The National VA Chaplain Center

Chaplain Service Spiritual and Pastoral Care Program

Annual Report

Appendixes

Appendix A

VHA Handbook

SPIRITUAL AND PASTORAL CARE PROCEDURES

CROSSWALK
Manual M-2, Part II, dated March 12, 1990
and
VHA Handbook 1111.2 Spiritual and Pastoral Care Procedures dated March 3, 2005

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Worship Services	3.06	Paragraph 12e, Paragraph 16a, b, Paragraph 21a, 21c(3)(c)

Department of Veterans Affairs **VHA HANDBOOK 1111.2**
Veterans Health Administration **Transmittal Sheet**
Washington, DC 20420 **(March 3, 2005)**

SPIRITUAL AND PASTORAL CARE PROCEDURES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Handbook delineates policies and procedures for providing Spiritual and Pastoral Care and the utilization of chaplains at VHA health care facilities.

2. SUMMARY OF MAJOR CHANGES: This Handbook is a total revision of VHA's Manual, M-2, Part II, dated March 12, 1990.

3. RELATED DOCUMENTS: VHA Directive 1111.

4. RESPONSIBLE OFFICE: The Office of the Director, Chaplain Service (111C) is responsible for the contents of this Handbook. Questions may be addressed to John J. Batten, Program Analyst, at (757) 728-3180.

5. RESCISSIONS: Veterans Health Services and Research Administration Manual M-2, Part II, Clinical Affairs, Chaplain Service, dated March 12, 1990, is rescinded. Questions may be addressed to 757-728-7062.

6. RECERTIFICATION: This VHA Handbook is scheduled for recertification on or before the last working day of January 2010.

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SPIRITUAL AND PASTORAL CARE PROCEDURES

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides the procedures for ensuring the spiritual welfare of all persons receiving Department of Veterans Affairs (VA) care. Chaplains work with the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA) to ensure that veterans who need medical care (including counseling for their religious and spiritual needs) are referred to VHA. This includes: providing opportunities for worship and religious expression by hospitalized veterans, providing ministry and pastoral counseling to patients (and their families if authorized), and ensuring that the spiritual aspect of health and wellness is recognized by all care givers and addressed in all patient care settings. ***NOTE: Nothing in this Handbook is intended or should be construed as suggesting or directing any policy, practice, or action that is contrary to the doctrine or practice of any faith group. Nevertheless, VHA's mission to care for veterans is paramount, and VHA may restrict or prohibit any practice that it deems detrimental to the health or safety of patients.***

2. BACKGROUND

a. The official title for VA clergy is "Chaplain." In official capacities the clergy person is addressed as "Chaplain," and must use this designation in signing official communications. VA chaplains are full-time, part-time, or intermittent Federal employees.

b. Chaplains provide spiritual and pastoral care to veterans and their families in accordance with VHA policy.

c. The mission of the National Chaplain Center is to empower VA chaplains to achieve standards of excellence in meeting the spiritual health needs of veterans receiving primary health care in VHA.

3. DEFINITIONS

a. <u>Pastoral.</u> The term "Pastoral" is an adjective derived from the Biblical image of shepherd and is used to describe a relationship characterized by expressions of compassionate care, including spiritual counseling, guidance, consolation, empathetic listening, and encouragement. Describing care as pastoral may refer to the motivation and/or attitude of the caregiver. In the VA, pastoral care refers to care provided by a chaplain, professionally educated and endorsed by a particular faith tradition to provide such care.

b. <u>Spiritual.</u> "Spiritual" has to do with that which is related to the "Spirit of Life." Spirituality may be used in a general sense to refer to that which gives meaning and purpose in life, or the term may be used more specifically to refer to the practice of a philosophy, religion, or way of living. The word "Spiritual" is derived from the old Latin

word "spiritus." The English words "inspire," meaning to breathe in and "expire" meaning to breathe out, come from the same Latin root. The concept of breathing captures the meaning of the word "spiritual" in relation to that which is or is not "life giving." Therefore, spirituality may positively or negatively affect one's overall health and quality of life.

c. Religious Expression. Religious expression refers to all types of worship, sacrament, ceremonies, prayer, meditation, traditional observances, etc., by which individuals carry out their religious beliefs and/or through which they maintain or enhance their relationship with the focus of their religion. This also includes wearing religiously significant clothing or jewelry, dietary customs, carrying or displaying religious artifacts, symbols, pictures, or scripture.

d. Proselytize. To Proselytize is to attempt to influence or change an individual's religious beliefs or expression.

e Clinical Chaplain. A clinical chaplain is an individual who meets all VA qualification requirements for Chaplain General Schedule (GS)-12, or above, whose spiritual and pastoral care and counseling is characterized by in-depth assessment, evaluation, and treatment of patients; a high degree of integration into the total care and treatment program of a health care facility; and close working relationships with staff members of other professional health care disciplines.

f. Ecclesiastical Endorsement. An ecclesiastical endorsement is a written official statement, by the official national endorsing agent of the religious faith group, certifying that an individual is in good standing with his/her religious faith group, and stating that the individual is, in the opinion of the endorsing agent, qualified to perform the full range of ministry required in the VA pluralistic setting [reference VA Handbook 5005, Part II, appendix F1].

g. Official National Endorsing Agent. The individual designated by a registered ecclesiastical endorsing organization to issue official ecclesiastical endorsements to VA of individuals within the particular religious faith group.

h. Registered Ecclesiastical Endorsing Organization. A registered ecclesiastical endorsing organization is a religious faith group which has been registered with VA in accordance with VHA policy (see VHA Handbook 1111.1).

4. MISSION

VA chaplains have a three-fold responsibility to the patients at every VA facility: first, to ensure that patients (both inpatients and outpatients) receive appropriate clinical pastoral care, second, to ensure that hospital, domiciliary, and nursing home patients' constitutional right to free exercise of religion is protected; and third, to protect patients from having religion imposed upon them. The spiritual dimension of health must be

integrated into all aspects of patient care, research, emergency preparedness, and health care education. Chaplains minister to the patients' family and loved ones, as appropriate (see subpar. 12i).

5. INTEGRATING SPIRITUAL AND PASTORAL CARE IN VA HEALTH CARE

VHA recognizes that Spiritual and Pastoral Care must be integrated into the total program of health care provided to veterans. The Network Directors and facility Directors are responsible for making available spiritual and pastoral care and counseling to patients. VA Chaplains are the professional health care providers on the interdisciplinary teams that are qualified, employed, and endorsed by their faith group endorsers to provide spiritual and pastoral care. VA Chaplains implement the Program of Spiritual and Pastoral Care on behalf of the Network and facility Directors throughout VHA.

6. CHAPLAIN'S OBJECTIVE

The Chaplain's objective is to plan, develop, and direct a program of spiritual and pastoral care and counseling consistent with the overall mission of health care delivery in VHA. The chaplain must conduct periodic (quarterly or annual) spiritual and pastoral care needs assessments to evaluate the spiritual and pastoral care needs of the ever-changing veteran patient population. Once these needs are identified, the chaplain develops a program of spiritual and pastoral care. This process of program development must include a plan for assessing patient needs, providing care, and evaluating the effectiveness of the care provided. This process of continuous quality improvement of the Spiritual and Pastoral Care Program ensures that holistic health care is a reality for all eligible veterans.

7. RELATIONSHIPS WITH THE NATIONAL CEMETERY ADMINISTRATION (NCA) AND THE VETERANS BENEFITS ADMINISTRATION (VBA)

a. <u>Responsibilities of Facility Managers.</u> VA considers all needs of veterans, family members, and others who seek information, benefits, or services, regardless of the specialized benefits and/or services they may be seeking at a given time. Therefore, chaplains and others responsible for the Spiritual and Pastoral Care Program at each VA health care facility must maintain close, continuing relationships with NCA and VBA officials who are responsible for serving veterans in the catchment area to ensure that these VA officials are aware of the services provided by chaplains. Health care facility managers are to establish methods to inform veterans and families who are served at NCA and VBA locations that VA medical care includes chaplains to address patients' spiritual and pastoral needs.

b. <u>Funeral and Committal Services.</u> VA chaplains may perform funeral and/or committal services for VA beneficiaries who died while receiving VA care. When

interment is made in a National Cemetery, unless arrangement has been made by the next-of-kin for another clergy person, the chaplain may conduct a committal service. Chaplains must notify their Directors when performing committal services at National Cemeteries for veterans who were not receiving VA care when they died. In these cases Directors should arrange for reimbursement to the medical care appropriation from the National Cemetery System appropriation. The chaplain may officiate at non-VA funerals or committal services during duty hours only when specifically authorized to do so by the facility Director. VA chaplains will not displace community clergy at funeral or committal services, but are to coordinate arrangements for the use of facility chapel(s).

c. VBA Beneficiaries. Spiritual and Pastoral care provided as part of VHA medical care may be of value to many veterans who seek benefits from VBA. Early provision of Spiritual and Pastoral care may improve veterans' spiritual health with significant long-term cost savings to VA. VBA needs to refer these veterans to VHA for needed care.

8. SCOPE OF PRACTICE

Each VA Chaplain must work under a written Scope of Practice, which will describe pastoral, clinical, and administrative functions the individual can provide by virtue of his/her professional qualifications. The minimum Scope of Practice reflects the professional education, training, and experience required for employment as a VA chaplain. (see App. A). The chaplain is responsible for continuing to meet the requirements as established by certification, and other relevant professional and ethical requirements as specifically applied to chaplains within the VA health care system.

9. STAFFING

VA health care facilities must provide adequate staffing to identify and meet the spiritual and pastoral care needs of veterans. Each medical center Director must ensure that Clinical Chaplains are utilized to plan and to oversee the Spiritual and Pastoral Care Program. The Spiritual and Pastoral Care Program includes interconnected responsibilities for planning and overseeing spiritual and pastoral care, typically in a variety of service lines or clinical specialties; integrating the program with other disciplines; training and orienting interdisciplinary staff; and liaison with community organizations. Each VA medical center needs to employ at least one full-time Clinical Chaplain to ensure that these responsibilities are assigned and implemented. ***NOTE: Chaplain staffing guidelines will be issued in a forthcoming Spiritual and Pastoral Care Program Guide.***

10. DIVERSITY

The representation of faith groups in the population of veterans served must be evaluated to determine the appropriate proportion of faith groups in chaplaincy. Although it is impossible for a facility to employ a chaplain of every faith group represented in its patient population, every facility must strive to achieve a workforce representative of the diversity of veterans served.

11. REPORTS

The Chief Patient Care Services Officer may require annual reports from field facilities regarding the spiritual and pastoral care program activities.

12. THE CHAPLAIN'S RESPONSIBILITY TO PATIENTS AND THEIR FAMILIES

a. Full-time chaplains are not to accept responsibilities outside of the medical center that may conflict with their commitment to provide spiritual and pastoral care duties within the medical center. Participation in religious and social activities in the local community on the chaplain's own time is encouraged as long as it does not compromise VA Chaplain duties.

b. Chaplains must not be assigned duties that conflict with their role of pastoral caregiver or assigned tasks that may require them to render judgment on the guilt, innocence, or character of an employee or patient. Such duties include, but are not limited to, narcotics inspections, Equal Employment Opportunity (EEO) investigations, and investigations of employee conduct. Chaplains may conduct inquiries of chaplain-related activities or incidents, may serve as mediators, may serve on EEO and other local and national committees, and may serve as liaisons with VA stakeholders.

c. If chaplains are assigned to service or product lines, coordination and continuity of the Spiritual and Pastoral Care Program must be ensured. Chaplains' work must be appropriately supervised and coordinated. If the organization does not have a supervisory chaplain, there must be careful, explicit delegation of authority and responsibilities for duties, such as: scheduling use of the chapel or worship space; contacting community clergy when necessary to meet a specific patient need; scheduling on-call coverage; coordinating professional Chaplaincy input into facility decisions and policy-making; providing expertise on committees such as health care ethics committees; and orienting and training staff, students, and volunteers in the Spiritual and Pastoral Care Program.

d. The chaplain must be sensitive to the variety of religious and cultural backgrounds of the patients and their families to whom ministry is provided.

e. Chaplains uphold the right to free exercise of religion by all hospital, domiciliary, and nursing home patients in the health care facility. This includes providing or facilitating appropriate worship opportunities.

f. Chaplains are responsible for ensuring that religion is not imposed on any patient.

g. Patients' needs for spiritual and pastoral care must be assessed as part of the total evaluation of their health care needs. A spiritual and pastoral care screening must be provided to patients as part of the interdisciplinary admissions process. The chaplain then determines the need for additional spiritual assessment and for any appropriate pastoral

care interventions, as needed.

h. Seriously ill and pre- and post-operative patients must be visited according to the patient's individualized treatment plan .

i. Chaplains must always be available to meet with relatives and visitors of patients during regular and emergency visits.

j. Chaplains may counsel members of a veteran's immediate family, a veteran's legal guardian, or the individual in whose household the veteran lives or certifies an intention to live, if:

(1) The counseling is essential to the treatment and rehabilitation of a hospitalized veteran or the outpatient treatment of a veteran's service connected disability;

(2) The counseling was initiated during a veteran's hospitalization and its continuation on an outpatient basis is essential to permit the veteran's discharge from the hospital; or

(3) The counseling was being provided at the time of a veteran's unexpected death or a veteran' s death while the veteran was participating in VA hospice or similar program and its continuation is provided for a limited period as determined to be reasonable and necessary to assist the individual with the emotional and psychological stress accompanying the veteran' s death.

