

Revisions to the CAMH Manual Effective July 1, 2006

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Revisions related to Telemedicine (standards MS.4.20, MS.4.120, LD.3.50)

MS.4.20

B 6. Before granting privileges, the organized medical staff evaluates the following:

- Challenges to any licensure or registration
- Voluntary and involuntary relinquishment of any license or registration
- Voluntary and involuntary termination of medical staff membership
- Voluntary and involuntary limitation, reduction, or loss of clinical privileges
- Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
- Documentation as to the applicant's health status
- Relevant practitioner-specific data are compared to aggregate data, when available
- ~~Morbidity and mortality data, when available~~ Performance Measurement Data including morbidity and mortality data, when available

Telemedicine

Introduction to MS.4.120

The services covered under these standards are narrowly defined, focusing solely on licensed independent practitioners who have either total or shared responsibility for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment, and services) through a telemedicine¹ link. Licensed independent practitioners who provide official readings of images, tracings, or specimens (interpretive services) through a telemedicine link are credentialed and privileged under the contracted services standard LD.3.50.

If the organization has a pressing clinical need and a practitioner can supply that service through a telemedicine link, the organization can evaluate the use of temporary privileges (standard MS.4.100) for this clinical situation.

These standards introduce the concept of credentialing and privileging by proxy. Under special circumstances, the originating site (the site where the patient is located at the time the service is provided) is allowed to accept the credentialing and privileging decisions of the distant site (the site where the practitioner providing the professional service is located). As in all other standards, these standards assume that the organization is following applicable law and regulation such as appropriate licensure to practice medicine or telemedicine in the states where the originating sites and distant sites are located. This approach involves the following:

¹ **Telemedicine** The use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services. **Source:** *American Telemedicine Association*.

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- Reduces the credentialing and privileging burden for the originating site, especially where there are large numbers of licensed independent practitioners who might provide telemedicine services
- Recognizes that the distant site has more relevant information upon which to base its privileging decisions
- Acknowledges that the originating site may have little experience in privileging in certain specialties

Other Standards Related to the Delivery of Telemedicine

Clinical privileging decisions encompass consideration of the appropriate use of telemedicine equipment by the telemedicine practitioner. See the “[Management of the Environment of Care](#)” chapter standards EC.6.10 and EC.6.20 for additional standards related to maintaining telemedical equipment.

For Originating Sites Only

Standard MS.4.120

Licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.

Rationale for MS.4.120

The originating site retains responsibility for overseeing the safety and quality of services offered to its patients.

Elements of Performance for MS.4.120

A 1. All licensed independent practitioners who are responsible for the patient’s care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms:

- a. The originating site ~~may~~ fully privileges and credential the practitioner according to standards MS.4.10 through MS.4.110
- b. The ~~practitioner may be privileged at the~~ originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission-accredited organization

Or

- c. The originating site ~~may~~ uses the credentialing and privileging ~~information decision~~ from the distant site to make a final privileging decision if all the following requirements are met:

1. The distant site is a Joint Commission-accredited hospital or ambulatory care organization².

² In the case of an accredited ambulatory care organizations the organization must verify that the distant site made its decision using the process described in MS.4.10 through MS.4.20 (excluding EP 2 from MS.4.10 and EPs 11 and 12 from MS.4.20) This is equivalent to meeting HR.4.10 through HR.4.34 in the Comprehensive Accreditation Manual for Ambulatory Care

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LD.3.50

A 4. The nature and scope of services provided by consultation, contractual arrangements, or other agreements are defined in writing.³

A 27. When using the services of licensed independent practitioners from a Joint Commission-accredited ambulatory care organization through a telemedical link for either direct care or interpretive services, the organization can accept the credentialing and privileging decisions of a Joint Commission-accredited ambulatory provider as long as those decisions are made using the process described in MS.4.10 through MS.4.20 (excluding EP 2 from MS.4.10 and EPs 11 and 12 from MS.4.20).

Disaster Responsibilities for Non-Licensed Independent Practitioners (new standard HR.1.25)

Standard HR.1.25

The organization may assign disaster responsibilities to volunteer practitioners⁴.

