Joint Commission Resources
Quality & Safety Network (JCRQSN)

Resource Guide

Medication Management: A Standards Update

April 26, 2018
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Program Summary

This page provides an overview of the program content and learning objectives. Please refer to the Table of Contents and Program Outline for a detailed list of the topics covered. The information included in this Resource Guide is intended to support but not duplicate the video presentation content. There may be additional information available online for this topic.

Program Description

Medication orders and the storage and security of medications have been ongoing compliance issues for many years. In addition, other areas such as labeling in operating room procedures, medication order review, preparing medications, reconciling medications, and labeling medications have been sighted by Joint Commission surveyors as problematic, as well.

This 60-minute activity focuses on the top issues that surround medication management, the importance of complying with the medication management standards, and highlights the importance of developing a comprehensive organizational oversight of these issues.

Program Objectives

After completing this activity, the participant should be able to:

1. Identify the top four challenging medication management standards for Hospital and Critical Access Hospital accreditation programs.
2. Explain the components of an effective antimicrobial stewardship program.
3. Describe key elements and strategies in the assessment of a sterile medications compounding program.
4. Define a process for decision-making in the management of drug product shortages.

Target Audience

This activity is relevant to pharmacists, nurse leaders, physicians, organization leaders, managers and supervisors, and staff responsible for performance improvement (PI), patient safety, and risk management initiatives.
Program Outline

Medication Management: A Standards Update
April 26, 2018

I. Introduction
II. Challenging Medication Management Standards for Hospitals and Critical Access Hospitals
III. Components of an Effective Antimicrobial Stewardship
IV. Assessing a Sterile Medications Compounding Program
V. Managing Drug Product Shortages
VI. Conclusion

<table>
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<tr>
<th>Program Broadcast Time</th>
<th>Eastern:</th>
<th>2:00 p.m. to 3:00 p.m.</th>
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<td></td>
<td>Central:</td>
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<td>Mountain:</td>
<td>12:00 p.m. to 1:00 p.m.</td>
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<tr>
<td></td>
<td>Pacific:</td>
<td>11:00 a.m. to 12:00 p.m.</td>
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Continuing Education (CE) Credit

After viewing the JCR Quality & Safety Network presentation and reading this Resource Guide, please complete the required online CE/CME credit activities (test and evaluation form). The test measures knowledge gained and/or provides a means of self-assessment on a specific topic. The evaluation form provides us with valuable information regarding your thoughts on the activity’s quality and effectiveness.

Prior to the Program Presentation Day

1. Login to the JCRQSN Learning Management System web site at http://jcrqsn.twnlms.com/
   • Select the course for this program, Medication Management: A Standards Update
   • When prompted, choose Access Content to confirm that you would like to access this program.

2. Display and print the desired documents (Resource Guide, etc.).

Online Process for CE/CME Credit

1. Read the course materials and view the entire video presentation.
2. Login to the JCRQSN Learning Management System web site at http://jcrqsn.twnlms.com/
3. Select Medication Management: A Standards Update from the courses menu block.
   Note: This assumes you have already been enrolled in the program, as described above.
4. If you did not view the broadcast video presentation, view it online.
5. Complete the online post test (see Appendix E).
   • You have up to three attempts to successfully complete the test with a minimum passing score of 80%.
   • Physicians must take the post test to obtain credit.
6. Complete the program evaluation form.
7. On the top-left corner of the main course page, you will see your completion status in the Status block.
8. Select Get Certificate from within the Status block to print your completion certificate.
   Note: Certificates for other completed courses can be printed from the “My History” tab, as well.
Top Four Non-Compliant Medication Management Standards for Hospitals and Critical Access Hospitals Based on Survey Data, January – July 2017

Top Non-Compliant Medication Management Standards for Hospitals

<table>
<thead>
<tr>
<th>Standard/National Safety Patient Goal (NPSG)</th>
<th>% Non-Compliant</th>
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<tr>
<td>MM.04.01.01 Medication Orders</td>
<td>49.28%</td>
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<tr>
<td>MM.03.01.01 Storage and Security of Meds</td>
<td>47.84%</td>
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<tr>
<td>MM.05.01.01 Medication Order Review</td>
<td>14.94%</td>
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<td>MM.05.01.07 Preparing Medications</td>
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Top Non-Compliant Medication Management Standards for Critical Access Hospitals

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<td>MM.03.01.03 Emergency Medications</td>
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Top Non-Compliant Medication Management Standards for Hospitals

Program: Hospital
Chapter: Medication Management
Standard: MM.04.01.01: Medication orders are clear and accurate.
Rationale: (None)

EPs:

1. The hospital has a written policy that identifies the specific types of medication orders that it deems acceptable for use.
   
   Note: There are several different types of medication orders. Medication orders commonly used include the following:
   - As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom
   - Standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances
   - Automatic stop orders: Orders that include a date or time to discontinue a medication
   - Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status
   - Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval
   - Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status
   - Signed and held orders: New prewritten (held) medication orders and specific instructions from a licensed independent practitioner to administer medication(s) to a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s)
   - Orders for compounded drugs or drug mixtures not commercially available
   - Orders for medication-related devices (for example, nebulizers, catheters)
   - Orders for investigational medications
   - Orders for herbal products
   - Orders for medications at discharge or transfer

2. The hospital has a written policy that defines the following: The required elements of a complete medication order.

3. The hospital has a written policy that defines the following: When indication for use is required on a medication order.

4. The hospital has a written policy that defines the following: The precautions for ordering medications with look-alike or sound-alike names.

5. The hospital has a written policy that defines the following: Actions to take when medication orders are incomplete, illegible, or unclear.

6. The hospital minimizes the use of verbal and telephone medication orders.

7. The hospital reviews and updates preprinted order sheets, within time frames it identifies or sooner if necessary, based on current evidence and practice.

8. The hospital prohibits summary (blanket) orders to resume previous medications.
9 A diagnosis, condition, or indication for use exists for each medication ordered.

   Note: This information can be anywhere in the medical record and need not be on the order itself. For example, it might be part of the medical history.

10 The hospital defines, in writing, the circumstances for which weight-based dosing is required for pediatric populations. (See also MM.01.01.01, EP 1)

   Note: This element of performance is also applicable to sample medications.

13 The hospital implements its policies for medication orders.

14 The hospital requires an order from a doctor of medicine or osteopathy or, as permitted by law and regulation, a hospital-specific protocol(s) approved by a doctor of medicine or osteopathy to administer influenza and pneumococcal vaccines.

15 For hospitals that use Joint Commission accreditation for deemed status purposes: Processes for the use of preprinted and electronic standing orders, order sets, and protocols for medication orders include the following:
   – Review and approval of standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership
   – Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines
   – Regular review of such standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols
   – Dating, timing, and authenticating of standing orders and protocols by the ordering practitioner or another practitioner responsible for the patient's care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.

21 For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses an electronic prescribing process.
Program: Hospital

Chapter: Medication Management

Standard: MM.03.01.01: The hospital safely stores medications.

Rationale: Medication storage is designed to assist in maintaining medication integrity, promote the availability of medications when needed, minimize the risk of medication diversion, and reduce potential dispensing errors. Law and regulation and manufacturers' guidelines further define the hospital's approach to medication storage.

EPs:

2 The hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.

Note: This element of performance is also applicable to sample medications.

3 The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, in accordance with law and regulation.


Note 2: This element of performance is also applicable to sample medications.

4 The hospital has a written policy addressing the control of medication between receipt by an individual health care provider and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage.

Note: This element of performance is also applicable to sample medications.

5 The hospital implements its policy addressing the control of medication between receipt by an individual health care provider and its administration.

Note: This element of performance is also applicable to sample medications.

6 The hospital prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation.

Note: This element of performance is also applicable to sample medications.

7 All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.

Note: This element of performance is also applicable to sample medications.

8 The hospital removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration.

Note: This element of performance is also applicable to sample medications.

9 The hospital keeps concentrated electrolytes present in patient care areas only when patient safety necessitates their immediate use, and precautions are used to prevent inadvertent administration. (See also MM.01.01.03, EP 2)

10 The hospital periodically inspects all medication storage areas.

Note: This element of performance is also applicable to sample medications.