13. DETERMINING HUMAN RESOURCES NEEDS

The total human resources needed to provide high-quality Spiritual and Pastoral care must be determined based on the following considerations:

a. Scope of practice statements need to clearly define the depth and complexity of chaplains' involvement with patient care in each clinical setting.

b. Spiritual and Pastoral Care must be available for all patients, including those in nursing homes, domiciliaries, outpatient clinics, vet centers, transitional residences, and hospital-based home care.

c. The variety of specialized clinical programs may require staff with specialized competencies; for example, the ability to meet the specialized spiritual care needs of patients with post traumatic stress syndrome, or the ability to minister effectively to women who have experienced sexual trauma.

d. Chaplain coverage must be 24 hours-per-day, 7 days-per-week to ensure a chaplain is always available to respond to emergencies..

e. Chaplains' expertise needs to be utilized to support medical center-wide programs

and committees such as health care ethics, employee assistance, and mediation and/or alternative dispute resolution.

f. Chaplains are expected to participate in new employee orientation and, as appropriate, in inter-professional education and training.

g. The amount of travel time between sites of care, the patient turnover rate, the proximity and activity of a national cemetery need to be considered.

h. Educational programs require qualified educational personnel in addition to patient care staff. (see par. 17). A facility with an accredited Clinical Pastoral Education (CPE) Program must have, in addition to a certified CPE Supervisor, a chaplain responsible for the ongoing Spiritual and Pastoral Care Program.

i.. Students may supplement, but may not perform independently of, or be substituted for, qualified employed chaplains.

14. VISITING CLERGY

The overall responsibility for spiritual and pastoral care rests with the assigned chaplain. However, as a matter of respect and courtesy, arrangements need to be made to allow community clergy to visit members of their church (or parish, congregation, synagogue, temple, mosque, etc).

a. When no chaplain staff member represents the specific faith group of a patient, every effort must be made to canvass the community, or draw from organized resources to provide the appropriate clergy to meet specific requests or needs.

b. "Authorized Faith Representatives" (e.g., Eucharistic Ministers) are authorized by registered religious faith groups to provide sacramental or other faith group specific religious ministry to their members. This ministry is an augmentation to the pastoral care provided by the Chaplain Service staff. Authorized Faith Representatives are <u>not</u> to provide services until it has been verified that their authorization is on file at the National Chaplain Center.

c. Under no circumstances may community clergy or Authorized Faith Representatives be used in lieu of an employed chaplain. All Visiting Clergy are guided by the policies of the facility and by the provisions of this Handbook.

d. A procedure must be established at each facility to identify and orient visiting clergy. This enables the chaplain staff to provide assistance with directions, personal safety, distribution of literature, and other pertinent concerns.

e. Patient information must be kept confidential in accordance with the Health

Insurance Portability and Accountability Act and other applicable statutes and policies. Chaplains must obtain and document the patient's permission before contacting community clergy on the patient's behalf.

15. VOLUNTEERS

VHA does not authorize "volunteer chaplains" or any volunteer to provide spiritual and pastoral care and counseling activities. Volunteers assist and augment the chaplain staff, but they do not replace them.

a. Volunteers who work on behalf of Chaplain Service are to be registered and oriented by the facility's Voluntary Services department. Each volunteer must be screened and trained by the Chaplain Staff to ensure that patients are protected from proselytization.

b. Volunteers must perform their assigned duties in accordance with VHA Handbook 1620.1.

16. CONTRACT AND FEE BASIS PERSONNEL

a. Chaplains and other personnel may work on a fee-basis appointment or under contract to supplement the full-time and part-time employed personnel when it is not feasible to obtain the needed services by employment of permanent full-time and part-time staff. Examples of appropriate (but not required) utilization include providing for on-call coverage, covering specific religious needs of patients when a staff chaplain is not available, and providing support services such as playing music at worship services.

b. Fee-basis and contract personnel are appropriate when the work to be performed can be clearly defined as a service that is not compensated on the basis of time and is otherwise not appropriate for full-time or part-time employees; for example: leading a religious ceremony or providing sacraments for patients of a specific faith group. When regular on-going participation in patient care is required, and when the work is to be performed with a variety of faith groups, fee-basis or contract personnel are not to be used.

c. A VA-employed chaplain must supervise the work of all fee-basis chaplains, and must monitor the work of all contract chaplains to ensure that professional standards of care are maintained.

d. Each contract and fee-basis chaplain must be certified as meeting minimum qualification requirements by the Board of Excepted Service Examiners prior to appointment or issuance of contract. Extensions of previously approved appointments and contracts may be approved by the medical center Director, or designee.

17. USE OF STUDENTS OR TRAINEES

a. Trainees (e.g., students or CPE residents) may be assigned to Chaplain Service to

further their clinical education and to gain experience in a health care setting. Trainees are supervised by an assigned chaplain who is qualified to assist with their specialized educational needs such as health care ethics or other clinical areas related to chaplaincy.

b. Trainees in CPE programs may provide supervised pastoral care including providing call-back coverage. Trainees may supplement the employed staff, but they may not perform independently of, and may not be substituted for, fully-qualified employed chaplains. Trainees must be supervised in accordance with the standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and the Association for Clinical Pastoral Education, Inc. (ACPE).

c. Trainees may be appointed as either paid or without compensation (WOC). ***NOTE: Paid trainees will be based upon the availability of training funds.***

18. CHAPLAIN SERVICE AND ETHICS

a. Chaplains must comply with all standards of ethical conduct for employees of the executive branch (see Title 5 Code of Federal Regulations (CFR) Part 2635). Additional information about the Federal employee standards of conduct may be obtained from the Regional Counsel or the Ethics Staff in the Office of General Counsel, VA Central Office. For example, Federal employees generally may not:

(1) Become personally involved in the business affairs of a patient or ex-patient,

(2) Have custody of the funds of any patient or ex-patient, or

(3) Become the guardian of any patient or ex-patient or be the conservator of the estate of any patient or ex-patient unless the employee and the patient or ex-patient had a personal relationship that pre- or post-dated their VA contact.

b. Chaplain Service is qualified to offer leadership and guidance to patients and VHA staff regarding health care decisions having ethical implications; therefore, each chaplain needs to stay abreast of health care ethics issues and be familiar with:

(1) Both religious and secular resources, such as those from the facility's local ethics advisory committee and VHA's National Center for Ethics in Health Care.

(2) VHA health care ethics policies, e.g., informed consent, advance directives, end of life care, etc.

(3) The laws, religious beliefs, and practices relative to the types of ethical questions that arise in clinical settings.

c. Each chaplain must be prepared to discuss and give guidance to any staff member,

patient, or patient's family requesting information regarding the relationship of ethical issues to their respective religious community's ethical and religious standards.

d. Chaplain Service aids and supports the professional staff in making ethical decisions; when requested, helps formulate and implement standards and criteria; and educates staff in making such decisions in a systematic and consistent manner.

e. The Endorser's Conference for Veterans Affairs Chaplaincy has written the "Covenant and Code of Ethics for Veterans Affairs Chaplains." The "Covenant and Code of Ethics for Veterans Affairs Chaplains" addresses specific ethical issues pertinent to pastoral care in VA, and promotes pluralistic pastoral care in VA facilities.

19. COUNSELING AND ASSISTANCE FOR STAFF

Facilities' employee health programs need to recognize staff's spiritual needs as well as their physical and mental needs. As part of facility health programs chaplains may provide occasional counseling and assistance to staff in order to assist staff in the performance of their care of patients. Staff members requiring in-depth or long-term counseling are to be referred to community resources. *NOTE: The employee health programs referenced in this paragraph are those established under Title 5 United States Code (U.S.C.) 7901.* Chaplains must not be assigned duties that conflict with their role of pastoral caregiver (see subpar. 12b).

20. COMPETITIVE LEVELS

Chaplains of different major faith groups (e.g., Protestant, Roman Catholic, Jewish, Islamic, etc.) are not interchangeable because they cannot meet all the religious needs of patients of the other groups. Therefore, chaplains of different major faith groups must not be in the same competitive level for reduction in force. Position descriptions must indicate the major faith group to which the incumbent provides complete ministry.

21. UTILIZATION OF RESOURCES IN SUPPORT OF THE SPIRITUAL AND PASTORAL CARE PROGRAM

a. <u>Chapels and Other Worship Facilities</u>

(1) The chapel, or a room set aside specifically for use as a chapel, is to be reserved exclusively for religious purposes. Such chapels are appointed and maintained as places for meditation and worship, and when not in use, they must be maintained as religiously neutral, reflecting no particular faith group subject to the following exception: any room where the Blessed Sacrament (Eucharist) is kept is reserved for Roman Catholics and may not be used by any other faith group.

(2) Existing chapel space is not to be altered without approval from the Director, Chaplain Service, VA National Chaplain Center.

(3) Where no chapel exists, but where a room or hall allocated for other purposes is used for religious services, every effort is to be made to have this room furnished to provide an atmosphere for worship. Management needs to provide assistance in the rearrangement of this room for services and returning it to its general function afterwards.

(4) The construction of a chapel for the exclusive use of a particular faith group is contrary to policy. The facility Director may designate a building or a room for the use of a particular faith group, as needed.

(5) The Chief, Chaplain Service, is responsible for arranging for the comfort of patients in the chapel.

(6) All worship spaces must be fully accessible to persons with disabilities.

(7) The use of candles, lights, draperies, etc., must be in accordance with local safety policies.

(8) Official Chapel Flags. The standard American flag, and Protestant, Roman Catholic, Jewish, and other appropriate religious chapel flags may be displayed in chapels.

(9) Funerals. Funerals at VA facilities are permitted only with the approval of the facility Director. VA chaplains may conduct interment services in a National Cemetery. ***NOTE: United States casket flags are to be folded and presented according to normal procedure.***

b. Offices. Office space for chaplains that ensures privacy in counseling patients, families, and staff must be provided (see VA Handbook 7610, Ch. 208).

c. Funds

(1) Appropriated Funds. Each VA facility is responsible for providing appropriated funds for the support of the Spiritual and Pastoral Care Programs.

(2) General Post Funds. General Post Funds exist, both at the national and local levels, for support of patient care programs. An annual allocation may be distributed to each facility from the national General Post Fund for the benefit of VA patients. Chaplain Service, Voluntary Service, and Recreation Service are authorized to use these funds. Local gifts may also be designated by the contributor for support of a particular spiritual and pastoral care function. General Post Funds may be used to purchase items such as:

(a) Expendable items; such as: religious literature for distribution to patients, copies of the Scriptures, missals, mass leaflets, prayer books, yarmulkes (skull caps), taleysim

(prayer shawls), and other religious articles.

(b) Non-expendable items of equipment that are not normally part of the equipment purchased by other VA funds.

(c) Honoraria for clergy, or musicians who provide services on a non-recurring basis. Payment for such services must be made in accordance with VA contracting policies and procedures.

(3) Donations to the General Post Fund. VHA Directive 4721 sets forth the policies and procedures for accepting, handling, and using donations to the General Post Fund.

(a) VA chaplains are authorized to accept gifts and donations on behalf of VA:

1. For the benefit of the religious needs of the patients at their facility and

2. To support all Chaplain Service activities at their facility.

(b) Chaplains receiving gifts and donations of funds must turn such funds over to the agent cashier as soon as practical for deposit into the General Post Fund. Chaplains are to instruct the agent cashier for what purpose, if any, the donor intended the funds to be used. Donors may designate that funds be used for patients of a particular faith group. Unless a donor specifically designates the purpose of the gifts and donations, gifts and donations received by chaplains are to be earmarked for support of the activities of the facility's Chaplain Service.

(c) Although it is not acceptable to solicit an offering by passing an offering plate during a religious service, a receptacle may be placed at an appropriate place in the chapel to permit visitors to contribute, if they desire.

(d) The Chief, Chaplain Service (or the Lead or Coordinating Chaplain) at each facility may authorize the withdrawal and expenditure of funds in the facility's General Post Fund earmarked for the religious needs of the patients to support Spiritual and Pastoral Care Program activities. Appropriate records of expenditures made must be maintained.

(e) Individuals and/or groups may make donations to the General Post Fund for the religious needs of VA patients. Funds donated to the General Post Fund for specific use by a particular faith group are to be earmarked as such within the General Post Fund and made available for that faith group's use when requested.

(f) Equipment or articles which a VA chaplain procures with General Post Fund monies, except for such items distributed to patients for their personal use, are designated as VA property.

(g) Gifts and donations received for religious purposes are not to be used for the:

1. Employment of personnel.

2. Remuneration of clergy to cover chaplain responsibilities during regular off-duty hours of the employed chaplain.

3. Personal or private use of any chaplain.

(h) Chaplains are not to take custody of, or maintain, patients' funds.

(i) Chaplains are not to accept personal gifts or gratuities where such acceptance would violate standards of conduct for Federal employees of the Executive Branch.

d. Supplies

(1) VA is responsible for providing the equipment and supplies necessary to carry out the mission of the Chaplain Service, except for:

(a) Religious articles to be used in the Chaplain Service which must be blessed, sanctified, or consecrated according to the regulations of the chaplain's religious faith group, cannot be purchased from appropriated funds.

