body
IC 01.04.01 EP 1	Goals set based on identified risk to minimize transmission of infections	Procedure	Annual	IP Committee
IC.01.05.01 EP 5	Written process for Investigation of outbreaks of infectious disease	Procedure	2 years	IP Director
IC 01.06.01 EP4	Written process for handling an influx of potentially infectious patients	Procedure	Annual	IP / Emergency
IC 02.05.01 EP 1	Does organization implement evidence-based practices - multidrug resistant organisms	Procedure	Annual	IP Committee

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
IC.01.04.01 EP 1-5	Infection Control Plan defines goals designed to prioritize risk, mitigate risk of transmission and exposure, specifically around medical equipment, devices and supplies and hand-hygiene compliance	Plan	Annual	Governing Body / Medical Staff
IC 01.05.01 EP 2	IC Plan includes written description of activities including surveillance to mitigate risk of infections	Plan	Annual	Governing Body / Medical Staff
IC 02.02.01 EP 1 - 3	Plan/Program for cleaning and disinfecting of low-level, high-level, sterilization of medical equipment and supplies	Plan Program	Annual	Governing Body / Medical Staff
IC 01.03.01 EP 5	The Identified risks for acquiring and transmitting infections are prioritized and documented	Plan	Annual	Governing Body / Medical Staff
IC.02.04.01 EP 4,5,6,8	IPC Plan includes: Influenza vaccination rate improvement plan, description of methodology used to calculate rate, evaluation process for reasons for declination, documented goal for vaccination rate improvement	Program	Annual	Governing Body / Medical Staff
Information Management				
IM 01.01.03 EP 2	Procedure to manage interruptions (scheduled, unscheduled, training of staff, backup of information systems)	Procedure	3 years	IT Director
IM.02.01.01 EP 1	Written policy addressing privacy of health information	Policy	3 years	Governing Body
IM 02.01.01 EP 3	Policy to use health information only for purposes as required by law or facility policy	Policy	3 years	Governing Body
IM.02.01.03 EP 1-4	Written policy on Information security and data integrity, destruction of medical information and removal of health information	Policy	3 years	IT Director
IM 02.01.01 EP 1	Privacy of Health Information	Policy	3 years	Governing Body
IM 02.02.03 EP 2	Procedure for access to health information when needed for care / treatment.	Procedure	3 years	IT Director
IM 01.01.01 EP 2	Plan for managing information (enter, flow within, leave – information security)	Plan	3 years	Governing Body
IM.01.01.03 EP 1	Continuity of Information Management (interruptions, paper/electronic)	Plan	3 years	Governing Body
Leadership				
LD.01.03.01 EP 1	Governing Body Responsibilities	Policy	2 years	Governing Body
LD 01.03.01 EP 3	Scope of Services	Policy	Annually	Governing Body
LD.02.02.01 EP 1-2	Conflict of Interest involving leaders	Policy	Annually	Governing Body
LD.03.01.01 EP 4	Code of Conduct	Policy	2 years	Executive Leaders
LD 03.09.01 EP 2	Procedures to respond to system or process failures	Procedure	2 years	Executive Leaders

Applicable to the following Accreditation Programs: (X) Hospital (X) Critical Access Hospital (X) Behavioral Health (X) Ambulatory Care (X) Office Based Surgery ( ) Disease Specific Certification ( ) Staffing Certification

Regulatory Information may change over time as healthcare expectations change. This document is current as of the date noted within this footer