Rationale for HR.1.25

When the disaster plan has been implemented (see Standard EC.4.10 for a description of emergency management planning requirements) and the immediate needs of the patients cannot be met, the organization may implement a modified process for determining qualifications and competence of volunteer practitioners (see Elements of Performance 5-8). The volunteer practitioners that are addressed by this standard only include those practitioners that are required by law and regulation to have a license, certification, or registration to practice their profession. The usual process to determine the qualifications and competence of these practitioners would not allow a volunteer practitioner to provide immediate care, treatment, and services in the event of a disaster (refer to the Glossary for definitions of disaster and emergency) due to the length of time it would take to

³ When a hospital contracts for patient care, treatment, and services rendered outside the hospital but under the control of a JCAHO-accredited organization, the primary organization can do the following:

- Specify in the contract that the contracting entity will ensure that all services provided by contracted individuals who are licensed independent practitioners will be within the scope of his or her privileges
- or
- Verify that all contracted individuals who are licensed independent practitioners and who will be providing patient care, treatment, and services have appropriate privileges, for example by obtaining a copy of the list of privileges

If the organization is providing the services of licensed independent practitioners through a telemedical link for either direct care or interpretive services they must also meet EP 27 in this standard.

When a hospital contracts for patient care, treatment, and services rendered outside the hospital and under the control of a non-JCAHO-accredited organization, all licensed independent practitioners who will be providing services are privileged by the JCAHO-accredited organization through the process described in the “Medical Staff” chapter in this manual.

⁴ Individuals who are qualified to practice a health care profession (for example, a nurse) and are engaged in the provision of care and services. Practitioners are often required to be licensed as defined by law.

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complete the process. A similar modified process for the assignment of disaster privileges for volunteer licensed independent practitioners exists at Standard MS.4.110.

While this standard allows for a method to streamline the process for determining qualifications and competence, safeguards must be in place to assure that the volunteer practitioners are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of two parts of the usual process for determining qualifications and competence must be maintained:

1. Verification of licensure, certification, or registration required to practice a profession
2. Oversight of the care, treatment, and services provided

This option to assign disaster responsibilities to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the organization and its patients, and on the qualifications of its volunteer practitioners.

There are a number of state and federal systems engaged in pre-event verification of qualifications that may facilitate the assigning of disaster responsibilities to volunteer practitioners at the time of a disaster. Examples of such systems include the Medical Reserve Corps (MRC⁵) and the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP⁶). It is expected that additional programs will emerge and evolve.

Elements of Performance for HR.1.25

A 1. Disaster responsibilities are assigned only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate patient needs.

A 2. The organization identifies in writing the individual(s) responsible for assigning disaster responsibilities.

B 3. The organization describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who are assigned disaster responsibilities.

⁵ MRC – Medical Reserve Corps units comprise of locally-based medical and public health volunteers who can assist their communities during emergencies, such as an influenza epidemic, a chemical spill, or an act of terrorism. The MRC Program was formed in 2002, in cooperation with the White House’s USA Freedom Corps, as one of the charter programs of Citizen Corps. Pre-identifying, training and organizing medical and public health professionals to strengthen their communities through volunteerism is at the core of the MRC concept. MRC volunteers offer their expertise throughout the year by supporting local public health initiatives, such as immunization and prevention activities. When an emergency community need occurs, MRC volunteers can work in coordination with existing local emergency response programs.

⁶ ESAR-VHP – The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program, created by the Health Resources and Services Administration (HRSA), allows for the advance registration and credentialing of healthcare professionals needed to augment a hospital or other medical facility to meet increased patient/victim care and increased surge capacity needs.

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B 4. The organization has a mechanism to identify volunteer practitioners that have been assigned disaster responsibilities.

B 5. Volunteer practitioners must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

- A current hospital picture identification card that clearly identifies professional designation
- A current license, certification, or registration
- Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession)
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT⁷), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
- Identification by current organization member(s) who possesses personal knowledge regarding the volunteer practitioner's qualifications

A 6. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

Note: In the extraordinary circumstance that primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster responsibilities.

B 7. The organization oversees the professional practice of volunteer practitioners.

⁷ DMAT – A group of medical and support personnel designed to provide emergency medical care during a disaster or other unusual event. The DMAT is a component of the National Disaster Medical System (NDMS). The Department of Health and Human Services in partnership with other Federal Agencies such as Department of Defense, Department of Veterans Affairs, and the Federal Emergency Management Agency administer the program.