(b) Vestments and ritual garments used by a chaplain, if purchased by the chaplain from personal funds, are the chaplain's property.

(2) If vestments and ritual garments used by a chaplain have been donated for the use of the Chaplain Service and are not to be blessed, sanctified, or consecrated according to the practice of a particular faith group, they are property of VA.

(3) Choir robes may be purchased from appropriated funds and remain the property of VA.

(4) If vestments, ritual garments and articles used in the religious services are blessed, sanctified or consecrated according to the practices of the religious faith group of which the chaplain is a member, they do not become the personal property of the chaplain or the property of VA. These are the property of the ecclesiastical endorsing organization of the chaplain concerned, and are placed at the field facility by that organization on a continual loan basis.

(a) The chaplain of the faith group concerned is to be the responsible custodian of these articles and cares for them according to the practices of the religious faith group.

(b) All articles used in the Chaplain Service which are on loan from an ecclesiastical endorsing organization are to be listed on a memorandum and forwarded to the Acquisition and Materiel Management Officer.

(c) When the chaplain who is the responsible custodian of such items is transferred or separated from service, the Acquisition and Materiel Management Officer is to inventory these articles and provide for their proper security until a new chaplain is assigned responsible custody.

e. Information Resources Management

(1) Chaplains and support staff must be provided with access to the Veterans Health Information System and Technology Architecture (VistA) and the Outlook/Exchange Server in order to:

(a) Input and retrieve accurate patient care data;

(b) Facilitate timely responses to local and national reports;

(c) Provide access to the National Chaplain Management Information System (the "Database");

(d) Participate in continuing education, distance learning, and quality improvement initiatives; and

(e) Keep abreast of current spiritual and pastoral care standards of accrediting organizations (i.e., JCAHO, CCAPS, CARF, ACPE, etc.).

(2) The Chief, Chaplain Service, or designee, is responsible for providing the National Chaplain Center with current accurate data necessary to maintain the National Chaplain Database.

(3) Chaplains, their support staff, volunteers, and others will only use veteran or patient information in accordance with VHA Handbook 1605.1, and will only access the minimum amount of information necessary to perform their duties in accordance with VHA Handbook 1605.2.

f. Religious Literature. Religious literature may be purchased to benefit the spiritual health of patients.

(1) Various religious denominations offer literature free of charge. The chaplains are responsible for reviewing all donated or purchased religious literature and determining its appropriate distribution.

(2) Upon request, chaplains may provide literature that describes a particular religious or denominational viewpoint to patients or family members.

(3) Material must not be distributed that may interfere with patient care, for example: material that is intended to proselytize, and material that makes offensive or defamatory

references to race, gender, or a religious faith group.

22. RESPONSIBILITIES OF THE NATIONAL CHAPLAIN CENTER

a. Field Support

(1) the National Chaplain Center empowers VHA Chaplains to achieve standards of excellence in meeting the spiritual health needs of veterans receiving health care by:

(a) Ensuring employment of a diverse and quality chaplain workforce.

(b) Providing education and training to chaplains and other providers.

(c) Maintaining liaison with VA Central Office, the Department of Defense (DOD), VISN and VA medical center Directors, Employee Education Service (EES), endorsing organizations, veterans service organizations, and religious communities.

(d) Supporting local chaplain services by:

1. Developing policies,

2. Providing guidance regarding standards and criteria,

3. Developing management competence,

4. Supporting a database management information system,

5. Networking,

6. Research and marketing, and

7. Professional career development including mentoring and succession programs.

(e) Providing the spiritual dimensions of specialized programs, such as:

1. Conflict resolution and mediation,

2. Wellness,

3. Suicide prevention,

4. Health care ethics, and

5. Patients rights.

(f) Providing consultation to the Patient Care Services Officer related to all spiritual and pastoral needs of patients, families, staff, networks, and facilities.

(g) Supporting field station chaplains, field administrators, and managers. This support is demonstrated by the following functions:

1. Facilitation of communication between VA chaplains for the purpose of sharing ideas and opportunities for ministry that enhance the field of pastoral and spiritual care.

2. Provision of a Board of Excepted Service Examiners to rate and rank all applicants for chaplain vacancies in VHA facilities in a timely fashion.

3. Dissemination of information to chaplains regarding trends and changes within VHA which may affect their ministry.

4. Guidance on programmatic pastoral care issues and resources related to spiritual care for patients, families and employees.

5. Assignment of an Associate Director of Chaplain Service to work with each of the networks and each facility to coordinate needs and conduct site visits.

6. Consultation with network directors to identify field chaplains from each network to serve on the National Chaplain Center's Field Leadership Council.

7. Provision of training opportunities to enhance the knowledge and clinical skills of chaplains. Training opportunities include both on-site and distance learning models.

8. Guidance regarding documentation of workload and clinical encounters.

9. Maintenance of the National Chaplain Database and National Chaplain web page.

10. Identify, recognize and promote excellence in chaplains and chaplain programs (i.e. Secretary's Award for Excellence in Chaplaincy, and Best Practices Awards).

(2) The Director, Chaplain Service, or designee, develops and implements policy to:

(a) Ensure that pastoral and spiritual care is made available to all veterans.

(b) Plan, develop, and direct a Spiritual and Pastoral Care Program consistent with the overall mission of health care delivery in VHA.

(c) Ensure the Spiritual and Pastoral Care Program is integrated into VHA's total care and treatment program.

(d) Organize, analyze, and improve programs that reflect the distinctive and

contributory role of spiritual and pastoral care within VA medical centers and VHA.

b. Education and Career Development for Chaplains and Interdisciplinary Health Care Providers

(1) Orientation for New Chaplains. The Orientation Course for new chaplains covers the basics all chaplains need to know about VHA regulations and Chaplain Service policies. All new Chaplains including part time, intermittent, fee basis, and contract chaplains must complete the Orientation Course no later than 1 year from their initial starting date.

(2) Career Development Classes. A variety of career development classes are scheduled annually to help chaplains and other professionals learn about the unique role of spiritual care in the treatment of veteran patients suffering with specific health problems, examples include: Post-traumatic Stress Disorder (PTSD), end of life issues and palliative care, substance abuse treatment, JCAHO standards, and the COMISS Network Commission for the Accreditation of Pastoral Services (CCAPS) standards. The National Chaplain Center provides training for newly-appointed Chiefs of Chaplain Service or the health care professional(s) responsible for supervision of the Spiritual and Pastoral Care Program, and training in Alternative Dispute Resolution (ADR).

(3) Spiritual Health Education

(a) The National Chaplain Center provides a program of spiritual health education for Chaplains and interdisciplinary health care providers. Educational programs are designed to meet the needs of all VHA employees and to promote spiritual health awareness throughout the veterans' community. Participants become more aware of the role of spirituality and faith issues in health care. VHA professionals learn about JCAHO, CCAPS and CARF Standards for Spiritual Care and the role of the Chaplain on the interdisciplinary health care teams.

(b) The goal of the Spiritual Health Education Program is to provide a comprehensive program of spiritual health education including:

1. Information regarding health care research in spirituality and religion,

2. Spiritual care standards,

3. Ethical decision making in health care,

4. Mediation and conflict resolution, and

5. Accrediting organization standards.

(4) Clinical Pastoral Education (CPE)

(a) CPE is interfaith professional education for ministry. CPE is the specialized clinical training required by the Association for Professional Chaplains, the National Association of Catholic Chaplains, and the National Association of Jewish Chaplains for clergy and chaplains to become Board Certified Chaplains. CPE programs are established in the VHA, according to the guidelines of the Associated Health Professions Handbook, Academic Affiliation (M-8, Part II, Chapter 2), and the annual program announcements for trainee support in associated health professions.

(b) CPE residents who have completed a 1-year (2080 hours) CPE Program in a VA health care facility and who meet all other VA qualification requirements for chaplain are eligible for appointment without numerical rating and ranking under the authority provided by 38 U.S.C. 7403(g) and 5 CFR 213.3102 (a), for 1 year following completion of their residency.

(5) Pastoral Counseling Education. Educational programs for Pastoral Counseling are to be accredited through the American Association of Pastoral Counselors and/or the American Association for Marriage and Family Therapy. Pastoral counseling education programs are to be kept current with the accreditation standards for the respective professional training organizations.

c. <u>Recruitment and Examining</u>

(1) The Board of Excepted Service Examiners (BESE) at the National Chaplain Center, has sole responsibility for examining and certifying applicants for permanent employment as VA chaplains, in accordance with applicable Human Resources policies (see VA Handbook 5005, Part II, Chapter 2).

(a) All selections for permanent appointment as a VA chaplain are made from certificates issued by the BESE. This includes selection of VA employees holding permanent competitive or excepted service positions in other occupations; selection of chaplains of other Federal agencies or departments; and reappointment of former VA and/or Federal chaplains.

(b) The Director, Chaplain Service, is the issuing official for BESE certificates.

(2) Based on anticipated staffing needs and administrative efficiency, BESE may elect to issue open-continuous announcements for chaplain positions of various grades and/or faith groups.

(3) In accordance with Federal regulations and VA policies the Director, Chaplain Service, approves requests for:

(a) Selective or quality rating factors for examining applicants, and

(b) Passing over or objecting to applicants on certificates.

(4) The Director, Chaplain Service establishes an affirmative action plan and conducts recruitment efforts to develop diverse applicant pools and to monitor and increase where necessary the representation of underrepresented groups in VA Chaplaincy.

(5) Time-limited appointments of chaplains may be made by the facility Director without BESE announcement and evaluation of the applicants.

(a) Time-limited appointments must only be made to accomplish work that is for a project or is of a time-limited nature. The principles of veterans preference must be followed to the extent administratively feasible.

(b) Persons selected for time-limited appointments must meet all qualification requirements prior to entering on duty. A copy of the selected individuals' current ecclesiastical endorsement must be provided to the National Chaplain Center prior to their entrance on duty.

(6) Individuals who have completed a 1 year (2080 hours) CPE Program in a VA health care facility and who meet all other VA qualification requirements for chaplain are eligible for appointment without numerical rating and ranking under the authority provided by 38 U.S.C. 7403(g) and 5 CFR 213.3102 (a).

NOTE: The BESE is responsible for accepting applications from students, verification of the student's qualifications, and the referral of qualified candidates to VA health care facilities.

d. Liaison With Religious, Professional, and Veterans Service Organizations (VSOs)

(1) The National Chaplain Center maintains contacts with ecclesiastical endorsers, professional certifying organizations, and VSOs. The National Chaplain Center and chaplains throughout VHA need to foster positive relationships with all VSOs, coordinating VA chaplain activities with VSOs as appropriate.

(2) The non-VA organizations with which the National Chaplain Center networks include, but are not limited to the:

(a) Endorser's Conference for Veterans Affairs Chaplaincy (ECVAC),

(b) Military Chaplains Association (MCA),

(c) Armed Forces Chaplains Board (AFCB),

(d) Association of Professional Chaplains (APC),

(e) Association for Clinical Pastoral Education (ACPE), and

(f) American Association of Pastoral Counselors (AAPC).

(3) The National Chaplain Center also maintains liaison with professional groups of chaplains formed solely of VA chaplains, such as, but not limited to the:

(a) National Association of VA Chaplains,

(b) VA National Black Chaplains Association, and

(c) National Conference of VA Catholic Chaplains.

e. Research. Field facilities are encouraged to include Spiritual and Pastoral Care as topics for research. Chaplains may serve on facility Research Committees.

Appendix B

COMISS Network

COMISS COMMISSION FOR ACCREDITATION OF PASTORAL SERVICES (CCAPS)

ACCREDITATION STANDARDS

COMISS Network

CCAPS
Standards

for Accrediting Pastoral Services
(Formerly JCAPS)

COMISS CCAPS STANDARDS

Approved October 2000

100 Care for the spiritual dimension of the client, family, and organizational community is evidenced in the mission and operation of the organization.

111 The organization documents a component for the spiritual care of the needs of all persons, as integral to a comprehensive approach to care.

112 Recognition of the spiritual needs and rights of the person is reflected in policies, procedures and administration's ability to articulate these needs and rights.

113 The budget includes monies to meet the operational, programmatic, and capital needs of the Pastoral Services Department.

200 Pastoral Services is the formal and identifiable means to demonstrate the organization's commitment to provide for the spiritual needs of the client, family and staff.

211 Pastoral Services is clearly identified on the organizational chart.

212 Pastoral Services has written policies and procedures which are reviewed annually.

213 The director is a member of middle or upper management levels.

<u>BUDGET</u>

221 Within the contexts of the organization and the profession, the salaries of the Pastoral Services personnel are consistent with their education, training and responsibilities.

222 The budget provides availability of Pastoral Services 24 hours a day, seven days a week.

223 The budget provides opportunities for the staff's continuing professional education and development.

STAFFING

231 The Pastoral Services Department has personnel sufficient to meet and implement the goals and objectives of the Pastoral Services Department.

232 A formal arrangement is documented when operational needs requires pastoral personnel from outside of the facility.

233 Pastoral Services has support personnel to carry on duties and programs.

FACILITIES

241 Space is available for private, confidential, and professional consultation.

242 Each staff member has an individual work area.

243 Space is available for departmental meetings.

244 Pastoral Services provides for confidential record keeping.

245 Space is available for a departmental library.

246 The director has a private office.

247 Space is made available for visiting clergy.

248 The organization provides worship space which is sensitive to a broad range of religious traditions.

249 All Pastoral Services facilities are well-identified, easily accessible, and barrier free.

300 A fully developed Pastoral Services program includes a variety of personnel who are qualified and trained to perform their assigned duties.