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
LD 04.01.05 EP 3	Define responsibilities of those with both Administrative & Clinical direction roles	Policy	2 years	Executive Leaders
LD.04.01.05 EP 10 (see note)	Social Work activities (for deemed psychiatric hospitals)	Policy Procedure	2 years	CEO
LD 04.01.05 EP 25	Radiation Safety Officer responsible for radiologic services	Policy Procedure	Annually	Medical Staff
LD.04.01.07 EP 1	Approval of patient care policies and procedures (Note: policy & procedure not required but Leaders must approve these policies)	Policy Procedure	3 years	Executive Leaders
LD.04.02.01 EP 1, 2, 5	Conflict of interest involving staff and LIPs	Policy Procedure	2 years	Executive Leaders
LD.04.04.05 EP 5	Response to system and process failures	Procedure	2 years	Executive Leaders
LD.04.04.05 EP 7	Patient Safety Event defined may be within an existing policy, plan, etc.	Policy	2 years	Executive Leaders
LD 01.02.01 EP 1	Quality Assessment and Performance Improvement Plan	Plan	Annual	Governing Body
LD 03.09.01 EP 1, 2	Safety Program / Patient Safety Program	Program	Annual	Governing Body
LD.04.01.01 EP 17	Utilization Review	Plan	Annual	Governing Body
LD.04.01.03 EP 4	Long-term capital expenditure plan	Plan	Annual	Governing Body
LD 04.01.05 EP 2	Define responsibilities of those in charge of programs and services	Plan	Annual	Governing Body
LD.04.03.11 EP 2	Plan for care of admitted patients in temporary bed locations	Plan	Annual	Governing Body
LD 04.03.13 EP 1 - 5	Program for Pain Management / Opioid practices (assessment, re-assessment, management, prescribing practices)	Program	Annual	Governing Body
LD.04.04.05 EP 1	Patient Safety	Program	Annual	Governing Body
Life Safety				
LS 01.01.01 EP 1	Process to identify an individual to assess compliance with Life Safety Code	Procedure	3 years	Executive Leaders
LS.01.02.01 EP 1 - 14	Interim Life Safety Measures Policy	Policy	Annually	Facilities Director
LS 02.01.10	Process to ensuring the building and fire protection features are maintained	Procedure	Annually	Facilities Director
Medication Management				
MM.01.01.01 EP 1	Patient information made available to those involved with medications	Policy	3 years	Governing Body

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
MM 01.01.03 EP 1	Process for managing hi-alert and hazardous medications	Procedure	Annually	Medical Staff
MM 02.01.01 EP 1,2,7,11,13	Written criteria for formulary inclusion; process to select, approve & procure non-formulary medications; process for communicating drug shortages & outages; Medication Substitution protocols	Policy	3 years or as needed	Medical Staff
MM.03.01.01 EP 4	Control, storage and delivery of medications between receipt & administration	Policy Procedure	2 years	Pharmacy Director
MM 03.01.01 EP 6	Prevent unauthorized individuals from obtaining medications	Policy	2 years	Pharmacy Director
MM.03.01.05 EP 1	Define when patient's own meds can be used	Policy	2 years	Medical Staff
MM.04.01.01 EP 1,2,3,4,5, 14	Types of Medication orders acceptable; required elements of medication order; when indication for use is required; precautions for ordering Look-alike/Sound-alike medications; Actions to be taken for incomplete/illegible/unclear orders, Influenza/Pneumococcal Vaccine protocols, standing orders	Policy	Annually	Medical Staff
MM.04.01.01 EP 2-5, 10	Required elements of orders. Required policies on indication for use, precautions for LASA, clarification actions, weight-based dosing	Policy	2 years	Medical Staff
MM.05.01.01 EP 1	Notes: Require policy on staff who may give medications before pharmacy review and "direct" supervision of Radiology staff administering IV contrast	Policy	3 years	Medical Staff
MM.05.01.07 EP 5	Preparation and administration of medications based upon order	Policy	3 years	Medical Staff
MM.05.01.13 EP 5	Medications obtained when the pharmacy is closed	Procedure	3 years	Pharmacy Director
MM.05.01.17 EP 1, 4	Retrieving recalled/discontinued medications	Policy Procedure	Annually	Pharmacy Director
MM 05.01.19 EP 2	Process for when the hospital will accept unused, expired or returned medications.	Procedure	3 years	Pharmacy Director
MM.06.01.01 EP 1	Disciplines responsible for medication administration	Policy	Annually	Medical Staff
MM.06.01.03 EP 1	Self or non-employee administration of medications	Procedure	Annually	Medical Staff
MM.06.01.05 EP 1	Investigational drugs	Procedure	Annually	Medical Staff / IRB
MM.07.01.03 EP 1-2	Adverse drug reactions and medication orders	Procedure	As needed	Medical Staff / Governing Body
MM 08.01.01 EP 16	Policy that describes types of overrides that will be reviewed for appropriateness and frequency of reviews – Automatic Dispensing Cabinets	Policy	Annually	Medical Staff