19 For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a pharmacy directed by a registered pharmacist or a supervised drug storage area, in accordance with law and regulation.

Note: This element of performance is also applicable to sample medications.

24 For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains records of the receipt and disposition of radiopharmaceuticals.
Program: Hospital

Chapter: Medication Management

Standard: MM.05.01.01: A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

Rationale: (None)

EPs:

1. Before dispensing or removing medications from floor stock or from an automated storage and distribution device, a pharmacist reviews all medication orders or prescriptions unless a licensed independent practitioner controls the ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation (including sudden changes in a patient's clinical status), in accordance with law and regulation.

   Note 1: The Joint Commission permits emergency departments to broadly apply two exceptions in regard to Standard MM.05.01.01, EP 1. These exceptions are intended to minimize treatment delays and patient back-up. The first exception allows medications ordered by a licensed independent practitioner to be administered by staff who are permitted to do so by virtue of education, training, and organization policy (such as a registered nurse) and in accordance with law and regulation. A licensed independent practitioner is not required to remain at the bedside when the medication is administered. However, a licensed independent practitioner must be available to provide immediate intervention should a patient experience an adverse drug event. The second exception allows medications to be administered in urgent situations when a delay in doing so would harm the patient.

   Note 2: A hospital's radiology service (including hospital-associated ambulatory radiology) will be expected to define, through protocol or policy, the role of the licensed independent practitioner in the direct supervision of a patient during and after IV contrast media is administered including the licensed independent practitioner's timely intervention in the event of a patient emergency.

2. When an on-site pharmacy is not open 24 hours a day, 7 days a week, a health care professional determined to be qualified by the hospital reviews the medication order in the pharmacist's absence.

3. When an on-site pharmacy is not open 24 hours a day, 7 days a week, a pharmacist conducts a retrospective review of all medication orders during this period as soon as a pharmacist is available or the pharmacy opens.

4. All medication orders are reviewed for the following: Patient allergies or potential sensitivities.

5. All medication orders are reviewed for the following: Existing or potential interactions between the medication ordered and food and medications the patient is currently taking.

6. All medication orders are reviewed for the following: The appropriateness of the medication, dose, frequency, and route of administration.

7. All medication orders are reviewed for the following: Current or potential impact as indicated by laboratory values.

8. All medication orders are reviewed for the following: Therapeutic duplication.

9. All medication orders are reviewed for the following: Other contraindications.

11. After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing.
**Program:** Hospital  
**Chapter:** Medication Management  
**Standard:** MM.05.01.07: The hospital safely prepares medications.  
**Rationale:** (None)  
**EPs:**  
1. A pharmacist, or pharmacy staff under the supervision of a pharmacist, compounds or admixes all compounded sterile preparations except in urgent situations in which a delay could harm the patient or when the product's stability is short.  
2. Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.  
3. During preparation, staff visually inspect the medication for particulates, discoloration, or other loss of integrity. (See also MM.03.01.05, EP 2; MM.06.01.01, EP 4)  
4. The hospital uses a laminar airflow hood or other ISO Class 5 environment in the pharmacy for preparing intravenous (IV) admixture or any sterile product that will not be used within 24 hours.  
5. For hospitals that use Joint Commission accreditation for deemed status purposes: Medications are prepared and administered in accordance with the orders of a licensed independent practitioner or other practitioner responsible for the patient's care, and in accordance with hospital policies; medical staff bylaws, rules, and regulations; and law and regulation. *  
   **Footnote**: For law and regulation guidance pertaining to those responsible for the care of patients, refer to 42 CFR 482.12(c).  
6. For hospitals that use Joint Commission accreditation for deemed status purposes: In-house preparation of radiopharmaceuticals is done by, or under the supervision of, an appropriately trained registered pharmacist or doctor of medicine or osteopathy.
Top Non-Compliant Medication Management Standards for Critical Access Hospitals

Program: Critical Access Hospital
Chapter: Medication Management

Standard: MM.03.01.01: The critical access hospital safely stores medications.

Rationale: Medication storage is designed to assist in maintaining medication integrity, promote the availability of medications when needed, minimize the risk of medication diversion, and reduce potential dispensing errors. Law and regulation and manufacturers' guidelines further define the critical access hospital's approach to medication storage.

EPs:

2 The critical access hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.

Note: This element of performance is also applicable to sample medications.

3 The critical access hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, in accordance with law and regulation.


Note 2: This element of performance is also applicable to sample medications.

4 The critical access hospital has a written policy addressing the control of medication between receipt by an individual health care provider and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage.

Note: This element of performance is also applicable to sample medications.

5 The critical access hospital implements its policy addressing the control of medication between receipt by an individual health care provider and its administration.

Note: This element of performance is also applicable to sample medications.

6 The critical access hospital prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation.

Note: This element of performance is also applicable to sample medications.

7 All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.

Note: This element of performance is also applicable to sample medications.

8 The critical access hospital removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration.

Note: This element of performance is also applicable to sample medications.

9 The critical access hospital keeps concentrated electrolytes present in patient care areas only when patient safety necessitates their immediate use, and precautions are used to prevent inadvertent administration. (See also MM.01.01.03, EP 2)
18 The critical access hospital periodically inspects all medication storage areas. 
   **Note:** This element of performance is also applicable to sample medications.

19 For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a pharmacy directed by a registered pharmacist or a supervised drug storage area, in accordance with law and regulation. 
   **Note:** This element of performance is also applicable to sample medications.

24 For rehabilitation and psychiatric distinct part units in critical access hospitals: The hospital maintains records of the receipt and disposition of radiopharmaceuticals.

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**Program:** Critical Access Hospital  
**Chapter:** Medication Management  
**Standard:** MM.04.01.01: Medication orders are clear and accurate.  
**Rationale:** (None)  
**EPs:**

1. The critical access hospital has a written policy that identifies the specific types of medication orders that it deems acceptable for use. 
   **Note:** There are several different types of medication orders. Medication orders commonly used include the following:
   - As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom
   - Standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances
   - Automatic stop orders: Orders that include a date or time to discontinue a medication
   - Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status
   - Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval
   - Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status
   - Signed and held orders: New prewritten (held) medication orders and specific instructions from a licensed independent practitioner to administer medication(s) to a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s)
   - Orders for compounded drugs or drug mixtures not commercially available
   - Orders for medication-related devices (for example, nebulizers, catheters)
   - Orders for investigational medications
   - Orders for herbal products
   - Orders for medications at discharge or transfer

2. The critical access hospital has a written policy that defines the following: The required elements of a complete medication order.
3 The critical access hospital has a written policy that defines the following: When indication for use is required on a medication order.

4 The critical access hospital has a written policy that defines the following: The precautions for ordering medications with look-alike or sound-alike names.

5 The critical access hospital has a written policy that defines the following: Actions to take when medication orders are incomplete, illegible, or unclear.

6 For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital minimizes the use of verbal and telephone medication orders.

7 The critical access hospital reviews and updates preprinted order sheets, within time frames it identifies or sooner if necessary, based on current evidence and practice.

8 The critical access hospital prohibits summary (blanket) orders to resume previous medications.

9 A diagnosis, condition, or indication for use exists for each medication ordered. 
   **Note:** This information can be anywhere in the medical record and need not be on the order itself. For example, it might be part of the medical history.

10 The critical access hospital defines, in writing, the circumstances for which weight-based dosing is required for pediatric populations. (See also MM.01.01.01, EP 1)  
   **Note:** This element of performance is also applicable to sample medications.

13 The critical access hospital implements its policies for medication orders.

14 The critical access hospital requires an order from a doctor of medicine or osteopathy or, as permitted by law and regulation, a critical access hospital-specific protocol(s) approved by a doctor of medicine or osteopathy to administer influenza and pneumococcal vaccines.

15 For rehabilitation and psychiatric distinct part units in critical access hospitals: Processes for the use of preprinted and electronic standing orders, order sets, and protocols for medication orders include the following:
   – Review and approval of standing orders and protocols by the medical staff and the critical access hospital's nursing and pharmacy leadership
   – Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines
   – Regular review of such standing orders and protocols by the medical staff and the critical access hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols
   – Dating, timing, and authenticating of standing orders and protocols by the ordering practitioner or another practitioner responsible for the patient's care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.