PROFESSIONAL STAFF

311 The staff is certified by an appropriate national pastoral credentialing agency recognized by COMISS Network.

312 Ongoing religious body endorsement is documented.

313 Staff demonstrates ability to minister with persons of diverse cultural and religious backgrounds.

314 The staff adheres to professional codes of ethics.

315 The staff of the department functions as a team intra-departmentally.

DIRECTOR

321 The director meets all of the criteria expected of the professional staff.

322 The director is certified by a national professional pastoral care recognized by the COMISS Network.

323 The director has management training or experience.

324 The director plans and coordinates staffing.

325 The director evaluates the department's staff and has the authority to take appropriate action.

326 The director effectively utilizes the department's human and economic resources.

327 The director has commitment to and responsibility for the provision of Pastoral Services as delineated by the administration.

328 The director provides procedures to assure that community clergy adhere to policies regarding patient visitation.

OTHER PASTORAL SERVICES PROVIDERS

331 All contract, on-call, faith group, student and volunteer pastoral services providers are screened, trained, and follow a clear plan of supervision.

332 All contract, on-call, faith group, student and volunteer pastoral services providers are accountable, either directly or indirectly, to the Director of Pastoral Services.

SUPPORT STAFF

341 The support staff exhibit an understanding of the role and function of Pastoral Services.

342 The support staff exhibit skills necessary to perform identified tasks.

400 Pastoral Care provides a comprehensive program of Pastoral Services.

411 Pastoral Services are made available to patients, residents, and families within the organization.

412 The personnel participate as team members in discharge planning and in patient/resident/family care conferences.

413 Pastoral Services demonstrates sensitivity to the sacramental and ritual needs of patients/residents and families.

414 Pastoral Services personnel are available for crisis intervention.

415 Pastoral Services staff provide clinically based ministry.

416 Pastoral Services has identified personnel available to address the linguistic, cultural and diverse spiritual needs of patients/residents/families and staff.

417 Pastoral Services has identified comprehensive resources available for pastoral counseling, spiritual direction and other specific spiritual care services.

418 Religious services and resources are offered utilizing various media.

ORGANIZATIONAL SERVICE

421 Pastoral Services staff are utilized as an ethical resource.

422 Pastoral Services personnel serve as a resource for staff counseling.

423 Information regarding the availability of Pastoral Services is included in orientation programs for new employees, professional staff and board members.

424 The staff demonstrates the ability to function collegially and professionally in relationship to other disciplines.

425 The staff actively contributes to assigned committees, such as ethics committee, patient/resident care committee, employee assistance committee, etc.

OUTREACH PROGRAMS

431 Pastoral Services are accessible to users throughout the integrated delivery network.

432 Pastoral Services provides referral services to the religious community when requested by patient and/or family.

COMMUNITY RELATIONS AND EDUCATION

441 Pastoral Services actively initiates and/or participates in community education projects.

442 Pastoral Services participates in the formation and facilitation of community support groups.

500 Pastoral Services has a system of accountability which measures both the quantitative and qualitative aspect of its service.

511 The Pastoral Services staff is involved in continuous quality improvement efforts or activities in the organization.

512 Pastoral Services meetings are held at least monthly.

513 Pastoral Services providers and support staff are evaluated annually.

514 The director is evaluated annually.

515 Pastoral Services has specific plans, goals and objectives to be reviewed and revised annually.

516 The accredited organization agrees to a CCAPS evaluation every five years.

517 The accredited organization agrees to notify CCAPS of any substantive change in leadership.

DOCUMENTATION

521 Minutes of Pastoral Services staff meetings are reported, filed and made

available to administration.

522 Scheduling of staff hours is consistent with patient and staff needs.

523 The Pastoral Services staff document their interventions in the record of the patient/resident.

524 Pastoral Services staff maintain an ongoing record of indicators which document pastoral services and activities.

Comments, questions or recommendations about the Standards can be addressed to:

CCAPS
P.O. Box 5432
Hampton, VA 23667

E-Mail: info@comissnetwork.org

Appendix C

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO)

ACCREDITATION STANDARDS RELEVANT FOR SPIRITUAL AND PASTORAL CARE PROGRAMS

Annual Review Companion Booklet

of

JCAHO Standard Extracts

from the 2004 Accreditation Program Manuals

Contents:

Patient/Resident Focused Functions

Organization Functions

Blue Lettering - Long Term Care Specific Standard Wording

Green Lettering - Behavioral Health Care Specific Standard Wording

Ethics, Rights, and Responsibilities (RI)

Patient rights

Patients have a right to receive the following:

Respect for cultural values and religious beliefs

The goal of rights and ethics is to help improve patient outcomes by respecting each patient's rights and providing care in an ethical manner.

Positive outcomes associated with a strong rights and ethics system include the following:

Consideration of religious and cultural beliefs.

Leaders ensure that the health care organization provides considerate care that safeguards personal dignity and respects the cultural, psychosocial, and spiritual values of patients.

Standard RI.1.10

The hospital follows ethical behavior in its care, treatment, and services and business practices.

Elements of Performance for RI.1.10

1. The hospital identifies ethical issues and issues prone to conflict.
2. The hospital develops and implements a process to handle these issues when they arise.
3. The hospital's policies and procedures reflect ethical practices for marketing, admission, transfer, discharge, and billing.
4. Marketing materials accurately represent the hospital and address the care, treatment, and services that the hospital can provide, directly or by contractual arrangement.
5. Patients receive information about charges for which they will be responsible.
6. The effectiveness and safety of care, treatment, and services does not depend on the patient's ability to pay.
7. The leaders ensure that care, treatment, and services are not negatively affected when the hospital grants a staff member's request to be excused from participating in an aspect of the care, treatment, and services.

Standard RI.1.20

The hospital addresses conflicts of interest.

Rationale for RI.1.20

Potential conflicts of interest can arise in subtle and obvious circumstances. The hospital needs to be aware of potential conflicts of interest and review relationships with other entities carefully to ensure that its mission and responsibility to the patients and community it serves is not harmed by any professional, ownership, contractual, or other relationships.

Elements of Performance for RI.1.20

1. The hospital defines what constitutes a conflict of interest.
2. The hospital discloses existing or potential conflicts of interest for those who provide care, treatment and services as well as governance.
3. The hospital reviews its relationship and its staff's relationships with other care providers, educational institutions, and payers to ensure that those relationships are within law and regulation and determine if conflicts of interest exist.
4. The hospital addresses conflicts of interest when they arise.

Standard RI.1.30

The integrity of decisions is based on identified care, treatment, and service needs of the patients.

Rational for RI.1.30

Decisions are based on the patients' care, treatment, and service needs, regardless of how the hospital compensates or shares financial risk with its leaders, managers, staff, and licensed independent practitioners (LIPs).

Elements of Performance for RI.1.30

1. The hospital has policies and procedures that address the integrity of clinical decision making.
2. To avoid compromising the quality of care, decisions are based on the patient's identified care, treatment, and service needs and in accordance with hospital policy.
3. Policies and procedures and information about the relationship between the use of care, treatment, and services and financial incentives are available to all patients, staff, LIPs, and contracted providers, when requested.

Standard RI.2.10

The hospital respects the rights of patients.

Elements of Performance for RI.2.10

1. The hospital's policies and practices address the rights of patients to treatment, care and services within its capability and mission and in compliance with law and regulation.
2. Each patient has a right to have his or her cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected.
3. The hospital supports the right of each patient to personal dignity.
4. The hospital accommodates the right to pastoral and other spiritual services for patients.

Standard RI.2.130

The hospital respects the needs of patients for confidentiality, privacy, and security.

Rationale for RI.2.130

This standard and its EPs allow flexibility in how a hospital can accomplish this requirement. Privacy, safety, and security can be demonstrated in various ways, for example, via policies and procedures, practices, or the design of the environment.

Elements of Performance for RI.2.130

1. The hospital protects confidentiality of information about patients.
2. The hospital respects the privacy of patients.
3. Patients who desire private telephone conversations have access to space and telephones appropriate to their needs and the care, treatment, and services provided.
4. The hospital provides for the safety and security of patients and their property.
LTC specific - 5. Residents who are married or have significant others are given a reasonable degree of privacy.
LTC specific - 6. The organization obtains documented resident/family consent when confidential information needs to be posted in the organization.

Standard RI.2.140

Patients have a right to an environment that preserves dignity and contributes to a positive self-image.

Rationale for RI.2.140

The hospital creates a supportive environment for all patients. Because a program or unit at times becomes the patient's "home," the hospital provides an

atmosphere that supports the patient's dignity. For example, in a long term care unit, residents have space to display greetings cards, calendars and other personal items important to their well-being.

Elements of Performance for RI.2.140

1. The environment of care supports the positive self-image of patients and preserves their human dignity.
2. The hospital provides sufficient storage space to meet the personal needs of the patients.
3. The hospital allows patients to keep and use personal clothing and possessions, unless this infringes on other's rights or is medically or therapeutically contraindicated (as appropriate to the setting or service).

Standard RI.2.150

Patients have the right to be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation.

Elements of Performance for RI.2.150

1. The hospital addresses how it will, to the best of its ability, protect patients from real or perceived abuse, neglect, or exploitation from anyone, including staff, students, volunteers, other patients, visitors, or family members.
2. All allegations, observations, or suspected cases of abuse, neglect, or exploitation that occur in the hospital are investigated by the hospital.

Standard RI.2.180

The Hospital protects research subjects and respects their rights during research, investigation, and clinical trials involving human subjects.

Rational for RI.2.180

A hospital that conducts research, investigations, or clinical trials involving human subjects knows that its first responsibility is to the health and well being of the research subjects. To protect and respect the research subjects' rights, the hospital reviews all research protocols. If another institution's Institutional Review Board (IRB) reviews the research protocols, the hospital does not need to perform this activity.

Elements of Performance for RI.2.180

1. The hospital reviews all research protocols in relation to its mission, values, and other guidelines and weighs the relative risks and benefits to the research subjects.
2. The hospital provides patients who are potential subjects in research, investigation, and clinical trials with adequate information to participate or refuse to participate in research.

3. Patients are informed that refusal to participate or discontinuing participation at any time will not compromise their access to care, treatment, and services.
4. Consent forms address the above EPs; indicate the name of the person who provided the information and the date the form was signed; and address the participant's right to privacy, confidentiality, and safety.
5. Subjects are told the extent to which their personally identifiable private information will be held in confidence.
6. All information given to subjects is in the medical record or research file along with the consent forms.
7. If a research-related injury (that is, physical, psychological, social, financial, or otherwise) occurs, the principle investigator attempts to address any harmful consequences that subject may have experienced as a result of research procedures.

LTC specific - Standard RI.2.220

Residents receive care that respects their personal values, beliefs, cultural and spiritual preferences, and life-long patterns of living.

Elements of Performance for RI.2.220

1. The organization respects residents' personal values, beliefs, and cultural and spiritual preferences.
2. The organization respects residents' life-long patterns of living, including lifestyle choices related to sexual orientation.

Standard RI.2.240

Residents can participate or refuse to participate in social, spiritual, or community activities and groups.

Element of Performance for RI.2.240

1. The organization supports each resident's right to participate or refuse to participate in social, spiritual, or community activities and groups.

Provision of Care, Treatment, and Services

Assessment

The goal of assessment is to determine the appropriate care, treatment, and services to meet a resident's initial needs aw well as his or her changing needs while in the setting.

Identifying and delivering appropriate care, treatment, and services depends on three processes:
1. Collecting data about each patient's health history; physical, functional, and psychosocial status; and needs as appropriate to the setting and circumstances.
2. Analyzing data to produce information about patients' needs for care, treatment, and services and to identify the need for additional data.
3. Making care, treatment, and service decisions based on information developed about each patient's needs and his or her response to care, treatment, and services.

Qualified staff assesses each resident's care needs throughout the resident's contact with the organization through assessments or screenings. These activities may also identify the need for additional assessments or planning. These assessments are as follows:

- ***Defined by the organization***
- ***Individualized to meet each resident's needs***
- ***Addressing the needs of special populations***

The depth and frequency of the assessment or screening depend on a number of factors, including the resident's needs, the program goals, and the care, treatment, and services provided. Assessment or screening activities may vary between settings, as defined by the clinical and other leaders of the organization. Resident screenings, assessments, and reassessments need to be done and documented within a reasonable time frame to identify the resident's needs and determine if these needs are being met.

Information gathered at the first contact can indicate the need for more data or more intensive assessment of the resident's physical, psychological, cognitive, or communicative skills; development; or social functioning. At a minimum, the need for further assessment is determined by the care, treatment, and services sought; the resident's presenting condition(s); and whether the resident agrees to care, treatment, and services.

Standard PC.2.20

The organization defines in writing the data and information gathered during assessment and reassessment.

Elements of Performance for PC.2.20

1. The organization's written definition of the data and information gathered during assessment and reassessment includes the following:

*** The scope of assessment and reassessment activities by each discipline**

*** The content of the assessment and reassessment**

*** The criteria for when an additional or more in-depth assessment is done**

2. The screening, assessment, and reassessment activities described are within the scope pf practice, state licensure laws, applicable regulation, or certification of the discipline doing the assessment.