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A 8. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer practitioner) within 72 hours related to the continuation of the disaster responsibilities initially assigned.

Disaster Privileges for Licensed Independent Practitioners (new standard MS.4.110)

Standard MS.4.110

~~Disaster privileges may be granted when the emergency management plan has been activated and the organization is unable to handle the immediate patient needs (see standard EC.4.10).~~

The organization may grant disaster privileges to volunteers eligible to be licensed independent practitioners.

Rationale for MS.4.110

~~During disaster(s) in which the emergency management plan has been activated, the CEO or medical staff president or their designee(s) has the option to grant disaster privileges. When the disaster plan has been implemented (see Standard EC.4.10 for a description of emergency management planning requirements) and the immediate needs of the patients cannot be met, the organization may implement a modified credentialing and privileging process for eligible volunteer practitioners (see Elements of Performance 5-8). The usual process to credential and privilege practitioners would not allow a volunteer practitioner to provide immediate care, treatment, and services in the event of a disaster (refer to the Glossary for definitions of disaster and emergency) due to the length of time it would take to complete the process. A similar modified process for the assignment of disaster responsibilities for volunteers that are not independent practitioners exists at Standard HR.1.25.~~

While this standard allows for a method to streamline the credentialing and privileging process, safeguards must be in place to assure that volunteer practitioners are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of two parts of the usual credentialing and privileging process must be maintained:

3. Verification of licensure
4. Oversight of the care, treatment, and services provided

This option to grant disaster privileges to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the organization and its patients, and on the qualifications of its volunteer practitioners.

There are a number of state and federal systems engaged in pre-event credentialing that may facilitate the implementation of disaster privileging of volunteers at the time of a

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disaster. Examples of such systems include the Medical Reserve Corps (MRC⁸) and the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP⁹). It is expected that additional programs will emerge and evolve.

Elements of Performance for MS.4.110

A 1. Disaster privileges are granted only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate patient needs.

A 12. The medical staff identifies in writing the individual(s) responsible for granting disaster privileges. As described in the bylaws, the individual(s) responsible for granting disaster privileges is identified.

~~A 2. The medical staff describes in writing the responsibilities of the individual(s) granting disaster privileges. (The responsible individual is not required to grant privileges to any individual and is expected to make such decisions on a case-by-case basis at his or her discretion.)~~

B 3. The medical staff describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to manage individuals oversee the professional performance of volunteer practitioners who receive disaster privileges.

A 4. The medical staff includes organization has a mechanism to allow staff to readily identify these individuals volunteer practitioners who have been granted disaster privileges.

~~A 5. The medical staff addresses the verification process as a high priority.~~

~~A 6. The medical staff begins the verification process of the credentials and privileges of individuals who receive disaster privileges as soon the immediate situation is under control.~~

⁸ MRC – Medical Reserve Corps units comprise of locally-based medical and public health volunteers who can assist their communities during emergencies, such as an influenza epidemic, a chemical spill, or an act of terrorism. The MRC Program was formed in 2002, in cooperation with the White House’s USA Freedom Corps, as one of the charter programs of Citizen Corps. Pre-identifying, training and organizing medical and public health professionals to strengthen their communities through volunteerism is at the core of the MRC concept. MRC volunteers offer their expertise throughout the year by supporting local public health initiatives, such as immunization and prevention activities. When an emergency community need occurs, MRC volunteers can work in coordination with existing local emergency response programs.

⁹ ESAR-VHP – The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program, created by the Health Resources and Services Administration (HRSA), allows for the advance registration and credentialing of healthcare professionals needed to augment a hospital or other medical facility to meet increased patient/victim care and increased surge capacity needs.

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~~A 7. This verification process is identical to the process established under the medical staff bylaws or other documents for granting temporary privileges to meet an important patient care need (see standard MS.4.100).~~

B 85. ~~The CEO or president of the medical staff or their designee(s) may grant disaster privileges upon presentation of any of the following~~ While disaster privileges are granted on a case-by-case basis, volunteers considered eligible to act as licensed independent practitioners in the organization must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

- A current picture hospital ID card that clearly identifies professional designation
-
- A current license to practice ~~and a valid picture ID issued by a state, federal, or regulatory agency~~
- Primary source verification of the license
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
- Presentation Identification by current hospital or medical staff member(s) ~~with~~ who possesses personal knowledge regarding practitioner's identity volunteer's ability to act as a licensed independent practitioner during a disaster

A 6. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

Note: In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

B 7. The medical staff oversees the professional practice of volunteer licensed independent practitioners.