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
MM 09.01.01 EP 6	Antimicrobial Stewardship program multidisciplinary protocols	Policy Procedure	Annually	Medical Staff / Governing Body
MM 01.01.01 EP 1	Medication Management program	Program	Annual	Medical Staff
MM 07.01.03 EP 1	Program for reporting adverse events and medication errors	Program	3 years	Medical Staff
MM 09.01.01 EP 1-9	Antimicrobial Stewardship Program	Program	Annual	Medical Staff
Medical Staff				
MS.01.01.01 EP 1-37	Medical Staff policies (Bylaws, rules & regulations are policies and procedures of the Medical Staff)	Policy	2 years	Governing Body
MS.01.01.05 EP 3	Medical staff establishes policies and procedures that address the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals	Policy Procedure	2 years	Medical Staff
MS.03.01.01 EP 2,6,9,10	When H&P require validation and countersignature by LIP (Bylaws or Rules & Regs)	Policy	Bylaw update	Medical Staff
MS.03.01.01 EP 11	Scope of H&P for non-inpatients (Bylaws)	Policy	Bylaw update	Medical Staff
MS.03.01.01 EP 13	Appraisal of Emergencies for off-campus locations	Policy Procedure	2 years	Medical Staff
MS 03.01.01 EP 16	Determine qualifications of Radiology staff who use equipment and administer procedures	Policy	2 years	Medical Staff
MS.03.01.01 EP 14	***Written policies and procedures*** for appraisal of emergencies, initial treatment of patients, and referral of patients when needed.	Policy	2 years	Medical Staff
MS.03.01.03 EP 5	Medical staff define when consultations required	Policy	2 years	Medical Staff
MS.04.01.01 EP 1-2	GME roles and responsibilities	Policy Procedure	2 years	Medical Staff
MS.04.01.01 EP 4	Written delineation of who may write patient care orders	Policy	2 years	Medical Staff
MS 05.01.01 EP 6	Medical Staff actively involved in measurement, assessment and improvement of operative and other procedures?	Procedure	2 years	Medical Staff
MS.06.01.03 EP 1,6	Credentialing – Written procedure for processing applications	Procedure	2 years	Medical Staff
MS.06.01.07 EP 2	Defined process for review of privileging request information	Policy	2 years	Medical Staff
MS.06.01.09 EP 4	Disseminating decisions on Privileging	Procedure	2 years	Medical Staff
MS 06.01.11 EP 1	Written criteria for an expedited process for granting privileges	Policy	2 years	Medical Staff
MS 07.01.01 EP 1	Written criteria for medical staff membership	Policy	2 years	Medical Staff
MS.08.01.01 EP 2,3,5,7,8	Focused Professional Provider Evaluation process (FPPE)	Procedure	As needed	Medical Staff

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
MS.08.01.03 EP 1	Ongoing Professional Provider Evaluation process (OPPE)	Procedure	Annually	Medical Staff
MS.09.01.01 EP 1	Clearly defined process for collecting/investigating and addressing clinical practice concerns	Procedure	2 years	Medical Staff
MS.10.01.01 EP 1-5	Hearing and Appeals process	Procedure	2 years	Medical Staff
MS.13.01.03 EP 1	Telemedicine	Policy	2 years	Medical Staff
National Patient Safety Goals				
NPSG 01.01.01 EP 1	Two Patient Identifier when providing care, treatment and services	Procedure	Annually	Governing Body
NPSG.02.03.01 EP 1	Define Critical Tests and Critical Results and Values	Policy	Annually	Governing Body
NPSG 02.03.01 EP 2	Procedure for reporting critical results of tests and diagnostic procedures on a timely basis	Procedure	Annually	Governing Body
NPSG 03.04.01 EP 3	Label all medications and medication containers on and off the field in procedural areas.	Procedure	Annually	Governing Body
NPSG.03.05.01 EP 4,5,6	Addresses baseline and ongoing laboratory tests for anticoagulants	Policy	Annually	Governing Body
NPSG.03.06.01 EP 1,4	Medication Reconciliation information to be collected by setting	Policy	Annually	Governing Body
NPSG.06.01.01 EP 3	Establish policies & procedures for managing clinical alarms	Policy Procedure	Annually	Governing Body
NPSG.07.03.01 EP 7	Reducing the transmission of infections	Policy Procedure	Annually	Governing Body
NPSG 15.01.01 EP 1 - 7	Suicide Prevention / Address the Risk for Suicide	Policy Procedure	Annually	Governing Body
UP.01.02.01 EP 5	Alternative process for surgical site marking	Procedure	Annually	Governing Body
UP.01.03.01 EP 5	Time out	Policy Procedure	Annually	Governing Body
NPSG 01.01.01	Patient Identification Program	Program	Annual	Governing Body
NPSG 03.05.01 EP 1 - 8	Anti-coagulant Therapy Program	Program	Annual	Governing Body
NPSG.07.01.01 EP 1	Hand Hygiene Program	Program	Annual	Governing Body
NPSG.07.03.01 EP 4	MDRO Surveillance Program	Program	Annual	Governing Body
NPSG 15.01.01 EP 1	Suicide Prevention Program	Program	Annual	Governing Body
Nursing				
NR.02.01.01 EP 1,2	Nursing standards of care for nursing practice and patient care services	Policy Procedure	3 Years	Nurse Executive