3. If applicable, separate specialized assessment and reassessment information is identified for the various populations served.

4. The information defined by the hospital to be gathered during the initial assessment includes the following, as relevant to the care, treatment, and services:

*** Each patient's functional status, as appropriate**

*** For patients receiving end-of-life care, the social, spiritual, and cultural variables that influence the perceptions and expressions of grief by the patient, family members, or significant others.**

5. Through 11. Not applicable

LTC specific -

12. The information defined by the organization to be gathered during the initial assessment(s) includes the following, as relevant to the care, treatment, and services:

*** Current diagnosis(es)**

*** Pertinent History**

*** Medication history including drug allergies and sensitivities**

*** Current medications**

*** Current treatments**

The information defined by the organization to be gathered during the initial assessment(s) also includes the following (EPs 13-20):

13. The resident's physical and neuropsychiatric status:

14. The resident's communication status:

15. The resident's functional status:

16. The resident's activity status, needs, and potential:

17. The resident's nutritional* and hydration status and needs, including the following:

Cultural, religious, or ethnic food preferences

18. The resident's dental status and oral health:

19. The resident's pain, including the following:

*** Pain status, including its origin, location, severity, and alleviating and exacerbating factors**

* Current treatment for pain and response to treatment

20. The resident's psychosocial and spiritual status, including the following:
    * Spiritual orientation, status, and needs
    * The dying resident's concerns related to hope, despair, guilt, or forgiveness

21. In addition, when the bereavement process is a significant factor, the psychosocial assessment includes the social, spiritual, and cultural variables that influence the perceptions and expressions of grief by the resident or family.

Standard PC.2.60

The Organization defines in writing the data and information gathered during the psychosocial assessment.

Elements of Performance for PC.2.60

1. As relevent to the care, treatment, and services, the information defined by the organization to be gathered during the psychosocial assessment includes conflicts or problems involving at least the following:
    * Religion and Spiritual Orientation

Standard PC.2.120

The hospital defines in writing the time frame(s) for conducting the initial assessment(s).

Elements of Performance for PC.2.120

1. The hospital defines the time frames for conducting the initial assessments. The hospital specifies the following times frames for these assessments:
2. A medical history and physical examination is completed within no more than 24 hours of inpatient admission
3. A nursing assessment is completed within no more than 24 hours of inpatient admission.

4-5. N/A

6. The history and physical must have been completed within 30 days before the patient was admitted or readmitted.
7. Updates to the patient's condition since the assessments are recorded at the time of admission.

Standard PC.2.130

Initial assessments are performed as defined by the hospital.

Elements of Performance for PC.2.130

1. Each patient is assessed per hospital policy.
2. Each patient's initial assessment is conducted within the time frame specified by the patient's needs, hospital policy, and law and regulation.
3. A registered nurse assesses the patient's need for nursing care in all settings, as required by law, regulation, or hospital policy.

Standard PC.2.150

Patients are reassessed as needed

Rationale for PC.2.150

Each patient may be reassessed for many reasons including the following:
*** To evaluate his or her response to care, treatment, and services**
*** To respond to a significant change in status and/or diagnosis or condition**
*** To satisfy legal or regulatory requirements**
*** To meet time intervals specified by the hospital**
*** To meet time intervals determined by the course of the care, treatment, and services for the patient.**

Element of Performance for PC.2.150

1. Each patient is reassessed as needed.

Standard PC.3.100 – BHC Specific

The assessment includes the client's religion and spiritual orientation.

Rationale for PC.3.100

A client's spiritual orientation may relate to the substance abuse, dependence, and other addictive behaviors in terms of how the client view himself or herself as an individual of value and worth. Spiritual orientation is not considered synonymous with a client's relationship with an organized religion.

Element of Performance for PC.3.100

1. The client's spiritual orientation and religion are obtained as part of the assessment.

Standard PC.3.120

The needs of patients receiving psychosocial services to treat alcoholism or other substance use disorders are assessed.

Elements of Performance for PC.3.120

1. The content of the assessment and reassessment of patients receiving psychosocial services to treat alcoholism includes at least the following:

- *** History of use**
- *** History of treatment**
- *** History of mental, emotional, and behavioral problems**
- *** History of biomedical complications associated with abuse**

2. As appropriate to the patient's age and specific clinical needs, the psychosocial assessment includes information about the following:

- *** The patient's religion and spiritual Orientation**

3. Those responsible for the patient's care determine the need for family members to participate in the patient's care.

4. As appropriate, vocational, legal, and functional assessments

Additional Standard for Patients Being Treated for Emotional or Behavioral Disorders

Standard PC.3.130

The needs of patients receiving treatment for emotional or behavioral disorders are assessed.

Elements of Performance for PC.3.130

1. The content of the assessment and reassessment of patients being treated for emotional and behavioral disorders includes at least the following:

- *** History of mental, emotional, behavioral, and substance abuse problems; their co-occurrence; and treatment**
- *** Current mental, emotional, and behavioral functioning, including a mental status examination**

2. As appropriate to the patient's age and specific clinical needs, the psychosocial assessment includes information about the following:

- *** Religion**

3. Those responsible for the patient's care determine the need for family members to participate in the patient's care.

4. As appropriate, vocational, legal, and functional assessments.

5. Community resources currently used by the patient.

6. Other age-specific assessments.

Planning Care, Treatment, and Services

Standard PC.4.10

Development of a plan for care, treatment, and services is individualized and appropriate to the patient's needs, strengths, limitations, and goals.

Rationale for PC.4.10

Planning care, treatment, and services is not limited to developing a written plan. Rather, planning is a dynamic process that addresses the execution of care, treatment, and services. The plan for care, treatment, and services must be consistently re-evaluated to ensure that the patient's needs are met. Planning for care, treatment, and services includes the following:

*** Integrating assessment findings in the care-planning process**
*** Developing a plan for care, treatment, and services that includes patient care goals that are reasonable and measurable**
*** Regularly reviewing and revising the plan for care, treatment, and services**
*** Determining how the planned care, treatment, and services will be provided**
*** Documenting the plan of care, treatment, and services**
*** Monitoring the effectiveness of care planning and the provision of care, treatment, and services**
*** Involving patients and/or families in care planning**

Elements for Performance for PC.4.10

1. Care, treatment, and services are planned to ensure that they are appropriate to the patient's needs.
2. Development of a plan of care, treatment, and services is based on the data from assessments.
LTC Specific - 3. The interdisciplinary team identifies and priorities each resident's care need based on the analysis of assessment data.
LTC Specific - 4. An individual, interdisciplinary plan for care, treatment, and services is developed by an interdisciplinary team representing all appropriate health care professionals as soon as possible after admission, but no later than 7 calendar days after comprehensive assessments are completed.
LTC Specific - 5. When sub acute care is provided, the interdisciplinary care plan is completed no later than 72 hors after comprehensive assessments are completed (which occurs within 72 hours of admission).
6. Patient needs, goals, time frames, settings, and serviced required to meet the patient needs and/or goals determine the plan for care, treatment, and services.
LTC Specific – 7. The plan identifies the following:
*** The services, care, treatment, and settings**
*** The frequency at which care, treatment, and services and interventions will occur**
*** The team members responsible for providing care, treatment, and services**

* The financial implications of care, treatment, and services
* Interventions to facilitate the resident's return to the community or discharge to an appropriate level of care

LTC Specific – 8. An interim plan of care, treatment, or services is developed for each resident immediately after the resident is admitted.

LTC Specific – 9. A process is in place for gathering input, collaborating on care plan development, and reporting the final plan to team members not available to participate in care planning.

LTC Specific – 10. Policies and procedures define how care plans can be modified between team meetings.

LTC Specific – 11. The organization implements a process for evaluating the plan for care, treatment, and services and its effectiveness, which includes the following:

* 90 day evaluation intervals or more frequent intervals in response to a significant change in the resident's physical, communicative, psychosocial, functional, or emotional status
* Care plan revisions that reflect the resident's current needs, problems, goals, care, and services.
* Review and revision of all components of care, treatment, and services needed by the resident by the interdisciplinary team.

12. The patient's evaluation is based on the patient's care goals and plan for care, treatment, and services.

13. The goals of care, treatment, and services are revised when necessary.

14. Plans for care, treatment, and services are revised when necessary.

LTC Specific – 15. When subacute care is provided, the interdisciplinary team revises care plans in collaboration with residents, family, and the individual responsible for financial resource monitoring.

LTC Specific – 16. When subacute care is provided, the care plan review occurs every two week for the first quarter, every month for the second quarter, and quarterly there-after, or more frequently when indicated by change in the resident's condition.

17. The plan for care, treatment, and services considers strategies to limit the use of restraints or seclusion as appropriate.

Standard PC.5.50

Care, treatment, and services are provided in an interdisciplinary, collaborative manner.

Rationale for PC.5.50

A collaborative, interdisciplinary approach to meeting the patient's needs and goals helps to coordinate care, treatment, and services and achieve optimal outcomes. The mix of disciplines involved and the intensity of the collaboration will vary as appropriate to each patient and the scope of services provided by the hospital (see standards MS.2.10 and MS.2.20). An interdisciplinary approach should not be interpreted as a requirement for an interdisciplinary care plan or the signing of other individual's notes. While an interdisciplinary care plan may be one method of accomplishing this goal, it is not required.

Element of performance for PC.5.50

1. Care, treatment, and services are provided in an interdisciplinary, collaborative manner as appropriate to the patient's needs and the hospital's scope of services.

Standard PC.5.60

The hospital coordinates the care, treatment, and services provided to a patient as part of the plan of care, treatment, and services and consistent with the hospital's scope of care, treatment, and services.

Rationale for PC.5.60

Throughout the provision of care, treatment, and services, patients should be matched with appropriate internal and external resources to meet their ongoing needs in a timely manner. Care, treatment, and services should be coordinated between providers and between settings, independent of whether they are provided directly or through written agreement.

Elements of Performance for PC.5.60

1. The hospital coordinates the care, treatment, and services provided through internal resources to an individual.
2. When external resources are needed, the hospital participates in coordinating care, treatment, and services with these resources.
3. The hospital has a process to receive or share relevant patient information to facilitate appropriate coordination and continuity when patients are referred to other care, treatment, or service providers.
4. There is a process to resolve duplication or conflict with either internal or external resources.
5. Care, treatment, and services are provided in a time frame that meets the patient's needs.

Education

Standard PC.6.10

The patient/resident receives education and training specific to the patient's needs and as appropriate to the care, treatment, and services provided.

Rationale for Standard PC.6.10

Patients/residents must be given sufficient information to make decisions and to take responsibility for self-management activities related to their needs. Patients, and as appropriate, their families are educated to improve individual outcomes by promoting healthy behavior and appropriately involving patients in their care, treatment, and service decisions.

Elements of Performance for PC.6.10

1. Education provided is appropriate to the patient/resident's needs.
2. The assessment of learning needs addresses cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication as appropriate.
3. As appropriate to the patient/resident's condition and assessed needs and the hospital's scope of services, the patient is educated about (activities important to their care).

Nutritional Care

This standard focuses on providing appropriate nutritional care, including food and nutritional therapy, in a timely and efficient manner using appropriate resources. Elements of nutritional care, such as screening or assessment and education, are addressed in other standards in this manual.

Standard PC.7.10

The hospital/organization has a process for preparing and/or distributing food and
nutrition products as appropriate to the care, treatment, and services provided.

Elements of Performance for PC.7.10

1. Food and nutrition products are provided for the patient/resident as appropriate to care, treatment, services.
2. Patients' cultural, religious, and ethnic food preferences are honored when possible unless contraindicated.
3. – 12. Not Applicable

End-of-Life Care

Standard PC.8.70

Comfort and dignity are optimized during end-of-life care

Rationale for PC.8.70

The patient at or near the end of his or her life has the right to physical and psychological comfort. The hospital provides care that optimizes the dying patient's comfort and dignity and addresses the patient's and his or her family's psychosocial and spiritual needs.

Elements of Performance for PC.8.70

1. To the extend possible, as appropriate to the patient's and family's needs and the hospital's services, interventions address patient and family comfort, dignity, and psychosocial, emotional, and spiritual needs, as appropriate, about death and grief.
2. Staff is educated about the unique needs of dying patients and their families and caregivers.

Improving Organizational Performance (PI)

Standard PI.1.10

The hospital collects data to monitor its performance.

Rationale for PI.1.10

Data help determine performance improvement priorities. The data collected for high priority and required areas are used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, or sustain improvement. Data collection helps identify specific areas that require further study. These areas are determined by considering the information provided by the data about process stability, risks, and sentinel events, and priorities set by the leaders. In addition, the hospital identifies those areas needing improvement and identifies desired changes. Performance measures are used to determine whether the changes result in desired outcomes. The hospital identifies the frequency and detail of data collection.