21 For critical access hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses an electronic prescribing process.
Program: Critical Access Hospital

Chapter: Medication Management

Standard: MM.05.01.01: A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the critical access hospital.

Rationale: (None)

EPs:

1. Before dispensing or removing medications from floor stock or from an automated storage and distribution device, a pharmacist reviews all medication orders or prescriptions unless a licensed independent practitioner controls the ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation (including sudden changes in a patient's clinical status), in accordance with law and regulation.

Note 1: The Joint Commission permits emergency departments to broadly apply two exceptions in regard to Standard MM.05.01.01, EP 1. These exceptions are intended to minimize treatment delays and patient back-up. The first exception allows medications ordered by a licensed independent practitioner to be administered by staff who are permitted to do so by virtue of education, training, and organization policy (such as a registered nurse) and in accordance with law and regulation. A licensed independent practitioner is not required to remain at the bedside when the medication is administered. However, a licensed independent practitioner must be available to provide immediate intervention should a patient experience an adverse drug event. The second exception allows medications to be administered in urgent situations when a delay in doing so would harm the patient.

Note 2: A critical access hospital's radiology service (including critical access hospital-associated ambulatory radiology) will be expected to define, through protocol or policy, the role of the licensed independent practitioner in the direct supervision of a patient during and after IV contrast media is administered including the licensed independent practitioner's timely intervention in the event of a patient emergency.

2. When an on-site pharmacy is not open 24 hours a day, 7 days a week, a health care professional determined to be qualified by the critical access hospital reviews the medication order in the pharmacist's absence.

3. When an on-site pharmacy is not open 24 hours a day, 7 days a week, a pharmacist conducts a retrospective review of all medication orders during this period as soon as a pharmacist is available or the pharmacy opens.

4. All medication orders are reviewed for the following: Patient allergies or potential sensitivities.

5. All medication orders are reviewed for the following: Existing or potential interactions between the medication ordered and food and medications the patient is currently taking.

6. All medication orders are reviewed for the following: The appropriateness of the medication, dose, frequency, and route of administration.

7. All medication orders are reviewed for the following: Current or potential impact as indicated by laboratory values.

8. All medication orders are reviewed for the following: Therapeutic duplication.

9. All medication orders are reviewed for the following: Other contraindications.

11. After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing.
Program: Critical Access Hospital

Chapter: Medication Management

Standard: MM.03.01.03: The critical access hospital safely manages emergency medications.

Rationale: Patient emergencies occur frequently in health care settings. The critical access hospital, therefore, needs to plan how it will address patient emergencies and what medications and supplies it will need. Although the processes may be different, the critical access hospital treats emergency medications with the same care for safety as it does medications in nonemergency settings.

EPs:

1. Critical access hospital leaders, in conjunction with members of the medical staff and licensed independent practitioners, decide which emergency medications and their associated supplies will be readily accessible in patient care areas based on the population served.

2. Emergency medications and their associated supplies are readily accessible in patient care areas.

4. Medications available for treating emergency cases include analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.

6. When emergency medications or supplies are used, the critical access hospital replaces them as soon as possible to maintain a full stock.
New Hospital Standard for 2018: MM.09.01.01

Program: Hospital

Chapter: Medication Management

Standard: MM.09.01.01: The hospital has an antimicrobial stewardship program based on current scientific literature.

Rationale: (None)

EPs:

1 Leaders establish antimicrobial stewardship as an organizational priority. (See also LD.01.03.01, EP 5)
   Note: Examples of leadership commitment to an antimicrobial stewardship program are as follows:
   – Accountability documents
   – Budget plans
   – Infection prevention plans
   – Performance improvement plans
   – Strategic plans
   – Using the electronic health record to collect antimicrobial stewardship data

2 The hospital educates staff and licensed independent practitioners involved in antimicrobial ordering, dispensing, administration, and monitoring about antimicrobial resistance and antimicrobial stewardship practices. Education occurs upon hire or granting of initial privileges and periodically thereafter, based on organizational need.

4 The hospital has an antimicrobial stewardship multidisciplinary team that includes the following members, when available in the setting:
   – Infectious disease physician
   – Infection preventionist(s)
   – Pharmacist(s)
   – Practitioner

   Note 1: Part-time or consultant staff are acceptable as members of the antimicrobial stewardship multidisciplinary team.

   Note 2: Telehealth staff are acceptable as members of the antimicrobial stewardship multidisciplinary team.
The hospital's antimicrobial stewardship program includes the following core elements:

- Leadership commitment: Dedicating necessary human, financial, and information technology resources.
- Accountability: Appointing a single leader responsible for program outcomes. Experience with successful programs show that a physician leader is effective.
- Drug expertise: Appointing a single pharmacist leader responsible for working to improve antibiotic use.
- Action: Implementing recommended actions, such as systemic evaluation of ongoing treatment need, after a set period of initial treatment (for example, “antibiotic time out” after 48 hours).
- Tracking: Monitoring the antimicrobial stewardship program, which may include information on antibiotic prescribing and resistance patterns.
- Reporting: Regularly reporting information on the antimicrobial stewardship program, which may include information on antibiotic use and resistance, to doctors, nurses, and relevant staff.
- Education: Educating practitioners, staff, and patients on the antimicrobial program, which may include information about resistance and optimal prescribing.

(See also IC.02.01.01, EP 1 and NPSG.07.03.01, EP 5)

**Note:** These core elements were cited from the Centers for Disease Control and Prevention's Core Elements of Hospital Antibiotic Stewardship Programs (http://www.cdc.gov/getsmart/healthcare/pdfs/core-elements.pdf). The Joint Commission recommends that organizations use this document when designing their antimicrobial stewardship program.

The hospital's antimicrobial stewardship program uses organization-approved multidisciplinary protocols (for example, policies and procedures).

**Note:** Examples of protocols are as follows:

- Antibiotic Formulary Restrictions
- Assessment of Appropriateness of Antibiotics for Community-Acquired Pneumonia
- Assessment of Appropriateness of Antibiotics for Skin and Soft Tissue infections
- Assessment of Appropriateness of Antibiotics for Urinary Tract Infections
- Care of the Patient with Clostridium difficile (C. diff)
- Guidelines for Antimicrobial Use in Adults
- Guidelines for Antimicrobial Use in Pediatrics
- Plan for Parenteral to Oral Antibiotic Conversion
- Preauthorization Requirements for Specific Antimicrobials
- Use of Prophylactic Antibiotics

The hospital collects, analyzes, and reports data on its antimicrobial stewardship program.

**Note:** Examples of topics on which to collect and analyze data may include evaluation of the antimicrobial stewardship program, antimicrobial prescribing patterns, and antimicrobial resistance patterns.

The hospital takes action on improvement opportunities identified in its antimicrobial stewardship program.

(See also MM.08.01.01, EP 6)
Medication Management Chapter FAQs: Antimicrobial Stewardship

Antimicrobial Stewardship – Examples – Standard MM.09.01.01 EPs 1, 3, 5, 6, and 7

When examples are provided within an EP, are these example considered to be part of the requirement?

No. The examples that are provided in EPs 1, 3, 5, 6, and 7 are not Joint Commission requirements and are provided to assist organizations during their review of the antimicrobial stewardship standard based on the care, treatment, and services provided.

Antimicrobial Stewardship – Accountability Document – Standard MM.09.01.01 EP 1

What is an accountability document, which is used as an example of leadership commitment?

An accountability document is any organizational document describing the formal chain of responsibility for the antimicrobial stewardship program.

Antimicrobial Stewardship – Core Element Documentation – Standard MM.09.01.01 EP 5

What type of documentation is needed for MM.09.01.01 EP 5, the required core elements of the antimicrobial stewardship program?

The organization needs to have a document indicating how each core element is addressed in its antimicrobial stewardship program. This information can be located in a separate document or can be included in other antimicrobial stewardship documents (see MM.09.01.01, EP 1). This documentation does not have to be provided in a lengthy format but needs to describe how the core elements are addressed in the antimicrobial stewardship program.

Antimicrobial Stewardship – Data Collection, Analysis, and Reporting – Standard MM.09.01.01 EP 7

What type of antimicrobial stewardship data should organizations collect, analyze, and report?