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
NR.02.02.01 EP 1,2,3,4	Written Standards of Practice; Nursing Standards for care, treatment & services; Policies and Procedures, Nursing staffing plans	Policy Procedure	3 Years	Nurse Executive
NR 02.03.01 EP 2	Procedures and Policies implemented to describe and guide care, treatment and services	Procedure	3 Years	Nurse Executive
NR 02.03.01.EP 9	***Policies and procedures*** that establish which outpatient departments, if any, are not required to have a registered nurse present. The policies and procedures are as follows: - Establish criteria that such outpatient departments need to meet, taking into account the types of services delivered, the general level of acuity of patients served by the department, and established standards of practice for the services delivered - Describe alternative staffing plans - Approved by the director of nursing - Reviewed at least once every three years	Policy Procedure	3 Years	Nurse Executive
NR.02.01.01 EP 1	Plan for provision of nursing care	Plan	3 years	Nurse Executive
NR.02.02.01 EP 4	Plan for nurse staffing	Plan	3 years	Nurse Executive
Provision of Care				
PC 01.01.01 EP 2	Written process for accepting patients that addresses the following: - Criteria to determine the patient's eligibility for care, treatment, and services - Procedures for accepting referrals	Procedure	2 years	Medical Staff
PC 01.01.01 EP 4	Plan in non-psychiatric hospitals for care of psych and sub abuse patients	Plan	3 years	Medical Staff
PC 01.02.01 EP 1,2	Assessment and reassessment requirements	Policy	3 years	Medical Staff
PC 01.02.01 EP 3	Defined criteria when nutritional plans are developed	Policy	3 years	Medical Staff
PC 01.02.01 EP 53	Hospital with swing beds: PASARR program (pre-admission screening and resident review)	Program	3 years	Executives
PC.01.02.03 EP 1	Time frames for conducting initial assessments and H&P	Policy	3 years	Medical Staff
PC 01.02.05 EP 1	Process for conducting an initial assessment by a RN	Procedure	3 years	Medical Staff
PC 01.02.07	Pain Assessment and Management	Policy Procedure	3 Years	Medical Staff
PC 01.02.08 EP 1-2	Assessing and intervening for fall risk	Procedure	3 years	Medical Staff
PC 01.02.09 EP 1,2	Written criteria for identification of potential victims of abuse Written list of private and public agencies that can provide care or make arrangements for care – victims of abuse	Policy	3 years	Medical Staff
PC 01.02.13 EP 1-7	Assessing needs of patients seeking psychosocial care for substance abues	Procedure	3 years	Medical Staff
PC 01.02.13 EP 1-7	Assessing needs of patients seeking emotional and behavioral care	Procedure	3 years	Medical Staff
PC 01.02.15 EP 2	Defined timeframes for provision of diagnostic testing and procedures	Policy	3 years	Medical Staff