Elements of Performance for PI.1.10

1. The hospital collects data for priorities identified by leaders (see standard LD.4.40).
2. The hospital considers collecting data in the following areas:
- **Staff opinions and needs.**
- **Staff perceptions of risks to patients and suggestions for improving patient safety.**
- **Staff willingness to report unanticipated adverse events.**

3. The hospital collects data on the perceptions of care, treatment, and services of patients including the following:
- **Their specific needs and expectations.**
- **How well the hospital meets these needs and expectations.**
- **How well the hospital can improve patient safety.**
- **The effectiveness of pain management, when applicable.**

The hospital collects data the measure the performance of each of the following potentially high-risk processes, when provided:
4. Medication management
5. Blood and blood product use
6. Restraint use
7. Seclusion use
8. Behavior management and treatment
9. Not applicable
10. Operative and other invasive procedures
11. Not applicable
12. Resuscitation and its outcomes
Relevant information developed from the following activities is integrated into performance improvement initiatives. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or

privilege of information established by applicable law.
13. Risk management
14. Utilization management
15. Quality control
16. Infection control surveillance and reporting
17. Research, as applicable
18. Autopsies, when performed

Standard PI.2.10

Data are systematically aggregated and analyzed.

Rationale for PI.2.10

Aggregating and analyzing data means transforming data in information. Aggregating data at points in time enables the hospital to judge a particular process's stability or a particular outcome's predictability in relation to performance expectations. Accumulated data are analyzed in such a way that current performance levels, patterns, or trends can be identified.

Elements of Performance for PI.2.10

1. Collected data are aggregated and analyzed.
2. Data are aggregated at the frequency appropriate to the activity or process being studied.
3. Statistical tools and techniques are used to analyze and display data.
4. Data are analyzed and compared internally over time and externally with other sources of information when available.
5. Comparative data are used to determine if there is excessive variability or unacceptable levels of performance when available.

Leadership (LD)

Standard LD.1.10

The hospital identifies how it is governed.

Rational for LD.1.10

The hospital has governance with ultimate responsibility and legal authority for the safety and quality of care, treatment, and services. Governance establishes policy, promotes performance improvement, and provides for organization management and planning.

Elements of Performance for LD.1.10

1. The hospital identifies how it is governed.
2. The hospital identifies lines of authority for key planning, management, and operations activities.
3. The hospital identifies those responsible for governance.
4. The governance provides for appropriate medical staff participation in governance.
5. The medical staff has the right to representation (through attendance and voice), by one or more medical staff members selected by the medical staff, at governing body meetings.
6. Medical staff members are eligible for full membership in the hospital's governance, unless legally prohibited.

Standard LD.1.20

Governance responsibilities are defined in writing, as applicable.

Elements of Performance for LD.1.20

1. Governance defines its responsibilities in writing, as applicable.
2. If the hospital is part of a larger corporate structure, the scope and degree of leaders' involvement, authority, and responsibility in corporate policy decisions are described in writing.
3. Governance provides for organizational management and planning.
4. The hospital's scope of services is defined in writing and approved by the governance.
5. Governance either selects the individual(s) responsible for operation the hospital or approves one selected by corporate management or another group.
6. Governance provides for coordination and integration among the hospital's leaders to establish policy, maintain quality care and patient safety, and provide for necessary resources.
7. Governance annually evaluates the hospital's performance in relation to its vision, mission, and goals.
LTC Specific - 8. If the organization has an organized medical staff, the governance approves the medical staff's bylaws and rules and regulations.

Standard LD.1.30

The hospital complies with applicable law and regulation.

Elements of Performance for LD.1.30

1. The hospital provides all services in accordance with applicable licensure requirements, law, rules, and regulation.
2. The hospital acts upon any reports and/or recommendations from authorized agencies, as appropriate.
3. The hospital possesses a license, certificate, or permit, as required by applicable law and regulation, to provide the health care services for which the hospital is seeking accreditation.

Standard LD.2.20

Each organizational program, service, site, or department has effective leadership.

Rationale for LD.2.20

Effective leaders at the site or department level help to create an environment or culture that enables a hospital to fulfill its mission and meet or exceed its goals. They support staff and instill in them a sense of ownership of their work processes. Although it may be appropriate for leaders to delegate work to qualified staff, the leaders are ultimately responsible for care, treatment, and services provided in their area.

Elements of Performance for LD.2.20

1. The program, service, site, or department leaders ensure that operations are effective and efficient.
2. Leaders hold staff accountable for their responsibilities.
3. Programs, services, sites or departments providing patient care are directed by one or more qualified professionals with appropriate training and experience or by a qualified licensed independent practitioner (LIP) with appropriate clinical privileges.
4. Responsibility for administrative and clinical direction of these programs, services, sites, or departments is defined in writing.
5. Leaders ensure that a process is in place to coordinate care, treatment, and service processes among programs, services, sites, or departments.

Standard LD.2.50

The leaders develop and monitor an annual operation budget and, as appropriate, a long-term capital expenditure plan.

Elements of Performance for LD.2.50

1. An operating budget is developed annually and approved by the governance.
2. The budget reflects the hospital's goals and objectives and, at a minimum, meets applicable law and regulation.
3. The leaders include staff input when developing the budget.
4. The governing body or authority develops and approves a long-term capital expenditure plan, as appropriate.
5. An independent public accountant conducts an annual audit of the hospital's finances, unless otherwise provided by law.
6. N/A
7. Implementation of the budget and, as appropriate, the long-term capital expenditure plan is monitored.

Standard LD.3.10

The leaders engage in both short-term and long-term planning.

Elements of Performance for LD.3.10

1. Leaders create vision, mission, and goal statements.
2. The hospital's plan for services specifies which care, treatment, or services are to be provided directly and which through consultation, contract, or other agreement.
3. Anesthesia services are available if surgery or obstetrical services are provided.
LTC Specific - 4. For subacute services only: The organization has a statement outlining the program's philosophy and scope of services that clearly distinguishes the subacute patient from the traditional skilled resident based on the patient's need and the organization's ability to meet those needs.

Standard LD.3.20

Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.

Rationale for LD.3.20

Factors such as different individuals providing care, treatment, and services; different insurers; or different settings of care do not intentionally negatively influence the outcome.

Elements of Performance for LD.3.20

1. Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.

2. The hospital plans, designs, and monitors care, treatment, and services so they ae consistent with the mission, vision, and goals.

3. Planning for care, treatment, and services addresses the following:

- *** The needs and expectations of patients and, as appropriate, families, as well as customers and referral sources.**
- *** Staff needs**
- *** The scope of care, treatment, and services needed by patients at all of the hospital's locations**
- *** Resources (financial and human) for providing care and support services**
- *** Recruitment, retention, development, and continuing education needs of all staff**
- *** Data for measuring the performance of processes and outcomes of care**

Standard LD.3.30 (Not Applicable for LTC)

A hospital demonstrates a commitment to its community by providing essential services in a timely manner.

Rationale for LD.3.30

Through the planning process, the leaders determine, first, what diagnostic, therapeutic, rehabilitative and other services are essential to the community; second, which of these services the hospital will provide directly and which through referral, consultation, contractual arrangements, or other agreements; and third, time frames for providing patient care, treatment, and services.

Elements of Performance for LD.3.30

1. Essential services include at least the following:

- *** Diagnostic radiology**
- *** Dietetic**
- *** Emergency**
- *** Nuclear medicine**
- *** Nursing care**
- *** Pathology and clinical laboratory**
- *** Pharmaceutical**
- *** Physical rehabilitation**
- *** Respiratory care**
- *** Social work**

2. In addition, the hospital has at least one of the following acute care clinical services:

- *** Medicine**
- *** Obstetrics and gynecology**

*** Pediatrics**
*** Surgery**
*** Child, adolescent, or adult psychiatry**
*** Substance use treatment**

Standard LD.3.50

Services provided by consultation, contractual arrangements, or other agreements are provided safely and effectively.

Elements of Performance for LD.3.50

1. The leaders approve sources for the hospital's services that are provided by consultation, contractual arrangements, or other agreements.
2. The medical staff advises the hospital's leaders on the sources of clinical services to be provided by consultation, contractual arrangements, or other agreements.
3. N/A
4. The nature and scope of services provided by consultation, contractual arrangements, or other agreements are defined in writing.
5. Services provided by consultation, contractual arrangements, or other agreements meet applicable Joint Commission Standards.
6. The hospital evaluates the contracted care and services to determine whether they are being provided according to the contract and the level of safety and quality that the hospital expects.
7. The hospital retains overall responsibility and authority for services furnished under a contract.
8. All reference and contract laboratory services meet the applicable federal regulations for clinical laboratories and maintain evidence of the same.

Standard LD.3.60

Communication is effective throughout the hospital.

Elements of Performance for LD.3.60

1. The leaders ensure processes are in place for communicating relevant information throughout the hospital in a timely manner.
2. Effective communication occurs in the hospital, among the hospital's programs among related organizations, with outside organizations, and with patients and families, as appropriate.
3. The leaders communicate the hospital's mission and appropriate policies, plans, and goals to all staff.

Standard LD.3.70

The leaders define the required qualifications and competence of those staff who provide care, treatment, and services, and recommend a sufficient number of qualified and competent staff to provide care, treatment, and services.

Rationale for LD.3.70

The determination of competence and qualifications of staff is based on the following:

* **The hospital's mission**
* **The hospital's care, treatment, and services**
* **The complexity of care, treatment, and services needed by patients**
* **The technology used**
* **The health statue of staff, as required by law and regulation**

Elements of Performance for LD.3.70

1. The leaders provide for the allocation of competent qualified staff.

2. The leaders ensure that physician assistants and advanced practice registered nurses who practice within the hospital are credentialed and privileged and reprivileged through the medical staff process or an equivalent process that has been approved by the governing body. An equivalent process at a minimum does the following:

* **Evaluates the applicant's credentials**
* **Evaluates the applicant's current competence**
* **Includes peer review**
* **Involves communication with and input from individuals and committees including the Medical Staff Executive Committee in order to make an informed decision regarding the applicant's request for privileges.**

Standard LD.3.80

The leaders provide for adequate space, equipment, and other resources.

Elements of Performance for LD.3.80

1. The leaders provide for the arrangement and allocation of space to facilitate efficient, effective delivery of care, treatment, and services.

2. The leaders provide for the appropriateness of interior and exterior space for the care, treatment, and services offered and for the ages and other characteristics of the patients.

3. The leaders provide for the safe use, maintenance, accessibility, and supervision of grounds, equipment and other resources.

4. The leaders provide for adequate equipment and other resources.

Standard LD.3.90

The leaders develop and implement policies and procedures for care, treatment, and services.

Elements of Performance for LD.3.90

1. The leaders develop policies and procedures that guide and support patient care, treatment, and services.
2. Policies and procedures are consistently implemented.

Standard LD.4.60

The leaders allocate adequate resources for measuring, assessing, and improving the hospital's performance and improving patient safety.

Elements of Performance for LD.4.60

1. Sufficient staff is assigned to conduct activities for performance improvement and safety improvement.
2. Adequate time is provided for staff to participate in activities for performance improvement and safety improvement.
3. Adequate information systems are provided to support activities for performance improvement and safety improvement.
4. Staff is trained in performance improvement and safety improvement approaches and methods.

Management of the Environment of Care (EC)

Standard EC.5.10

The hospital manages fire safety risks.

Rationale for EC.5.10

All facilities are designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. Because the safety of occupants cannot be ensured adequately be dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities; adequate, trained staff; and development of operating and maintenance procedures composed of the following:

Design, construction, and compartmentalization

Provision for detection, alarm, and extinguishment

Fire prevention and the planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building.

Elements of Performance for EC.5.10

1. The hospital develops and maintains a written management plan describing the processes it implements to effectively manage fire safety.

2. The hospital identifies and implements proactive processes for protecting patients, staff, and others coming to the hospital's facilities as well as protecting property from fire, smoke, and other products of combustion.

3. The hospital identifies and implements processes for regularly inspecting, testing, and maintaining fire protection and fire safety systems, equipment, and components.

4. The hospital develops and implements a fire response plan that addresses the following:

- **Facility-wide fire response**
- **Are-specific needs including fire evacuation routes**
- **Specific roles and responsibilities of staff, licensed independent practitioners (LIPs), and volunteers at a fire's point of origin**
- **Specific roles and responsibilities of staff, LIPs, and volunteers away from a fire's point of origin.**
- **Specific roles and responsibilities of staff, LIPs, and volunteers in preparing for building evacuation.**

5. The hospital reviews proposed acquisitions of bedding, window draperies, and other curtains, furnishings, decorations, and other equipment for fire safety.

Standard EC.8.10

The hospital established and maintains an appropriate environment.

Rationale for EC.8.10

It is important that the physical environment is functional and promotes healing and caring. Certain key physical elements in the environment can be significant in their ability to positively influence patient outcomes and satisfaction and improve patient safety. These elements can also contribute on creating the way the space feels and work for patients, families, visitors and staff experiencing the care, treatment, and service delivery system.

Elements of Performance for EC.8.10

1. **Interior spaces should be the following:**
   - *** Appropriate to the care, treatment, and services provided and the needs of the patients related to age and other characteristics.**
   - *** Include closet and drawer space provided for storing personal property and other items provided foe us by patients. Lockers, drawers, or closet space is provided for patients who are in charge of their own personal grooming and who wear street clothes.**
   - *** For hospital settings that provide longer term care (more than 30 days), allow for good recreational interchange, consider personal preferences when feasible, and accommodate equipment, such as wheelchairs, tat are necessary to activities of daily living.**
   - *** For hospital settings that provide longer term care (more than 30 days), have equipment for rehabilitation and activities adequate to accomplish goals without compromising the environment's safety.**
2. **Furnishings and equipment should do the following:**
   - *** Be maintained to be safe and in good repair**
   - *** Reflect the patient's level of ability and needs**
   - *** For hospital settings that provide longer term care (more than 30 days), help to normalize the patient's living environment.**
3. **For hospital settings that provide longer term care (more than 30 days), outside areas are the following:**
   - *** Provided when required by the care, treatment, and services (for example, when certain patient groups, such as pediatric, experience long lengths of stay)**
   - *** Appropriate and safe considering the care, treatment, and services provided and the needs of the patients related to age and other characteristics**
4. **Areas used by the patient are safe, clean, functional, and comfortable**
5. **Lighting is suitable for care, treatment, and services and the specific activities being conducted**
6. **N/A**
7. **Ventilation provides for acceptable levels of temperature and humidity and eliminates odors.**

8.–10. N/A

11. Door locks and other structural restraints used are consistent with the needs of patients, program policy, law, and regulation. Emergency access provision is provided to all locked occupied spaces.