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A 8. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

Emergency Management Drills (revised EC.4.20)

Introduction

Periodic testing of an emergency management plan enables organizations to assess the plan's appropriateness, adequacy, and the effectiveness of logistics, human resources, training, policies, procedures, and protocols. Exercises should stress the limits of the organization's emergency management system. The goal of this testing is to assess the organization's preparedness capabilities and performance when systems are stressed during an actual emergency or a simulated situation.

Exercises should be developed using plausible scenarios that are realistic and relevant to the organization. Events should be based on each organization's hazard vulnerability analysis (HVA), and should validate the effectiveness of the plan and identify opportunities to improve.

This standard will assist health care organizations to test their emergency management plans, identify deficiencies, and take corrective actions to continuously improve the effectiveness of their emergency management plan. Only a thorough and objective evaluation of performance during an emergency management event or a planned exercise will demonstrate how effective the organization's planning efforts have been.

It is important to communicate the strengths and weaknesses of the performance revealed by the exercise to all levels of the organization, including administration, clinical staff, governing body, and those responsible for managing the patient safety program.

Standard EC.4.20

The hospital conducts drills regularly to test emergency management.

Elements of Performance for EC.4.20

~~A 1. The hospital tests the response phase of its emergency management plan twice a year, either in response to an actual emergency or in planned drills.¹⁰~~

~~**Note:** Staff in each freestanding building classified as a business occupancy (as defined by the LSC) that does not offer emergency services nor is community-designated as a disaster-receiving station need to participate in only one emergency management drill annually. Staff in areas of the building that the organization occupies must participate in this drill.)~~

¹⁰ ~~Drills that involve packages of information that simulate patients, their families, and the public are acceptable.~~

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~~**Note:** Tabletop exercises, though useful in planning or training, are **only** acceptable substitutes for communitywide practice drills.)~~

~~A 2. Drills are conducted at least four months apart and no more than eight months apart.~~

~~A 3. Hospitals that offer emergency services or are community-designated disaster receiving stations must conduct at least one drill a year that includes an influx of volunteers or simulated patients.~~

~~A 4. The hospital participates in at least one communitywide practice drill a year (where applicable) relevant to the priority emergencies identified in its hazard vulnerability analysis. The drill assesses the communication, coordination, and effectiveness of the hospital's and community's command structures.~~

~~**Note:** "Communitywide" may range from a contiguous geographic area served by the same health care providers, to a large borough, town, city, or region.~~

~~**Note:** Tests of EPs 3 and 4 may be separate, simultaneous, or combined.~~

~~A 5. Not applicable~~

~~B 6. All drills are critiqued to identify deficiencies and opportunities for improvement.~~

Standard EC.4.20

The hospital regularly tests its emergency management plan.

Elements of Performance for EC.4.20

Number and Types of Exercises

A 1. The hospital tests its emergency management plan twice a year, either in response to an actual emergency or in a planned exercise.

Note 1: Staff in freestanding buildings classified as a business occupancy (as defined by the Life Safety Code[®]) that does not offer emergency services nor is community-designated as a disaster-receiving station need to conduct only one emergency preparedness exercise annually.)

Note 2: Tabletop sessions, though useful, are **not** acceptable substitutes for exercises.)

A 2. Hospitals that offer emergency services or are community-designated disaster receiving stations conduct at least one exercise a year that includes an influx of actual or simulated patients.

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A 3. Hospitals that have a defined role in the communitywide emergency management program participate in at least one communitywide exercise a year.

Note 1: “Communitywide” may range from a contiguous geographic area served by the same health care providers, to a large borough, town, city, or region.

Note 2: Exercises for Element of Performance 2 and 3 may be conducted separately or simultaneously

Note 3: Table top sessions are acceptable in meeting the community portion of this exercise.

4. Not applicable

Scope of Exercises

B 5. Planned exercise scenarios are realistic and related to the priority emergencies identified in the organization’s hazard vulnerability analysis.