The Joint Commission is not requiring any specific antimicrobial stewardship data in Standard MM.09.01.01. The organization must determine the antimicrobial stewardship data it will collect, analyze, and report. The CDC's Core Elements of Hospital Antibiotic Stewardship Programs at https://www.cdc.gov/getsmart/healthcare/pdfs/core-elements.pdf and The Core Elements of Antibiotic Stewardship for Nursing Homes at https://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html provide examples of measures that can be used to collect antimicrobial stewardship data and should be considered by organizations. Additionally, the National Quality Partners Playbook on Antibiotic Stewardship in Acute Care provides examples of basic, intermediate, and advanced measures. (http://www.qualityforum.org/Publications/2016/05/National_Quality_Partners_Playbook__Antibiotic_Stewardship_in_Acute_Care.aspx)
Antimicrobial Stewardship – Education Requirements for Staff and Licensed Independent Practitioners - Standard MM.09.01.01 EP 2

Will Joint Commission surveyors review human resource records and medical staff credentialing and privileging records to determine if antimicrobial resistance and antimicrobial stewardship education was provided by the organization?

Joint Commission surveyors will not be reviewing staff or medical staff/licensed independent practitioner records on education received regarding antimicrobial resistance and antimicrobial stewardship. Joint Commission surveyors will inquire about the type of education provided by the organization during the Medication Management System Tracer (or other system tracers). During patient tracers, surveyors may ask staff and licensed independent practitioners about the education they have received. Providing written material such as the organization's antibiogram will meet the educational requirement of MM.09.01.01, EP 2.

Antimicrobial Stewardship – Improvement Opportunities – Standard MM.09.01.01 EP 8

Are there any specific improvement opportunities that surveyors will look for regarding the organization's antimicrobial stewardship program?

During the survey, organizations need to identify improvement opportunities based on their collected and analyzed data. Surveyors will ask the organization to discuss the antimicrobial stewardship improvement opportunities it has identified and the actions taken to improve its program. This information should be documented. If the data demonstrates that antimicrobial stewardship improvements are not necessary, the organization should share this data with the surveyor.

Antimicrobial Stewardship – Multidisciplinary Protocol Requirements – Standard

Do organizations need to have multidisciplinary protocols for each example in MM.09.01.01, EP 6?

The examples of protocols are provided for organizations to consider based on the care, treatment, and services delivered and are not requirements.

Antimicrobial Stewardship – Multidisciplinary Team Requirements – Standard MM.09.01.01, EP 4

If an organization does not have an infectious disease physician on the antimicrobial stewardship multidisciplinary team will it receive a Requirement for Improvement (RFI)?

This depends on the availability of infectious disease physicians to serve in this capacity. The Joint Commission is aware that the composition of this multidisciplinary team may vary based on the type of organization being surveyed as well as the geographic location of the organization. This is the reason MM.09.01.01, EP 4 indicates that the four practitioners listed should be on the multidisciplinary team “when available in the setting.” However, it would not be acceptable for an organization to have a team consisting of only a pharmacist and a nurse when physicians and other licensed independent practitioners are available in the organization (e.g., an infectious disease consultation team exists).

Note: Some organizations such as critical access hospitals and nursing care centers may not have the Medication Management System Tracer. In these cases, antimicrobial stewardship will be evaluated during other scheduled activities, such as Orientation to the Organization, Data Use System Tracer, and Individual Patient Tracers.

Antimicrobial Stewardship – Organizational Priority – Standard MM.09.01.01 EP 1

How will surveyors evaluate that an organization's leaders have established antimicrobial stewardship as an organizational priority?

During the Leadership Session, leaders should be prepared to discuss how they have established antimicrobial stewardship as an organizational priority. Surveyors may ask to review documents related to antimicrobial stewardship such as strategic plans, budget plans, and performance improvement plans.
Medication Management Chapter FAQ: Sterile Compounding

Medication – Sterile Compounding – Compounding Staff Competency Requirements

What competencies are required for personnel compounding medications in the Main Pharmacy or Satellite Pharmacy areas?

The following items are expected to be completed for all compounding staff:

- Media fill testing (representing the highest complexity level of compounding performed)
- Gloved fingertip sampling (initial and ongoing testing)
- Written didactic testing
- Evaluation of hand washing and donning PPE

The listed items are expected with the following time frames:

- Low-Risk and Medium-Risk* Sterile Compounding: Annually for staff performing (defined as every 12 months +/- one month.)
- High-Risk Sterile Compounding*: Every 6 months

* NOTE: Sterile compounding risk levels are adapted from USP 797

Medication – Sterile Compounding – Extending Beyond Use Dates (BUD) with Closed System Transfer Devices (CSTD)

Can a Closed System Transfer Device be utilized to extend the beyond use date of a single dose container?

The Joint Commission would evaluate compliance with the use of a closed system transfer device (CSTD) based on the FDA approved indications of a device. Based on feedback received directly from the FDA, the extension of a beyond use date beyond 6 hours for a single dose vial has not been approved as an indication.

The Joint Commission is aware of published articles which supports the use of these devices to extend beyond use dating longer than the 6 hours allowed for a single dose vial. However, this has not been approved by the FDA and is not supported as a standard of practice.

Medication – Sterile Compounding – Low Volume Hazardous Medication Preparation

Our Organization compounds a small quantity of hazardous medications. Are there any special requirements we should follow?

Ideally, hazardous medications would be compounded in a negative pressure environment. Currently, according to USP 797, if an organization prepares a low volume of hazardous drugs, the use of two tiers of containment is acceptable in a non-negative pressure area. An example of 2-tier containment would be the use of a closed system transfer device utilized within a biological safety cabinet or compounding aseptic containment isolator.
Medication – Sterile Compounding – Nurse Competency Requirements

Are we required to do Finger Tip Testing and Media Fill Testing on nurses who compound emergent-use items outside of the pharmacy?

No, immediate-use Compounding is reserved for situations where an immediate/urgent need for medications is present and a delay in waiting for the pharmacy to compound items could delay care and for items with limited stability once compounded. Therefore, The Joint Commission will not evaluate staff performing this type of compounding with an expectation that they have Finger Tip and Media Fill testing completed as a component of their competencies.

Medication – Sterile Compounding – Personal Protective Equipment (PPE) Requirements with Compounding Isolators

What Personal Protective Equipment (PPE) should be worn when compounding sterile products in a Compounding Aseptic Isolator (CAI) or Compounding Aseptic Containment Isolator (CACI)?

The same personal protective equipment expected in a clean room when compounding in a laminar workflow bench are required when utilizing a CAI or CACI unless the manufacturer has written information based on validated environmental testing that any component(s) of PPE or personnel cleansing are not required. This includes double gloving for the preparation of hazardous medications.

Medication – Sterile Compounding – Primary Engineering Control (PEC) Testing/Certification Requirements

What testing is required for our Primary Engineering Controls (Laminar Air Flow Work Bench; Compounding Aseptic Isolator, Biological Safety Cabinets, etc.)?

The following items are expected to be tested at a minimum with a frequency not to exceed 6 month intervals. Lack of testing of these items will result in non-compliance with Joint Commission standards.

- ISO level of the primary engineering control
- Viable particle testing surface of the primary engineering control
- Viable particle testing air within the primary engineering control
- HEPA filter leak test of the primary engineering control
- Evidence of remediation/retesting if assessed levels were not in compliance with those listed in USP 797

Medication – Sterile Compounding - Secondary Engineering Control (SEC) Testing/Certification Requirements

What testing is required for our Secondary Engineering Controls?

The following items are expected to be tested at a minimum with a frequency not to exceed 6 month intervals. Lack of testing of these items will result in non-compliance with Joint Commission standards.

- Air exchanges per hour of the buffer area
- Pressure differential (between buffer area/ante area; ante area/non-classified area)
- ISO level of the buffer area and ante area
- Viable particle testing surface of the buffer area and ante area
- Viable particle testing air-HEPA filter leak test of HVAC HEPA filter system
- Evidence of remediation/retesting if assessed levels were not in compliance with those listed in USP 797
Medication – Sterile Compounding – Segregated Compounding Area (SCA)

Our hospital has a segregated compounding area in the Emergency Department with an IV hood. Are there any restrictions on what medications can be compounded in that area?