12. N/A

13. N/A

LTC Specific - 14. Spaces are accessible for wandering and exploring.

Standard EC.8.30

The hospital manages the design and building of the environment when it is renovated, altered, or newly created.

Elements of Performance for EC.8.30

1. When planning for the size, configuration, and equipping of the space of renovated, altered, or new construction, the hospital uses on of the following:

*** Applicable state rules and regulations**

*** *Guidelines for Design and Construction of Hospitals and Health Care Facilities, 2001 Edition.***

*** Standards or guidelines that provide equivalent design criteria**

2. When planning demolition, construction, or renovation, the hospital conducts a proactive risk assessment using risk criteria to identify hazards that could potentially compromise care, treatment, and services in occupied areas of the hospital's buildings. The scope and nature of the activities should determine the extent of risk.

3. When planning demolition, construction, or renovation, the hospital uses risk criteria that address the impact of demolition, renovation, or new construction on air quality requirements, infection control, utility requirements, noise, vibration, and emergency procedures.

4. When planning demolition, construction, or renovation, the hospital selects and implements proper controls, as required, to reduce risk and minimize impact of these activities.

Management of Human Resources (HR)

Standards, Rationales, Elements of Performance, and Scoring

Standard HR.1.10

The hospital provides an adequate number and mix of staff that are consistent with the hospital's staffing plan.

Element of Performance for HR.1.10

1. The hospital has an adequate number and mix of staff to meet the care, treatment, and service needs of the patients.

Standard HR.1.20

The hospital has a process to ensure that a person's qualifications are consistent with his or her job responsibilities

Rationale for HR.1.20

This requirement pertains to staff and students as well as volunteers who work in the same capacity as staff who provide care, treatment, and services.

Elements of Performance for HR.1.20

1. The leaders define the required competence and qualifications of staff in each program or service.
2. The leaders define the required competence and qualifications of staff who make decisions about and implement restraint or seclusion use.
The hospital verifies the following according to law, regulation, and hospital policy (EP's3-6):
3. Current licensure, certification, or registration.
4. Education, experience, and competency appropriate for assigned responsibilities
5. Information on criminal background
6. Compliance with applicable health screening requirements established by the organization
7. Staff supervises students when they provide patient care, treatment, and services as part of their training
8. Through 17. Not applicable
18. Individuals who do not possess a license, registration, or certification do not provide or have not provided care, treatment, and services in the hospital that would, under applicable law or regulation, require such a license, registration, or certification.
19. Individuals who do not possess a license, registration, or certification do not provide or have not provided care, treatment, and services in the hospital that would, under applicable law or regulation, require such a license, registration, or certification and which would have placed the hospital's patients at risk for a serious adverse outcome.

Standard HR.1.30

The hospital uses data on clinical/service screening indicators* in combination with human resource screening indicators+ in combination with human resource screening indicators to assess staffing effectiveness

Rationale for HR.1.30

Multiple screening indicators that relate to patient outcomes, including clinical/service and human resources screening indicators, may be indicative of staffing effectiveness.

Elements of Performance for HR.1.30

1. The hospital selects a minimum of four screening indicators, two clinical/service and two human resources indicators. The focus is on the relationship between human resource and clinical/service screening indicators, with the clear understanding that no in indicator, in and of itself, can directly demonstrate staffing effectiveness.
2. The hospital selects at least one of the human resource and one of the clinical/service screening indicators from a list of Joint Commission-identified screening indicators. The hospital chooses additional screening indicators based on its unique characteristics, specialties, and services.
3. The hospital determines the rationale for screening indicator selection.
4. The hospital defines the direct and indirect caregivers included in the human resource screening indicators based on the impact, if any, the absence of such caregivers is expected to have on patient outcomes.
5. The hospital uses the data collected and analyzed from the selected screening indicators to identify potential staffing effectiveness issues when performance varies from expected targets (for example, ranges of desired performance, external comparisons, improvement goals).
6. The hospital analyzes data over time per screening indicator (for example, identification of trends or patterns using a line graph, run chart, or control chart) to determine the stability of a process.
7. The hospital analyzes all screening indicator data in combination (for example, a table or matrix report, multiple line graphs, spider or radar diagrams, scatter diagrams).
8. The hospital analyzes screening indicator data at the level in which staffing needs are planned in the hospital and in collaboration with other areas in the organization, as needed.
9. The hospital reports at least annually to the leaders on the aggregation and analysis of data related to staffing effectiveness (*see* standards PI.1.10 and PI.2.20) and any actions taken to improve staffing.
10. The hospital can provide evidence of actions taken, as appropriate, in response to analyzed data.

*** An example of a clinical/services screening is adverse drug events.**
+ Examples of human resource screening indicators are overtime and staff vacancy rate.

List of Joint Commission Screening Indicators for Hospitals

1. **Family complaints (Clinical/Service)**
2. **Patient complaints (Clinical/Service)**
3. **Patient falls (Clinical/Service)**
4. **Adverse Drug events (Clinical/Service)**
5. **Injuries to patients (Clinical/Service)**
6. **Skin breakdown (Clinical/Service)**
7. **Pneumonia (Clinical/Service)**
8. **Postoperative infections (Clinical/Service)**
9. **Urinary tract infections (Clinical/Service)**
10. **Upper gastrointestinal bleeding (Clinical/Service)**
11. **Shock/cardiac arrest (Clinical/Service)**
12. **Length of stay (Clinical/Service)**
13. **Overtime (Human Resource)**
14. **Staff vacancy rate (Human Resource)**
15. **Staff satisfaction (Human Resource)**
16. **Staff turnover rate (Human Resource)**
17. **Understaffing as compared to hospital's staffing plan (Human Resource)**
18. **Nursing care hours per patient day (Human Resource)**
19. **Staff injuries on the job (Human Resource)**
20. **On-call or per diem use (Human Resource)**
21. **Sick time (Human Resource)**

List of Joint Commission Screening Indicators for Long Term Care

1. **Prevalence of pressure ulcers (Clinical/Service)**
2. **Resident satisfaction (Clinical/Service)**
3. **Family satisfaction (Clinical/Service)**
4. **Prevalence of falls (Clinical/Service)**
5. **Resident complaints (Clinical/Service)**
6. **Injuries to residents (Clinical/Service)**
7. **Family complaints (Clinical/Service)**
8. **Restraint use (Clinical/Service)**
9. **Prevalence of weight loss (Clinical/Service)**
10. **Elopements/wandering of residents (Clinical/Service)**
11. **Adverse drug events (Clinical/Service)**
12. **Prevalence of dehydration (Clinical/Service)**
13. **Pain assessment and management (that is , wait time to receive medications) (Clinical/Service)**
14. **Urinary tract infection rate (Clinical/Service)**
15. **Change in resident functioning (Clinical/Service)**
16. **Prevalence of malnutrition (Clinical/Service)**
17. **Activities of daily living (ADL's) met or unmet (Clinical/Service)**
18. **Prevalence of urinary catheter use (Clinical/Service)**
19. **Average time in activities (Clinical/Service)**

20. Antibiotic use (Clinical/Service)
21. Unexpected hospital admissions or emergency department visits (Clinical/Service)
22. Prevalence of depression (Clinical/Service)
23. Prevalence of more than 8 prescribed medications (Clinical/Service)
24. Pneumonia rate (Clinical/Service)
25. Antipsychotic medication usage (Clinical/Service) Staff vacancy rate (Human
Resource)
27. Staff turnover rate (Human Resource)
28. Staff satisfaction (Human Resource)
29. Use of overtime (Human Resource)
30. Staff injury rate (Human Resource)
31. Nursing hours per resident day (RN, LPN, CNA) compared to baseline such as
actual versus planned or budgeted (Human Resource)
32. Staff training hours (Human Resource)
33. Agency usage/contract staff (Human Resource)
34. Understaffing as compared to organization's staffing plan (Human Resource)
35. Use of sick time (Human Resource)
36. Activity staff hours per resident day (Human Resource)
37. Number of dietary staff per resident (Human Resource)
38. Number of housekeeping staff per resident (Human Resource)
39. Average response time for consultation order (Human Resource)

Orientation, Training, and Education

Standard HR.2.10

Orientation provides initial job training and information

Rationale for HR.2.10

Staff members, students, and volunteers are oriented to their jobs as appropriate and the work environment before providing care, treatment, and services.

Elements of Performance for HR.2.10

As appropriate, each staff member, student, and volunteer is oriented to the following:

1. The hospital's mission and goals
2. Hospital-wide policies and procedures (including safety and infection control) and relevant unit, setting, or program-specific policies and procedures
3. Specific job duties and responsibilities and unit, setting, or program-specific

job duties and responsibilities related to safety and infection control
4. N/A
5. Cultural diversity and sensitivity
6. Persons are educated about the rights of patients and ethical aspects of care, treatment, and services and the process used to address ethical issues.
LTC Specific - 7. Staff is oriented to the effects of psychotropic medications as appropriate.
8. Orientation and education for forensic staff include how to interact with patients; procedures for responding to unusual clinical events and incidents; the hospital's channels of clinical, security, and administrative communication; and distinctions between administrative and clinical seclusion and restraint.
9. The hospital assesses and documents each person' ability to carry out assigned responsibilities safely, competently, and in a timely manner upon completion of orientation

Standard HR.2.20

Staff members, licensed independent practitioners, students, and volunteers, as appropriate, can describe or demonstrate their roles and responsibilities, based on specific job duties or responsibilities, relative to safety.

Rationale for HR.2.20

The human element is the most critical factor in any process, determining whether the right things are done correctly. The best policies and procedures for minimizing risks in the environment where care, treatment, and services are provided are meaningless if staff, LIPs if applicable, and volunteers do not know and understand them well enough to perform them properly.

It is important that everyday precautions identified by the health care organization for minimizing various risks, including those related to patient/resident safety and environmental safety, be properly implemented. It is also important that the appropriate emergency procedures be instituted should an incident or failure occur in the environment.

Elements of Performance for HR.2.20

Staff members, LIPs, students, and volunteers, as appropriate, can describe or demonstrate the following:

1. **Risks within the hospital's environment.**
2. **Actions to eliminate, minimize, or report risks**
3. **Procedures to follow in the event of an incident**
4. **Reporting processes for common problems, failure, and user errors.**

Standard HR.2.30

Ongoing education, including in-services, training, and other activities, maintains and improves competence.

Elements of Performance for HR.2.30

The following occurs for staff, students, and volunteers who work in the same capacity as staff providing care, treatment, and services:

1. Training occurs when job responsibilities or duties change
2. Participation in ongoing in-services, training, or other activities occurs to increase staff, student, or volunteer knowledge of work-related issues
3. Ongoing in-services and other education and training are appropriate to the needs of the population(s) served and comply with law and regulation
4. Ongoing in-services, training, or other activities emphasize specific job-related aspects of safety and infection prevention and control
5. Ongoing in-services, training, or other education incorporate methods of team training, when appropriate
6. Ongoing in-services, training, or other education reinforce the need and ways to report unanticipated adverse events
7. Ongoing in-services, training, or other education is offered in response to learning needs identified through performance improvement findings and other data analysis (that is, data from staff surveys, performance evaluations, or other needs assessments)
8. Ongoing education is documented

Assessing Competence

Standard HR.3.10

Competence to perform job responsibilities is assessed, demonstrated, and maintained.

Rationale for HR.3.10

Competence assessment is systematic and allows for a measurable assessment of the person's ability to perform required activities. Information used as part of competence assessment may include data from performance evaluations, performance improvement, and aggregate data on competency, as well as the assessment of learning needs.

Elements of Performance for HR.3.10

Competence assessment for staff, students, and volunteers who work in the same capacity as staff providing care, treatment, and services is based on the following (EPs 1-8):

1. **Populations served**
2. **Defined competencies to be required**

3. **Defined competencies to be assessed during orientation**
4. **Defined competencies that need to be assessed and reassessed on an ongoing basis, based on techniques, procedures, technology, equipment, or skills needed to provide care, treatment, and services.**
5. **A defined time frame for how often competency assessments are performed for each person, minimally, once in the three-year accreditation cycle and in accordance with law and regulation.**
6. **Assessment methods (appropriate to determine the skill being assessed).**
7. **Individuals who assess competency are qualified to do so.**
8. **The competence assessment program described is implemented.**
9. **When improvement activities lead to a determination that a person with performance problems is unable or unwilling to improve, the hospital modifies the person's job assignment or takes other appropriate action.**

Management of Information

Information Management Planning

Standard IM.1.10

The hospital plans and designs information management processes to meet internal and external information needs.