6. Not applicable

A 7. During planned exercises, an individual whose sole responsibility is to monitor performance and who is knowledgeable in the goals and expectations of the exercise, documents opportunities for improvement.¹¹

A 8. During planned exercises the hospital monitors at least the following core performance areas: Event notification including processes related to activation of the emergency management all hazards command structure, notification of staff, and notification of external authorities;

A 9. During planned exercises the hospital monitors at least the following core performance areas: Communication including the effectiveness of communication both within the hospital as well as with response entities outside of the hospital such as local governmental leadership, police, fire, public health, and other healthcare organizations within the community.

A 10. During planned exercises the hospital monitors at least the following core performance areas: Resource mobilization and allocation including responders, equipment, supplies, personal protective equipment, transportation, and security.

A 11. During planned exercises the hospital monitors at least the following core performance areas: Patient management including provision of both clinical and support care activities, processes related to triage activities, patient identification and tracking processes.

B 12. All exercises are critiqued to identify deficiencies and opportunities for improvement based upon all monitoring activities and observations during the exercise.

¹¹ This individual may be a staff member of the organization who is not participating in the exercise.

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B13. Completed exercises are critiqued through a multi-disciplinary process that includes administration, clinical (including physicians), and support staff.

B14. The hospital modifies its emergency management plan in response to critiques of exercises.

B 15. Planned exercises evaluate the effectiveness of improvements that were made in response to critiques of the previous exercise.

Note: When improvements require substantive resources that can not be accomplished by the next planned exercise, interim improvements must be put in place until final resolution.

B 16. The strengths and weaknesses identified during exercises are communicated to the multidisciplinary improvement team responsible for monitoring environment of care issues (see EC.9.20).

Resuscitation Standard (revised PC.9.30, EP 4)

Standard PC.9.30

Resuscitation services are available throughout the hospital.

Elements of Performance for PC.9.30

B 1. Policies, procedures, processes, or protocols govern the provision of resuscitation services.

A 2. Equipment is appropriate to the patient population (for example, adult, pediatric).

A 3. Appropriate equipment is placed strategically throughout the hospital.

A 4. An evidence-based¹² training program(s) is used to train appropriate staff ~~is trained and competent~~ to recognize the need for and use of designated equipment and techniques in resuscitation efforts.

Revisions to the Medication Management Standards (Standards MM.2.20, MM.4.20, MM.4.50 MM.8.10)

Standard MM.2.20

Medications are properly and safely stored.

¹² Evidence-based: Based on empirical evidence or in the absence of empirical evidence, expert consensus (such as consensus statements promoted by professional societies).

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Rationale for MM.2.20

Appropriate medication storage increases patient safety. 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.

Note: *The following elements of performance also apply to emergency medications. Additional requirements for emergency medications are addressed at standard MM.2.30.)*

Elements of Performance for MM.2.20

(M) A 1. Only approved medications are routinely stocked or stored.¹³

(M) A 2. Medications are stored under conditions suitable for product stability.

A 3. There is a written policy addressing the storage of medication between receipt of a medication by an individual health care provider and medication administration. At a minimum, the policy addresses:

- Safe storage
- Safe handling
- Security and
- Disposition of these medications including return to the (HAP only: pharmacy) medication storage area at the end of the individual's shift.

(M) C 4. The policy addressing the storage of medication between receipt of a medication by an individual health care provider and medication administration is implemented.

~~A 3~~ 5. Unauthorized persons, in accordance with the hospital's policy and law and regulation, cannot obtain access to medications.

A 46. Controlled substances are stored to prevent diversion and according to state and federal laws and regulations.

A 57. All expired, damaged, and/or contaminated medications are segregated until they are removed from the hospital.

A 68. Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.

Note: *The preceding requirement is not scored here. It is scored at NPSG 3, Requirement 3C.*

¹³ **Note:** *See standard MM.2.40 for the exception to this standard: The [organization] has a process to safely manage medications brought in by the [patient] or the [patient]'s family.*

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A ~~79~~. Medications and chemicals used to prepare medications are accurately labeled with contents, expiration dates, and warnings.

A ~~810~~. Standardize and limit the number of drug concentrations available in the hospital.

Note: The preceding requirement is not scored here. It is scored at NPSG 3, Requirement 3B.