Organization may utilize a segregated compounding area to prepare items classified as Low Risk Level Compounding as long as the beyond use date does not extend beyond 12 hours. Low Risk items are defined as those items prepared in an ISO 5 environment which:

1. The compounding involves only transfer, measuring, and mixing manipulations using not more than three commercially manufactured packages of sterile products and not more than two entries into any one sterile container or package (e.g., bag, vial) of sterile product or administration container/device to prepare the CSP.

2. Manipulations are limited to aseptically opening ampules, penetrating disinfected stoppers on vials with sterile needles and syringes, and transferring sterile liquids in sterile syringes to sterile administration devices, package containers of other sterile products, and containers for storage and dispensing.

Medication – Sterile Compounding – Testing/Certification Remediation Requirements for Primary and Secondary Engineering

If our Primary Engineering Control or Secondary Engineering Control certification/testing reports show a value outside of acceptable limits, what should we do?

Organizations are required to develop a remediation program to address the identified issue which must include retesting the tested components which were out of range. The remediation process should include an overall review of compliance with procedures including those of compounding staff, cleaning processes and products, and air filtration efficiency. These should be evaluated to identify any potential adverse impact affecting testing results.

Medication – Sterile Compounding – Unit Dose Alcohol Swabs

Can an alcohol swab be utilized on more than one vial septum or bag injection entry point?

The current standard of practice does not allow for alcohol swabs to touch another object prior to its use when cleaning a critical point (i.e. vial septum, ampule neck, or injection entry port on an IV bag). If this is identified during a survey, it will be scored as non-compliant with Joint Commission Standards as an infection control risk.

Medication – Sterile Compounding – Using Primary and Secondary Engineering Controls with Testing/Certification Failures

Can we still use our Primary Engineering Control if it fails its testing/certification?

It is up to the organization to determine whether or not the compounding space is acceptable to continue producing sterile compounded medication products. Factors should include the pathogenicity of the organism grown in the positive growth viable sample; complexity level of the compounded product; any known/potential associated hospital acquired infections; and guidance from the infection control practitioner.
Medication Management Chapter FAQs: Managing Medication Shortages

Medication Selection and Procurement – Managing Medication Shortages

What are The Joint Commission requirements for managing medication shortages?

Organizations are required to establish a process for communicating medication shortages to Licensed Independent Practitioners (LIP) and staff who participate in medication management (MM.02.01.01). Examples of 'staff' may include those responsible for ordering, preparing, stocking, storing and administering medications. Each organization determines the most effective means of communicating this information to key constituents.

While not required, organizations may wish to consider several different means of communicating this information. Examples may include emails, medical staff newsletters, daily staff briefings and huddles, alerts posted in dictation/documentation stations often used by LIPs, medication dispensing stations, etc. Periodic assessment of the effectiveness of the communication process should be conducted to ensure compliance with organizational requirements.

The timeframe for receiving notice of medication shortages is often short and preparing for shortages can be time-consuming and difficult, therefore, advanced planning is crucial. If the organization intends to automatically substitute medications during times of shortage, organizations are required to develop written medication substitution protocols. Such protocols must be approved by leadership and the medical staff. The intent of these protocols is to allow for automatic substitutions which would be utilized if the ordering practitioner had not indicated an alternative medication to an individual patient order. If providers are expected to determine and order an alternative medication or dosage form, then the protocol would not be required.

If the substitution is made to items located in floor stock or crash carts, where an individual might retrieve a product different than what would be typically used, an approved substitution protocol would also be required. This would apply to substituting: dosage form; route; concentration (strength); or medication. Staff education should be conducted for those assigned to those areas affected by medication shortages and where the substitution may occur.

To ensure reduction of risk from variations introduced as a result of shortages, compliance with substitution practices should be included when evaluating the effectiveness of all medication management systems (see MM.08.01.01). One example may be to review medication errors/adverse drug events to determine if a medication shortage was directly or indirectly associated with the event. The focus of this evaluation would be to identify performance improvement opportunities and implement risk reduction strategies that can be applied to subsequent shortages. Organizations may also find it helpful to develop a safety checklist that addresses each step of medication management systems when dealing with medication shortages.

Additional Resources:

Individual State Pharmacy Boards
Approved: New Antimicrobial Stewardship Standard

The Joint Commission Perspectives, July 2016, Volume 36, Number 7

The Joint Commission recently announced a new Medication Management (MM) standard for hospitals, critical access hospitals, and nursing care centers. Standard MM.09.01.01 addresses antimicrobial stewardship and becomes effective January 1, 2017.

Current scientific literature emphasizes the need to reduce the use of inappropriate antimicrobials in all health care settings due to antimicrobial resistance. According to the World Health Organization (WHO): “Antimicrobial resistance threatens the effective prevention and treatment of an ever-increasing range of infections caused by bacteria, parasites, viruses and fungi.”¹ The Centers for Disease Control and Prevention (CDC) identified that 20%–50% of all antibiotics prescribed in US acute care hospitals are either unnecessary or inappropriate.² The CDC has also stated: “Antibiotics are among the most commonly prescribed medications in nursing homes. Up to 70% of long-term care facilities’ residents receive an antibiotic every year.”³

On June 2, 2015, The Joint Commission participated in the White House Forum on Antibiotic Stewardship. The Joint Commission joined representatives from more than 150 major health care organizations, food companies, retailers, and animal health organizations at the forum to express commitment for implementing changes over the next five years to slow the emergence of antibiotic-resistant bacteria, detect resistant strains, preserve the efficacy of existing antibiotics, and prevent the spread of resistant infections.⁴

Subsequently, The Joint Commission developed the antimicrobial stewardship standard for hospitals, critical access hospitals, nursing care centers, ambulatory care organizations, and office-based surgery practices and conducted a field review in November and December 2015. Prior to and during the field review, Joint Commission staff conducted stakeholder calls on the proposed antimicrobial stewardship standard with several governmental and professional organizations, including the Centers for Medicare & Medicaid Services (CMS), the CDC, and the Society for Healthcare Epidemiology of America (SHEA).

There was significant support for the antimicrobial stewardship standard for the hospital, critical access hospital, and nursing care center accreditation programs. Additionally, CMS is in the process of developing a Condition(s) of Participation (CoP) on antimicrobial stewardship for the hospital and nursing home settings, which therefore aligns the Joint Commission’s standard with CMS’s plans for a CoP(s) in this area. In the meantime, the antimicrobial stewardship standard for Joint Commission–accredited ambulatory care organizations and office-based surgery practices is still in development.

The approved antimicrobial stewardship standard and EPs are shown in the box that begins below and will also be displayed on The Joint Commission website at http://www.jointcommission.org/standards_information/prepublication_standards.aspx. In addition, the requirements will be posted in the fall 2016 E-dition® update and published in the 2017 Comprehensive Accreditation Manual for the Critical Access Hospital, Hospital, and Nursing Care Center Accreditation Programs.

Questions regarding the new antimicrobial stewardship standard may be directed to Kelly Podgorny, DNP, CPHQ, RN, project director, Department of Standards and Survey Methods, The Joint Commission, at kpodgorny@jointcommission.org.

References
Official Publication of Joint Commission Requirement

New Antimicrobial Stewardship Standard

Applicable to Hospitals and Critical Access Hospitals

Effective January 1, 2017

Medication Management (MM)

Standard MM.09.01.01

The [critical access] hospital has an antimicrobial stewardship program based on current scientific literature.

Elements of Performance for MM.09.01.01

1. Leaders establish antimicrobial stewardship as an organizational priority. (See also LD.01.03.01, EP 5)

   Note: Examples of leadership commitment to an antimicrobial stewardship program are as follows:
   - Accountability documents
   - Budget plans
   - Infection prevention plans
   - Performance improvement plans
   - Strategic plans
   - Using the electronic health record to collect antimicrobial stewardship data

2. The [critical access] hospital educates staff and licensed independent practitioners involved in antimicrobial ordering, dispensing, administration, and monitoring about antimicrobial resistance and antimicrobial stewardship practices. Education occurs upon hire or granting of initial privileges and periodically thereafter, based on organizational need.