Rationale for IM.1.10

Organizations vary in size, complexity, governance, structure, decision-making processes, and resources. Information management systems and processes vary accordingly. Only by first identifying the information needs can one then evaluate the extent to which they are planned for, and at what performance level the needs are being met. Planning for the management of information does not require a formal written information plan, but does require evidence of a planned approach that identifies the hospital's information needs and supports its goals and objectives.

Elements of Performance for IM.1.10

1. The hospital bases its information management processes on a thorough analysis of internal and external information needs.

- *** The analysis ascertains the flow of information in a hospital, including information storage and feedback mechanisms.**
- *** The analysis considers what data and information are needed: within and among departments, services, or programs: within and among the staff, the administration, and governance structure; to support relationships with outside services and contractors; with licensing, accrediting, and regulatory bodies; with purchasers, payers, and employers; and to participate in national research and databases.**

2. To guide development of processes for managing information used internally and externally, the hospital assesses its information management needs based on the following:

- *** Its mission**
- *** Its goals**
- *** Its services**
- *** Personnel**
- *** Patient safety considerations**
- *** Quality of care, treatment, and services**
- *** Mode(s) of service delivery**
- *** Resources**
- *** Access to affordable technology**
- *** Identification of barriers to effective communication among caregivers**

3. The hospital bases management, staffing, and material resource allocations for information management on the scope and complexity of care, treatment, and

services provided.
4. Appropriate staff participates in assessment, selection, integration, and use of information management systems for clinical/service and hospital information.
5. The hospital engages in an ongoing systematic effort to assess the needs of the organization, departments, and individuals for knowledge-based information and uses this assessment as a basis for planning.

Confidentiality and Security

Standard IM.2.10

Information privacy and confidentiality are maintained.

Rationale for IM.2.10

Confidentiality of data and information applies across all systems and automated, paper, and verbal communications, as well as to clinical/service, financial and business records and employee-specific information. The capture, storage and retrieval processes for data and information are designed to be performed on a timely basis without compromising the data and information's confidentiality. Protecting privacy and confidentiality of information is the responsibility of the whole organization. In achieving this responsibility, the hospital provides appropriate safeguards for patient privacy and the confidentiality of information. These safeguards are consistent with available technology and legitimate needs for accessibility of the information to authorized individuals for the delivery of care, treatment, and services, effective functioning of the organization, research, and education.

Elements of Performance for IM.2.10

1. The hospital has developed a written process (in one or more policies) based on and consistent with applicable law that addresses the privacy and confidentiality of information.
2. The hospital's policy, including significant changes to the policy, has been effectively communicated to applicable staff.
3. The hospital has an effective process for enforcing the policy.
4. The hospital monitors compliance with its policy.
5. The hospital uses monitoring of information and developments in technology to improve privacy and confidentiality.
6. Individuals about whom personally identifiable health data and information may be maintained or collected are made aware of what uses and disclosures of the information will be made.
7. For uses and disclosures of health information, the removal of personal identifiers is encouraged to the extent possible, consistent with maintaining the usefulness of the information.
8. Protected health information is used for the purposes identified or as required by law and not further disclosed without patient authorization.

9. The hospital preserves the confidentiality of data and information identified as sensitive and requires extraordinary means to preserve patient privacy.

Information Management Processes

Standard IM.3.10

The hospital has processes in place to effectively manage information, including the capturing, reporting, processing, storing, retrieving, disseminating, and displaying of clinical/service and non-clinical data and information.

Rational for IM.3.10

Records resulting from data capture and report generation are used for communication and continuity of the patient's care, treatment, and services or financial and business operations over time. Records are also used for other purposes, including litigation and risk management activities, reimbursement, and statistics. Improved data capture and report generation systems enhance the value of the records. Potential benefits include improved patient care quality and safety, improved efficiency effectiveness and reduced costs in patient care, treatment, and services, and financial and business operation. To maximize the benefits of data capture and report generation, these processes exhibit the following characteristics: unique ID, accuracy, completeness, timeliness, interoperability, irretrievability, authentication and accountability, auditability, confidentiality, and security.

The processing, storage, and retrieval functions are integral to electronic, computerized, and paper-based information systems in organizations. Important considerations for these functions include data elements, data accuracy, data confidentiality, data security, data integrity, permanence of storage (the time a medium can safely store information), ease of irretrievability, aggregation of information, interoperability, clinical/service practice considerations, performance improvement, and decision support processing.

A goal for information storage is to be linked or centrally organized and accessible. This could include the hospital having an index identifying where the information is stored and how to access it; or, as the hospital moves to electronic systems, the hospital creates all information systems to be interoperable within the enterprise. As more organizations automate various processes and activities, it is important to share critical data among systems. As challenges of interoperability have arisen, standards organizations have stepped in to develop industry standards, it is important the hospital is aware of these standards development organizations and their recommendations.

Internally and externally generated data and information are accurately disseminated to users. Access to accurate information is required to deliver, improve, analyze, and advance patient care, treatment, and services and the systems that support health care delivery. Information may be accessed and disseminated through electronic information systems or paper-based records and reports. The use of information should be considered in developing forms, screen displays, and standard or ad hoc reports.

Elements of Performance for IM.3.10

1. Uniform data definitions and data capture methods are used.

*** Minimum data sets, terminology, definitions, classifications, vocabulary, and nomenclature are standardized as needed.**

*** Industry standards are used whenever possible.**

2. Abbreviations, acronyms, and symbols are standardized throughout the hospital, and there is a list of abbreviations, acronyms, and symbols *not* to use.

3. Quality control systems are used to monitor data content and collection activities.

*** The method used assures timely and economical data collection with the degree of accuracy, completeness, and discrimination necessary for their intended use.**

*** The method used minimizes bias in the data and regularly assesses that data's reliability, validity, and accuracy.**

*** Those responsible for collecting and reviewing the data are accountable for information accuracy and completeness.**

4. Storage and retrieval systems are designed to support hospital needs for clinical/service and organization-specific information.

*** Storage and retrieval systems are designed to balance the ability to retrieve data and information with the intended use for the data and information.**

*** Storage and retrieval systems are designed to balance security and confidentiality issues with accessibility.**

*** Systems for paper and electronic records are designed to reduce disruptions or inaccessibility during such times as diminished staffing and scheduled and unscheduled down times of electronic information systems.**

5. Data and information are retained for sufficient time to comply with law and regulation, as well as standards for quality of care, treatment, and services and other hospital needs.

6. The necessary expertise and tools are available for collecting, retrieving, and analyzing data and their transformation into information.

7. Data are organized and transformed into information in formats useful to decision makers.

8. Dissemination of data and information is timely and accurate.

9. Data and information are disseminated in standard formats and methods to meet user needs and provide for easy retrievability and interpretation.

10. Specific attention is directed to the processes for ensuring accurate, timely, and complete verbal and written communication among caregivers and all others

involved in the use of data.
11. Industry or hospital standards are used whenever possible for data display and transmission.

Standard IM.6.20 - LTC Specific

Records contain resident-specific information, as appropriate, to the care, treatment, and services provided.

Element of Performance for IM.6.20

1. Each clinical record contains the resident's name, address, date of birth, religion, marital status, social security number, gender, and the name of any legally authorized representative.

Standard IM.6.60

The hospital can provide access to all relevant information from a patient's record when needed for use in patient care, treatment and services.

Rational for IM.6.60

To facilitate continuity of care, providers have access to information about all previous care, treatment, and services provided to a patient by the organization.

Elements of Performance for IM.6.60

1. There is a manual or automatic mechanism to track the location of all components of the medical record.
2. The hospital uses a system to assemble required information or make available a summary of information related to patient care, treatment, and services when the patient is seen.

Glossary

Hospice An organized program that comprises services provided and coordinated by an interdisciplinary team to meet the needs of patients who are diagnosed with a terminal illness and who have a limited life span. The program specializes in palliative management of pain and other physical symptoms, meeting the psychosocial and spiritual needs of the patient and the patients family or other primary care person(s), making use of volunteers, and providing bereavement care to survivors. This includes, but is not limited to, all programs licensed as hospices and Medicare-certified hospice programs. All services provided by the hospice (for example, pharmacy and home medical equipment services), and care, treatment, and services provided in all settings (in-patient, nursing home, and so for the) are included.

Spiritual Assessment (Hospital Program)

Q: Does the Joint Commission specify what needs to be included in a spiritual assessment?

A: Spiritual assessment should, at a minimum, determine the patient's denomination, beliefs, and what spiritual practices are important to the patient. This information would assist in determining the impact of spirituality, if any, on the care/services being provided and will identify if any further assessment is needed. The standards require organization's to define the content and scope of spiritual and other assessments and the qualifications of the individual(s) performing the assessment.

Examples of elements that could be but are not required in a spiritual assessment include the following questions directed to the patient or his/her family:

Who or what provides the patient with strength and hope?

Does the patient use prayer in their life?

How does the patient express their spirituality?

How would the patient describe their philosophy of life?

What type of spiritual/religious support does the patient desire?

What is the name of the patient's clergy, ministers, chaplains, pastor, rabbi?

What does suffering mean to the patient?

What does dying mean to the patient?

What are the patient's spiritual goals?

Is there a role of church/synagogue in the patient's life?

How does your faith help the patient cope with illness?

How does the patient keep going day after day?

What helps the patient get through this health care experience?

How has illness affected the patient and his/her family?

Revised Date: January 1, 2004
Origination Date: July 31, 2001

Spiritual Assessment (Long Term Care Program)

Q: Does the Joint Commission specify what needs to be included in a spiritual assessment?

A: Spiritual assessment should, at a minimum, determine the patient's denomination, beliefs, and what spiritual practices are important to the patient. This information would assist in determining the impact of spirituality, if any, on the care/services being provided and will identify if any further assessment is needed. The standards require organization's to define the content and scope of spiritual and other assessments and the qualifications of the individual(s) performing the assessment.

Examples of elements that could be but are not required in a spiritual assessment include the following questions directed to the patient or his/her family:

Who or what provides the patient with strength and hope?

Does the patient use prayer in their life?

How does the patient express their spirituality?

How would the patient describe their philosophy of life?

What type of spiritual/religious support does the patient desire?

What is the name of the patient's clergy, ministers, chaplains, pastor, rabbi?

What does suffering mean to the patient?

What does dying mean to the patient?

What are the patient's spiritual goals?

Is there a role of church/synagogue in the patient's life?

How does your faith help the patient cope with illness?

How does the patient keep going day after day?

What helps the patient get through this health care experience?

How has illness affected the patient and his/her family?

Revised Date: January 1, 2004
Origination Date: July 31, 2001

Spiritual Assessment (Behavioral Healthcare Program)

Q: Does the Joint Commission specify what needs to be included in a spiritual assessment?

A: Spiritual assessment should, at a minimum, determine the patient's denomination, beliefs, and what spiritual practices are important to the patient. This information would assist in determining the impact of spirituality, if any, on the care/services being provided and will identify if any further assessment is needed. The standards require organization's to define the content and scope of spiritual and other assessments and the qualifications of the individual(s) performing the assessment.

Examples of elements that could be but are not required in a spiritual assessment include the following questions directed to the patient or his/her family:

Who or what provides the patient with strength and hope?

Does the patient use prayer in their life?

How does the patient express their spirituality?

How would the patient describe their philosophy of life?

What type of spiritual/religious support does the patient desire?

What is the name of the patient's clergy, ministers, chaplains, pastor, rabbi?

What does suffering mean to the patient?

What does dying mean to the patient?

What are the patient's spiritual goals?

Is there a role of church/synagogue in the patient's life?

Has belief in God been important in the patient's life?

How does your faith help the patient cope with illness?

How does the patient keep going day after day?

What helps the patient get through this health care experience?

How has illness affected the patient and his/her family?

Behavioral Health: An assessment of a client's spiritual orientation is necessary in order to determine any barriers that the client might encounter in affiliating with certain types of self-help groups. Standard PE.1.21.4 reads "Assessment or reassessment of individuals receiving treatment for chemical dependency addresses spiritual orientation." The assessment gathers information about the individual that will help to match the individual's needs with appropriate setting and intervention. ***Spiritual orientation refers to the individual's attitudes and outlook about the non-physical aspects of life--the "spirit". It is often reflected in belonging to a church, following a religion, or holding specific religious beliefs.*** The assessment should, at a minimum, determine the patient's denomination, beliefs, and important spiritual practices, if any.

Spiritual Assessment (Home Care Program)

Q: Does the Joint Commission specify what needs to be included in a spiritual assessment?

A: Spiritual assessment should, at a minimum, determine the patient's denomination, beliefs, and what spiritual practices are important to the patient. This information would assist in determining the impact of spirituality, if any, on the care/services being provided and will identify if any further assessment is needed. The standards require organization's to define the content and scope of spiritual and other assessments and the qualifications of the individual(s) performing the assessment.

Examples of elements that could be but are not required in a spiritual assessment include the following questions directed to the patient or his/her family:

Who or what provides the patient with strength and hope?

Does the patient use prayer in their life?

How does the patient express their spirituality?

How would the patient describe their philosophy of life?

What type of spiritual/religious support does the patient desire?

What is the name of the patient's clergy, ministers, chaplains, pastor, rabbi?

What does suffering mean to the patient?

What does dying mean to the patient?

What are the patient's spiritual goals?

Is there a role of church/synagogue in the patient's life?

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