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
PC 01.02.15 EP 5	Radiation exposure value documentation for CT	Procedure	3 years	Medical Staff
PC 01.02.15 EP 10	Pre-procedure verification for CT, MRI, PET, Nuclear Medicine Studies	Procedure	3 years	Medical Staff
PC 01.02.15 EP 13	Documentation of Fluoroscopy exposure	Procedure	3 years	Medical Staff
PC 01.02.15 EP 13	Considerations of patient age and recent exams when selecting appropriate exam for CT, MRI, PET and Nuclear Medicine Studies	Procedure	3 years	Medical Staff
PC.01.03.03 EP 1-5	Behavior Management Policies	Policy	3 years	Medical Staff
PC.01.03.05 EP 2,3,4,6,8	Behavior Health management, including restraint use	Procedure	3 years	Medical Staff
PC.02.01.01 EP 10, 15	Administration of Blood and IV medications	Policy Procedure	3 years	Medical Staff
PC.02.01.01 EP 30	Identification process of radiation exposure and skin dose threshold levels that, when exceeded, triggers further review and/or patient evaluation to assess for adverse radiation effects.	Procedure	3 years	Medical Staff
PC 02.01.30 EP 20	Verbal order/critical result read back process	Procedure	3 years	Medical Staff
PC.02.01.11 EP 1	Resuscitation services	Policy Procedure	3 years	Medical Staff
PC 02.01.11 EP 4	Evidence Based training program for resuscitation equipment and techniques	Program	3 years	Nursing Executive
PC 02.01.19 EP 2	Written criteria – early warning signs/changes in condition	Policy	3 years	Medical Staff
PC 02.01.20 EP 1-2	Policies, procedures, or protocols based on current scientific literature for interdisciplinary post–cardiac arrest care including determine neurological prognosis.	Policy Procedure	3 years	Medical Staff
PC 02.01.20 EP 3	Written criteria or a protocol for inter-facility transfers of patients for post–cardiac arrest care	Policy Procedure	3 years	Medical Staff
PC 02.01.21 EP 1-2	Identifying the patient's oral and written communication needs, including the patient's preferred language, and providing communication based on those needs.	Procedure	3 years	Medical Staff
PC 02.02.01 EP 1	Process to receive or share patient information when the patient is referred to other internal or external provider	Procedure	3 years	Medical Staff
PC 02.02.01 EP 2	Hand-Off process	Procedure	3 years	Medical Staff
PC 02.02.01 EP 29	Hospital with Swing Beds – procedures for lost dentures	Procedure	3 years	Medical Staff
PC 02.02.03 EP 22	Dietetic Manual	Policy	5 years	Dietitian and Medical Staff
PC 02.03.01	Evaluating patient learning needs, providing education and evaluating effectiveness	Procedure	3 years	Medical Staff

Applicable to the following Accreditation Programs: (X) Hospital (X) Critical Access Hospital (X) Behavioral Health (X) Ambulatory Care (X) Office Based Surgery ( ) Disease Specific Certification ( ) Staffing Certification

Regulatory Information may change over time as healthcare expectations change. This document is current as of the date noted within this footer

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
PC 03.01.01 EP 10	Those permitted to administer anesthesia	Policy	3 years	Medical Staff
PC 03.01.03 EP 1, 4, 8	Pre-sedation/anesthesia patient assessment, re-assessment, evaluation and education	Procedure	3 years	Medical Staff
PC 03.01.05 EP 1	Continuous monitoring of oxygen, ventilation, circulation during moderate or deep sedation.	Procedure	3 years	Medical Staff
PC 03.01.07 EP 4, 8	Discharge criteria and Post-anesthesia evaluation	Policy	3 years	Medical Staff
PC 03.01.08 EP 1-2	Management Criteria for Surgical tissue specimens	Policy Procedure	3 years	Medical Staff and Pathologist
PC 03.01.09 EP 1	Electroconvulsive therapy	Policy	3 years	Medical Staff
PC 03.05.09 EP 1, 2	Use of Restraint and Seclusion	Policy Procedure	3 years	Medical Staff
PC 03.05.17 EP 5	Documentation of staff training on the use of restraints	Procedure	3 years	Medical Staff
PC 03.05.19 EP 2-3	Patient death in restraints	Policy Procedure	3 years	Medical Staff
PC 04.01.01 EP 32	The patient's discharge plan includes a list of home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, or long-term care hospitals that are available to the patient, participating in the Medicare program, and serving the geographic area in which the patient resides	Procedure	3 years	Medical Staff
PC 04.01.03 EP 5	Swing Bed Hospitals: Written notice of transfer or discharge required under paragraph 42 CFR 483.12(a)(4) must be made by the hospital at least 30 days before the resident is transferred or discharged.	Procedure	3 years	Medical Staff
PC 04.01.03 EP 6	Swing Bed Hospitals: Written notice before transfer or discharge specified in the CoP from 42 CFR 483.12(a)(4)	Procedure	3 years	Medical Staff
PC 05.01.09 EP 1	Written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27.	Policy Procedure	3 years	Medical Staff
PC 06.01.01 EP2	Evidence based management of pregnant and postpartum patient who experience maternal hemorrhage.	Procedure	New	Medical Staff
PC 06.03.01 EP 1	Measurement and Re-measurement of blood pressure	Procedure	New	Medical Staff
PC 06.03.01 EP 2	Written procedures for managing pregnant and postpartum hypertension / preeclampsia	Policy Procedure	New	Medical Staff
Performance Improvement				
PI 01.01.01	Data collection procedures	Procedure	Annual	Governing Body