3. The [critical access] hospital educates patients, and their families as needed, regarding the appropriate use of antimicrobial medications, including antibiotics. (For more information on patient education, refer to Standard PC.02.03.01)

   Note: An example of an educational tool that can be used for patients and families includes the Centers for Disease Control and Prevention’s Get Smart document, “Viruses or Bacteria—What’s got you sick? at http://www.cdc.gov/getsmart/community/downloads/getsmart-chart.pdf.

4. The [critical access] hospital has an antimicrobial stewardship multidisciplinary team that includes the following members, when available in the setting:
   - Infectious disease physician
   - Infection preventionist(s)
   - Pharmacist(s)
   - Practitioner

   Note 1: Part-time or consultant staff are acceptable as members of the antimicrobial stewardship multidisciplinary team.

   Note 2: Telehealth staff are acceptable as members of the antimicrobial stewardship multidisciplinary team.

5. The [critical access] hospital’s antimicrobial stewardship program includes the following core elements:
   - Leadership commitment: Dedicating necessary human, financial, and information technology resources.
   - Accountability: Appointing a single leader responsible for program outcomes. Experience with successful programs shows that a physician leader is effective.
   - Drug expertise: Appointing a single pharmacist leader responsible for working to improve antibiotic use.
   - Action: Implementing recommended actions, such as systemic evaluation of ongoing treatment need, after a set period of initial treatment (for example, “antibiotic time out” after 48 hours).
   - Tracking: Monitoring the antimicrobial stewardship program, which may include information on antibiotic prescribing and resistance patterns.
New Antimicrobial Stewardship Standard (continued)

- Reporting: Regularly reporting information on the antimicrobial stewardship program, which may include information on antibiotic use and resistance, to doctors, nurses, and relevant staff.
- Education: Educating practitioners, staff, and patients on the antimicrobial program, which may include information about resistance and optimal prescribing. *(See also IC.02.01.01, EP 1 and NPSG.07.03.01, EP 5)*

**Note:** These core elements were cited from the Centers for Disease Control and Prevention’s Core Elements of Hospital Antibiotic Stewardship Programs (http://www.cdc.gov/getsmart/healthcare/pdfs/core-elements.pdf). The Joint Commission recommends that organizations use this document when designing their antimicrobial stewardship program.

6. The [critical access] hospital’s antimicrobial stewardship program uses organization-approved multidisciplinary protocols (for example, policies and procedures).

**Note:** Examples of protocols are as follows:
- Antibiotic Formulary Restrictions
- Assessment of Appropriateness of Antibiotics for Community-Acquired Pneumonia
- Assessment of Appropriateness of Antibiotics for Skin and Soft Tissue Infections
- Assessment of Appropriateness of Antibiotics for Urinary Tract Infections
- Care of the Patient with Clostridium difficile (c.-diff)
- Guidelines for Antimicrobial Use in Adults
- Guidelines for Antimicrobial Use in Pediatrics
- Plan for Parenteral to Oral Antibiotic Conversion
- Preauthorization Requirements for Specific Antimicrobials
- Use of Prophylactic Antibiotics

7. The [critical access] hospital collects, analyzes, and reports data on its antimicrobial stewardship program.

**Note:** Examples of topics to collect and analyze data on may include evaluation of the antimicrobial stewardship program, antimicrobial prescribing patterns, and antimicrobial resistance patterns.

8. The [critical access] hospital takes action on improvement opportunities identified in its antimicrobial stewardship program. *(See also MM.08.01.01, EP 6)*
Consistent Interpretation Joint Commission Surveyors’ Observations on MM.03.01.03, EPs 1–3

The Joint Commission Perspectives, July 2016, Volume 36, Number 7

The bimonthly Consistent Interpretation column is designed to support standards compliance efforts. Each column draws from a de-identified database containing surveyors’ observations—as well as guidance from the Standards Interpretation Group on how to interpret the observations—on one or more elements of performance (EPs) in the Comprehensive Accreditation Manual for Hospitals. This installation (the fourth in the series) highlights three of the four requirements for Medication Management (MM) Standard MM.03.01.03 (EPs 1–3).

Note: Interpretations are subject to change to allow for unique and/or unforeseen circumstances.

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<thead>
<tr>
<th>Medication Management (MM) Standard MM.03.01.03: The hospital safely manages emergency medications.</th>
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<tr>
<td><strong>EP 1:</strong> Hospital leaders, in conjunction with members of the medical staff and licensed independent practitioners, decide which emergency medications and their associated supplies will be readily accessible in patient care areas based on the population served.</td>
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<th>Surveyor Observations</th>
<th>Guidance/Interpretation</th>
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<tr>
<td>There was no evidence that hospital leaders consulted with the medical staff to determine which emergency medications and supplies would be readily available for specific populations served, such as pediatrics.</td>
<td>“Readily available” items may be described as the specific medication(s) that, while they may not be on a crash cart, are available elsewhere and without delay. Organizations should consider conducting a risk assessment to ensure emergency medications are readily available when not contained within an emergency cart. The risk assessment should include staff knowledge as to where such medications are located.</td>
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| **EP 2:** Emergency medications and their associated supplies are readily accessible in patient care areas. (See also PC.03.01.01, EP 8) |

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<tr>
<th>Surveyor Observations</th>
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<td>Staff were unable to articulate where the malignant hyperthermia cart containing dantrolene was stored and where additional vials of dantrolene or Ryanodex® could be obtained. In some cases, the organization had secured emergency medications on crash carts with combination or keyed padlocks. In other cases, expired dantrolene was noted in the malignant hyperthermia emergency box.</td>
<td>The organization should define and follow what is meant by “readily accessible.” These meds need not be on the crash cart, for example, but the Malignant Hyperthermia Association of the United States (MHAUS) does recommend having 36 vials of (unexpired) dantrolene available. Some health care organizations may be transitioning to a product called Ryanodex®, which is a concentrated, soluble form of dantrolene containing 50 mg/ml of the drug. Each vial contains 250 mg of dantrolene sodium in lyophilized powder form requiring 5 mL of sterile water for reconstitution. MHAUS recommends that health care organizations have three vials available. The vials may be divided between the obstetrics operating room and the main operating room with the understanding that the additional vials can be immediately available. The “associated supplies” addressed in this EP are specific to administration of emergency medications. For nonmedication-related emergency supplies, see Provision of Care, Treatment, and Services (PC) Standard PC.02.01.11, EP 2.</td>
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| **EP 3:** Whenever possible, emergency medications are available in unit-dose, age-specific, and ready-to-administer forms. |

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<th>Surveyor Observations</th>
<th>Guidance/Interpretation</th>
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<tr>
<td>Multidose vials were observed in a crash cart when unit-dose vials were readily available. In addition, although infant-dose unit-dose vials of resuscitation medication were stocked, there were no pediatric-dose or unit-dose vials available where pediatric surgery or procedures were performed.</td>
<td>“Readily available” may signify that a specific medication in a multidose vial on the crash cart is available elsewhere within the health care organization as a unit-dose vial. Nonemergency medications are cited at Standard MM.03.01.01, EP 10. If multidose vials are used, the organization should be prepared to discuss the rationale behind not using unit-dose emergency medications.</td>
</tr>
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Revised Medication Management EPs Across Programs

The Joint Commission Perspectives, August 2017, Volume 37, Number 8

Effective January 1, 2018, The Joint Commission has edited its Medication Management (MM) standards for the ambulatory care, behavioral health care, critical access hospital, home care, hospital, nursing care center, and office-based surgery practice programs to assure that they continue to reflect evidence-based practices and quality and safety issues that have emerged from the field in recent years. (During the review, it was determined that some additions and revisions also were needed for Environment of Care [EC] standards and Record of Care, Treatment, and Services [RC] standards.)

The Joint Commission conducted a field review of all proposed revisions in September and October of 2016. The final changes require organizations to take the following actions:

• Implement a policy to provide emergency backup for essential medication dispensing equipment identified by the organization.
• Implement a policy to provide emergency backup for essential refrigeration for medications identified by the critical access hospital.
• Manage hazardous medications in behavioral health care settings that engage in the medication management processes.
• Add “wasting” of medications to the required written policy addressing the control of medications between when they are received by an individual health care provider and when they are administered.
• Implement a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews when automatic dispensing cabinets are used.
• Record, in the patient’s clinical record, the date and time of any medication administered.