(M) A ~~911~~. Concentrated electrolytes are removed from care units or areas, (unless patient safety is at risk if the concentrated electrolyte is not immediately available on a specific care unit or area, in such situations, specific precautions are taken to prevent inadvertent administration).

B ~~4012~~. Medications in care areas are maintained in the most ready-to-administer forms available from the manufacturer or if feasible, in unit-doses that have been repackaged by the pharmacy or a licensed repackager.

~~413~~. **Not applicable**

~~4214~~. **Not applicable**

(M) C ~~4315~~. All medication storage areas are periodically inspected according to the hospital's policy to make sure medications are stored properly.

Standard MM.4.20

Medications are prepared safely.

Elements of Performance for MM.4.20

B 1. When an on-site, licensed pharmacy is available, only the pharmacy compounds or admixes all sterile medications, intravenous admixtures, or other drugs except in emergencies or when not feasible (for example, when the product's stability is short).

A 2. The hospital has a written policy that addresses the safety and use of medications acquired by a practitioner from sources other than the hospital for use in patient care in that hospital. The policy addresses:

- Whether such medications are allowed to be used.
- If allowed, a process to evaluate the integrity of medications brought in by a practitioner prior to use in patient care.

A 3. The written policy that addresses the safety and use of medications acquired by a practitioner from sources other than the organization for use in patient care is implemented.

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(M) C ~~24~~. Wherever medications are prepared, staff uses safety materials and equipment while preparing hazardous medications.

(M) C ~~35~~. Wherever medications are prepared, staff uses techniques to assure accuracy in medication preparation.

(M) C ~~46~~. Wherever medications are prepared, staff follow techniques to avoid contamination during medication preparation including, but not limited to the following:

- Using clean or sterile techniques
- Maintaining clean, uncluttered, and functionally separate areas for product preparation to minimize the possibility of contamination
- Using a laminar airflow hood or other class 100 environment while preparing any intravenous (IV) admixture in the pharmacy, any sterile product made from non-sterile ingredients, or any sterile product that will not be used within 24 hours)
- Visually inspecting the integrity of the medications

MM.4.50

Standard MM.4.50

The hospital has a system for safely providing medications to meet patient needs when the pharmacy is closed.

Rationale for MM.4.50

Note: This standard only applies when a hospital has an on-site pharmacy and patients present in the hospital.

If an urgent or emergent patient need occurs, the hospital is able to provide medications to the patients in its facility.

Elements of Performance for MM.4.50

B 1. The hospital has a process for providing medications to meet patient needs when the pharmacy is closed.

B 2. When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following safeguards are applied:

- ~~Access is limited to a set of medications that has been approved by the [organization]. These medications can be stored in a night cabinet, automated storage and distribution device, or a limited section of the pharmacy.~~
- A limited set of medications approved by the hospital is available.
- These medications are stored outside of the pharmacy.
- These medications are locked.
- Only trained, designated prescribers and nurses are permitted access to medications.
- Quality control procedures (such as an independent second check by another individual or a secondary verification built into the system, such as bar coding) are in place to prevent medication retrieval errors.

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- The hospital arranges for a qualified pharmacist to be available either on-call or at another location (for example, at another organization that has 24-hour pharmacy service) to answer questions or provide medications beyond those accessible to non-pharmacy staff.

B 3. This process is evaluated on an on-going basis to determine the medications accessed routinely and the causes of accessing the pharmacy after hours.

(M) C 4. Changes are implemented to minimize the number of times non-pharmacist health care professionals obtain medications after the pharmacy is closed.

Standard MM.8.10

The hospital evaluates its medication management system.

Elements of Performance for MM.8.10

B 1. The hospital evaluates its medication management system for risk points and identifies areas to improve safety.

B 2. The hospital identifies opportunities for improvement by routinely evaluating the literature for new technologies or successful practices that have been demonstrated to enhance safety in other organizations to determine if it can improve its own medication management system.

B 3. The hospital reviews internally generated reports to identify trends or issues in its medication management system (*see* standards PI.2.10 and PI.2.20).

B 4. The hospital acts to implement improvements based on

- evaluation of its medication management system
- review of new technologies
- external data
- successful practices that have been demonstrated to enhance safety.

B 5. The performance of new and modified medication management processes is measured.

B 6. The hospital uses information from data analysis to identify subsequent changes to improve its medication management system.