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
PI 02.01.01	Performance Improvement Plan with priorities set by leadership and reviewed/updated at least annually	Plan Procedure Program	Annual	Governing Body
PI 03.01.01	Data Analysis process and tools	Plan Procedure Program	Annual	Governing Body
PI 03.01.01 EP 4, 6-8, 12-14, 18-22	Procedures for Performance Improvement	Plan Procedure Program	Annual	Governing Body
PI 04.01.01 EP 3	Use of improvement tools or methodologies to improve its performance	Procedure	Annual	Governing Body
Record of Care				
RC 01.01.01 EP 1	Requirements of complete and accurate Medical Record	Policy	3 years	Medical Staff
RC 01.02.01 EP 2	Entries requiring countersignature by LIP	Policy	3 years	Medical Staff
RC 01.03.01 EP 1-2	Timely entries in the medical record and completion of medical record	Policy	3 years	Medical Staff
RC 01.05.01 EP 1	Retention timeframes of Medical Records	Policy	3 years	Medical Staff
RC 02.01.03 EP 15	Licensed practitioner enters all surgical and procedural diagnosis, information and procedure in post operative summary or operative register	Procedure	3 years	Medical Staff
RC 02.03.07 EP 1	Identify those authorized to receive and record verbal orders	Policy	3 years	Medical Staff
Ethics, Rights & Responsibilities				
RI 01.01.01 EP 1	Patient rights – written policies (including visitation)	Policy Procedure	3 years	Governing Body
RI 01.03.01 EP 1-6	Informed consent policy	Policy	3 years	Governing Body
RI 01.03.05 EP 2, 3, 4	Consent to participate in research	Policy	3 years	Governing Body
RI 01.05.01 EP 1, 4,	Policy for Advance Directives:	Policy	3 years	Governing Body
RI 01.05.01 EP 15	Patient rights concerning Organ donation and honor the wishes of the patient	Policy	3 years	Governing Body
RI 01.06.01 EP 1	Swing Bed Hospitals – patients right to be free of chemical or physical restraints	Policy	3 years	Governing Body
RI 01.06.03 EP 4	Swing Bed Hospitals - Written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	Policy Procedure	3 years	Governing Body
RI 01.07.01 EP 18	Complaint resolution process	Procedure	3 years	Governing Body
RI 01.07.07 EP 1	Written criteria for when organizations* use patients as employees	Policy	3 years	Governing Body

REQUIRED JOINT COMMISSION PLANS, POLICIES, PROCEDURES & PROGRAMS				
Standard	**Requirement**	**Document**	**Frequency of Review**	**Approval Level**
RI 02.01.01 EP 1,2	Mechanism for informing patients of their responsibilities	Policy	3 years	Governing Body
Transplant Safety				
TS 01.01.01 EP 1, 3	Written donation and procurement/recovery policies Written agreements with OPO, Tissue Bank and Eye Bank	Policy Procedure	3 years	Medical Staff
TS 01.01.01 EP 4	Written Donation policy (identification, reporting, decision, recovery)	Policy	3 years	Medical Staff
TS 01.01.01 EP 6	Family notification of option to donate	Procedure	3 years	Medical Staff
TS 03.01.01 EP 2	Acquire, receive, store and issue tissue	Procedure	3 years	Medical Staff
TS 03.02.01 EP 2	Preparation and processing of tissue	Procedure	3 years	Medical Staff
TS 03.03.01 EP 1	Investigate adverse event and donor infections	Procedure	3 years	Medical Staff
Waived Tests				
WT 01.01.01 EP 2-4	Policy and procedures for waived test requirements	Policy Procedure	3 years	Physician named on CLIA license
WT 02.01.01 EP 1-2	Identification of staff performing waived testing and supervising waived testing	Policy	3 years	Physician named on CLIA license
WT 03.01.01 EP 2	Orientation process for waived testing is defined	Policy	3 years	Physician named on CLIA license
WT 03.01.01 EP 6	Competency process and frequency for Waived Testing	Policy	3 years	Physician named on CLIA license
WT 04.01.01 EP 1-5	Quality control plan for waived tests	Plan	Annual	LIP on CLIA license

**Applicable to psychiatric hospital settings that provide longer term care (> 30 days)*