Not all new requirements and revisions are applicable to all accreditation programs. To view these updates by accreditation program, please refer to the prepublished standards on The Joint Commission website at https://www.jointcommission.org/standards_information/prepublication_standards.aspx. These revisions will be published in the fall 2017 E-dition® and print updates for the Comprehensive Accreditation Manuals.

For more information, please contact Kelly Podgorny, DNP, RN, project director, Department of Standards and Survey Methods, The Joint Commission at kpodgorny@jointcommission.org.
Clarification: Use of Secure Text Messaging for Patient Care Orders Is Not Acceptable

The Joint Commission Perspectives, December 2016, Volume 36, Number 12

In 2011 The Joint Commission published a Frequently Asked Question (FAQ) document stating that it is not acceptable for physicians or licensed independent practitioners (LIPs) to text orders for patient care, treatment, or services to hospitals or other health care settings. At the time, the technology available could not provide the safety and security necessary to adequately support the use of text messaging for orders.

In the May 2016 issue of Perspectives, The Joint Commission acknowledged that technology has advanced and secure text messaging platforms now offer the functionality to address all of the data privacy and security concerns outlined in the 2011 FAQ. As such, The Joint Commission revised its previous position to allow LIPs or other practitioners, in accordance with professional standards of practice, law and regulation, and policies and procedures, to use a secure text messaging platform to send orders as long as the system met specific requirements and all the typical required components of an order are included.

Following publication of the May Perspectives article, The Joint Commission determined that although its prior data privacy and security concerns had been addressed, concerns remained about transmitting text orders even when a secure text messaging system is used. In collaboration with the Centers for Medicare & Medicaid Services (CMS), The Joint Commission developed the following recommendations:

- All health care organizations should have policies prohibiting the use of unsecured text messaging—that is, short message service (SMS) text messaging from a personal mobile device—for communicating protected health information. Joint Commission Information Management (IM) Standard IM.02.01.01, Element of Performance (EP) 1 requires organizations to have a written policy addressing the privacy of health information, and this requirement applies to the privacy of health information transmitted through text messaging. Organizations are expected to incorporate limitations on the use of unsecured text messaging in their policies protecting the privacy of health information. This policy should be routinely discussed during orientation of all practitioners and staff working in the facility.

- The Joint Commission and CMS agree that computerized provider order entry (CPOE) should be the preferred method for submitting orders as it allows providers to directly enter orders into the electronic health record (EHR). CPOE helps ensure accuracy and allows the provider to view and respond to clinical decision support (CDS) recommendations and alerts. CPOE is increasingly available through secure, encrypted applications for smartphones and tablets, which will make following this recommendation less burdensome.

- In the event that a CPOE or written order cannot be submitted, a verbal order is acceptable. However, verbal orders should be used infrequently, and the use of verbal orders should be closely monitored to ensure that these are used only when it is impossible or impractical to use CPOE or written orders without delaying treatment. Verbal orders are not to be used for the convenience of the ordering practitioner. The requirements around the use of verbal orders are included in both the Joint Commission standards and the Medicare Conditions of Participation (CoPs).
The use of secure text orders is not permitted at this time. The implementation of secure text orders was discussed with numerous text messaging platform vendors, experts in EHRs, and other key stakeholders. After extensive discussion weighing the pros and cons of using secure text messaging systems to place orders, The Joint Commission and CMS have concluded that the impact of secure text orders on patient safety remains unclear. A variety of issues were identified that influenced this decision, including the following:

- The implementation of an additional mechanism to transmit orders may lead to an increased burden on nurses to manually transcribe text orders into the EHR. This could adversely affect nurses’ ability to do their other critical patient care duties.

- The transmission of a verbal order allows for a real-time, synchronous clarification and confirmation of the order as it is given by the ordering practitioner. As the process for texting an order is an asynchronous interaction, an additional step(s) is required to contact the ordering practitioner for any necessary discussion prior to order entry.

- In the event that a CDS recommendation or alert is triggered during the order entry process, the individual manually entering the order into the EHR may need to contact the ordering practitioner for additional information. If this occurs during transmission of a verbal order, the conversation is immediate. If this occurs with a text order, the additional step(s) required to contact the ordering practitioner may result in a delay in treatment.

The Joint Commission and CMS will continue to monitor advancements in the field and engage with key stakeholders to determine whether future guidance on the use of secure text messaging systems to place orders is necessary. In the meantime, questions may be directed to textingorders@jointcommission.org.
Appendix A: Resources

**Print Resources**

*JCR periodical articles can be purchased on PubMed via Ingenta* ([http://www.ingentaconnect.com/](http://www.ingentaconnect.com/)).

**Electronic Resources**

The Joint Commission: [http://www.jointcommission.org](http://www.jointcommission.org)

Joint Commission Resources: [http://www.jcrinc.com](http://www.jcrinc.com)

**NOTE:** The Internet is an ever-evolving environment and links are subject to change without notice.
Appendix B: Faculty Biographies

NOTE: These presenters do not have any financial arrangements or affiliations with corporate organizations that either provide educational grants to this program or may be referenced in this activity. These presenters have also attested that their discussion will not include any unapproved or off-label use of products.

Don R. Janczak, PharmD, MS, BCPS, CPHQ
Consultant
Joint Commission Resources, Inc.

Dr. Don Janczak brings over 30 years of clinical and administrative health system experience to Joint Commission Resources. Dr. Janczak is a Corporate Director of Pharmacy Services for an integrated healthcare delivery system located in Southcentral Wisconsin and Northern Illinois. Prior to joining Joint Commission Resources, Dr. Janczak served as a Joint Commission hospital surveyor on an intermittent basis.

Dr. Janczak has experience leading teams in the provision of evidence-based clinical practice decision-making about drug use, controlling pharmaceutical expenses, patient safety and regulatory compliance, formulary management, and maximizing patient and organizational benefit through the use pharmacy services across a continuum of care. He has a strong knowledge of pharmaceutical supply chain, clinical therapeutics, physician prescribing habits, medication management systems, healthcare quality and patient safety, medication use policy development and the technology used to deliver and support patient care. As a pharmacy executive he is responsible for overseeing the design, implementation, and management of safe and effective medication management systems in the acute care hospital and retail pharmacy setting.

Dr. Janczak has over 15 years of experience in the academic setting as clinical faculty and lecturer for the University of Wisconsin – Milwaukee College of Nursing, where he has instructed in the area of pharmacology both at the undergraduate and graduate level. Dr. Janczak is a registered pharmacist licensed in Wisconsin and Illinois.

Burton L. Thelander, RN, MS, NE-BC
Field Representative, The Joint Commission
Performance Improvement Specialist, NYU-Langone Hospitals

Burton Thelander currently is a resident of New York State. He surveys the standards in the Comprehensive Accreditation Manual for Hospitals and Behavioral Health Care and presently is a surveyor in the Hospital and Behavioral Health Accreditation Program.

Mr. Thelander is employed part time at NYU Langone Medical Center in New York, New York as a Performance Improvement Specialist. Prior to joining The Joint Commission, Mr. Thelander was a Director of Nursing and Director of Advanced Practice within the New York State Office of Mental Health inpatient and outpatient behavioral health service.

Mr. Thelander is certified as a Nurse Executive by the American Nurse Credentialing Center and currently is licensed in New York State as a Professional Registered Nurse.
Appendix C: Continuing Education (CE) Accrediting Bodies

To be eligible for CE credit from any of the following accrediting bodies, you MUST view the video presentation and read the Resource Guide first. Then, complete the post test at http://twnlms.com/ by the due date listed online. See Appendix E.

The Joint Commission is accredited by the Accreditation Council for Continuing Medical Education (ACCME-AMA PRA Category 1™), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

Live activity ACPE #0573-0000-18-025-L05-P; Enduring ACPE #0573-0000-18-025-H05-P

The Joint Commission is provider approved by the California Board of Registered Nursing, provider number CEP 6381, for 1 contact hour.

The Joint Commission is authorized to award 1.0 contact hour of pre-approved ACHE Qualified Education credit for this program toward advancement or recertification in the American College of Healthcare Executives. Participants in this program wishing to have the continuing education hours applied toward ACHE Qualified Education credit should indicate their attendance when submitting application to the American College of Healthcare Executives for advancement or recertification.

This activity has been approved by the National Association for Healthcare Quality (NAHQ) for 1.0 Certified Professional Healthcare Quality (CPHQ) credit.

The Joint Commission Enterprise has been accredited as an Authorized Provider by the International Association for Continuing Education and Training (IACET).

This education offering qualifies for 1.0 Certified Joint Commission Professional (CJCP) credit hours towards CJCP recertification. In order to obtain CJCP credit hours, an individual must first be certified before they start acquiring CJCP credit hours. CJCP credit hours will not be retroactive.

Full attendance at every session is a prerequisite for receiving full continuing education credits. If a participant needs to leave early, his or her continuing education credits will be reduced.

Successful completion of this CE activity includes the following:

• View the presentation and read the accompanying Resource Guide.
• Complete the online Evaluation Form and Post Test.
• A CE certificate/statement of credit can be printed online following successful completion of the Post Test and the Evaluation Form.

NOTE: This information applies to The Joint Commission Resources Quality & Safety Network program titled, Medication Management: A Standards Update, originally presented on Thursday, April 26, 2018 from 2:00 – 3:00 p.m. ET. There is no individual participant fee for this educational activity.
Appendix D: Discipline Codes Instructions

Some of our programs are accredited for more than one discipline. To ensure that we issue each participant a certificate by the appropriate accrediting body, we ask that you supply us with the following information: 1) two-digit discipline code. 2) followed by the position code (example: for a medical doctor, use 10 MD).

<table>
<thead>
<tr>
<th>Discipline (CME)</th>
<th>Discipline Code</th>
<th>Position Code</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Physician</td>
<td>10 MD</td>
<td>RT</td>
<td>Respiratory Therapist, Registered</td>
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<tr>
<td></td>
<td>MDFP MD-Family Practice</td>
<td>RTC</td>
<td>Respiratory Therapist, Certified</td>
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<tr>
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<td>MDPS MD-Psychiatrist</td>
<td>RPNC</td>
<td>Resp. Practitioner, Non-Critical Care</td>
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<td></td>
<td>MDPH MD-Public Health Certificate</td>
<td>RPCC</td>
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<td></td>
<td>MDPP MD-Public Psychiatry Certificate</td>
<td>RHA</td>
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<td></td>
<td>MDAC MD-Area Clinical Needs</td>
<td>RHT</td>
<td>Health Information Technician</td>
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<tr>
<td></td>
<td>MDFM MD-Medical Faculty Certificate</td>
<td>CCS</td>
<td>Coding Specialist</td>
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<td></td>
<td>MSP MD-Medical Staff Physician</td>
<td>CCP</td>
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<tr>
<td></td>
<td>MDLL MD-Limited License</td>
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<tr>
<td></td>
<td>DO</td>
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<td></td>
<td>PHA Physician Assistant</td>
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<td></td>
<td>DDS Doctor of Dental Science</td>
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<td></td>
<td>OP Other Medical Professional</td>
<td>Health Information Administrator</td>
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<td></td>
<td>40 HA Hospital Administrator</td>
<td>Health Information Technician</td>
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<td>Administration</td>
<td>12 HA</td>
<td>RHT</td>
<td>Health Information Technician</td>
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<td></td>
<td>ADM LTC Administrator</td>
<td>CCS</td>
<td>Coding Specialist</td>
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<tr>
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<td>OA Other Administrator</td>
<td>CCP</td>
<td>Coding Specialist, Physician-Based</td>
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<tr>
<td>Pharmacy</td>
<td>13 PH</td>
<td>Rad</td>
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<td>PHN Pharmacist, Nuclear</td>
<td>Resp. Practitioner, Non-Critical Care</td>
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<td>PHC Pharmacist, Consultant</td>
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<td></td>
<td>PA Pharmacy Technician</td>
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<td>RD Registered Dietitian/Nutritionist</td>
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<td>NC Nutrition Counselor</td>
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<td>DTR Dietetic Technician</td>
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<td>Dietary</td>
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<td>Registered Nurse</td>
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<td>Advanced RN Practitioner</td>
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<td>Nurse Practitioner</td>
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<tr>
<td></td>
<td>LC Other Medical Professional</td>
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<tr>
<td></td>
<td>15 DOD Dietary Manager</td>
<td>Other Nursing Professional</td>
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<td>Counseling</td>
<td>16 MHC</td>
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<td>SW Social Worker, Licensed</td>
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<td>OCT Other Counselor/Therapist</td>
<td>Licensed Practical Nurse (or LVN)</td>
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<td>MFT Marriage/Family Therapist, Licensed</td>
<td>Other Nursing Professional</td>
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<tr>
<td>Laboratory</td>
<td>17 LGT</td>
<td>Registered Nurse</td>
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<td></td>
<td>LT Laboratory Technician</td>
<td>Nurse Practitioner</td>
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<td>LS Laboratory Supervisor</td>
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<td>LD Laboratory Director</td>
<td>Other Nursing Professional</td>
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<td>Physical Therapy</td>
<td>18 PT</td>
<td>Registered Nurse</td>
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<td></td>
<td>PTA Physical Therapy Assistant</td>
<td>Nurse Practitioner</td>
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<tr>
<td>Occupational Therapy</td>
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<td>OTA Occupational Therapy Assistant</td>
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<tr>
<td>Other</td>
<td>27 OTH</td>
<td>Other Nursing Professional</td>
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</tbody>
</table>
Appendix E: Post-Test

To be eligible for CE credit, you MUST view the video presentation and read the Resource Guide first. Then complete the post-test at http://jcrqsn.twnlms.com/ by the due date listed online.

1. Which of the following is a core element of a hospital's Antimicrobial Stewardship Program?
   a. Leadership commitment
   b. Accountability
   c. Drug expertise
   d. All of the above.

2. _____ are key stakeholders in an Antimicrobial Stewardship Program.
   a. Pharmacists
   b. Infection control practitioners
   c. Physicians
   d. All of the above.

3. _____ orders are NOT an acceptable medication order type.
   a. Standing
   b. Range
   c. Text message
   d. Titration

4. With regard to medication orders, to use a protocol there must be an order in the patient's chart for the use of the protocol and a copy of the protocol in the chart.
   a. True
   b. False

5. _____ are/is (a) required element(s) for a titration medication order.
   a. Medication name, route of administration, and starting rate of infusion
   b. Incremental dosing and frequency
   c. Maximum rate of infusion
   d. An objective clinical endpoint
   e. All of the above.

6. A key component and strategy in the assessment of a sterile medications compounding program includes _____.
   a. reviewing certification testing of the compounding environment
   b. evaluating staff handwashing and PPE garbing
   c. confirming proper beyond-use dating based on the level of risk for compounding
   d. visual observation and didactic testing of IV personnel
   e. All of the above.

7. A standing order is an order that may be initiated by the RN without an initial order from a physician or LIP, if the patient meets certain criteria.
   a. True
   b. False
8. A key component of a malignant hyperthermia medical management program in a surgical suite setting includes _____.
   a. the staff’s ability to identify the location of a malignant hyperthermia treatment cart
   b. the staff’s training on the use of the malignant hyperthermia cart and its contents
   c. mock drills, including evaluation and continued improvement
   d. All of the above.

9. The decision-making process in the management of drug shortages includes _____.
   a. engaging key stakeholders after plans have been implemented and data has been collected
   b. confirming the nature of the shortage and assessing the impact of the shortage on patient care
   c. identifying and implementing mitigating strategies
   d. establishing and communicating the plan
   e. All of the above.

10. The hospital has a written policy addressing the control of medications between receipt by the individual healthcare provider and administration of the medication, including safe storage, handling, security, disposition, and return to storage. Wasting of medications is suggested to be included in the policy, but is not a requirement.
   a. True
   b. False
Appendix F: JCRQSN Contact Information

General information, customer service issues, or program reception issues
JCRQSN Customer Service Team
support@jcrqsn.com
toll-free 1-888-219-4678

Questions or comments about JCRQSN educational programming
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Questions about standards
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