Errata Sheet
JCI Accreditation Standards for Hospitals, 6th Edition
Issued 8 January 2018

Joint Commission International

This errata sheet lists errors and their corrections for the *Joint Commission International Accreditation Standards for Hospitals*, 6th Edition.

Location	Correction Deletions in ~~strikethrough~~. New text is underlined.	Explanation for Correction
Pages 47–48 **IPSG.3 – IPSG.3.1** **Intent**	**Intent of IPSG.3 and IPSG.3.1** **Examples** of lists of high-alert medications are available from organizations such as the Institute for Safe Medication Practices (ISMP) and the World Health Organization (WHO).[15] For safe management, the hospital needs to develop its own list(s) of high-alert medications based on its unique utilization patterns of medications and its own internal data about near misses, medication errors, and sentinel events. (*Also see* MMU.7.1 and QPS.7) The list includes medications identified as high risk for adverse outcomes. Information from the literature and/or Ministry of Health may also be useful in helping to identify which medications should be included.[16,17] These medications are stored in a way that reduces the likelihood of inadvertent administration or ideally provides directions on the proper use of the medication. Strategies to improve the safety of high-alert medications may be tailored to the specific risk of each medication and should include consideration of prescribing, preparation, administration, and monitoring processes, in addition to safe storage strategies.[18-22] Medications at risk for look-alike/sound-alike confusion, such as similar medication names and similar product packaging, may lead to potentially harmful medication errors. Hospitals need to institute risk management strategies to minimize adverse events with LASA medications and enhance patient safety.[20,22-25] (*Also see* MMU.4.1)	Added superscript numbers, which were inadvertently omitted from initial publication
Page 51 **IPSG.4.1, ME 1**	**Measurable Elements of IPSG.4.1** ❑ 1. The full team actively participates in a time-out process, which includes a) through c) in the intent, in the area in which the surgical/invasive procedure will be performed, immediately before starting the procedure. Completion of the time-out is documented and includes date and time. (*Also see* MOI.11.1)	Added text to clarify expectation and align with language in the intent
Page 51 **IPSG.5, ME 3**	**Measurable Elements of IPSG.5** ❑ 3. Hand-washing and hand-disinfection procedures are used in accordance with hand-hygiene guidelines throughout the hospital. (*Also see* ~~IPSG.9, ME 4~~ PCI.9, ME 4)	Corrected typo in cross-reference
Pages 93 and 113 **AOP.6.1**	**Standard AOP.6.1** A qualified individual(s) is responsible for managing the radiology and diagnostic imaging services. Ⓟ	Added missing policy symbol
Pages 93 and 114 **AOP.6.3**	**Standard AOP.6.3** A ~~Radiation~~ radiation safety ~~guidelines~~ program for staff and patients ~~are~~ is in place, followed, and documented; and compliance with the facility management and infection control programs is maintained. Ⓟ	Corrected text to clarify expectation and align with language in the measurable elements

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Page 120 **COP.8.6**	**Standard COP.8.6** The transplant program has documented protocols, clinical practice guidelines, or procedures for organ recovery and organ receipt to ensure the compatibility, safety, efficacy, and quality of human cells, tissues, and organs for transplantation. Ⓟ	Added missing policy symbol
Pages 120 and 137 **COP.9.1**	**Standard COP.9.1** Transplant programs performing living donor transplants obtain informed consent specific to organ donation from the prospective living donor. Ⓟ	Added missing policy symbol
Page 129 **COP.4, ME 6**	**Measurable Elements of COP.4** ❑ 6. Food provided by family or others is stored ~~according~~ under proper conditions to prevent contamination.	Corrected typo in measurable element
Pages 155 and 157 **MMU.1.1**	**Standard MMU.1.1** The hospital develops and implements a program for the prudent use of antibiotics based on the principle of antibiotic stewardship. Ⓟ	Added missing policy symbol
Page 167 **MMU.5.1, ME 4**	**Measurable Elements of MMU.5.1** ❑ 4. When the designated licensed professional is not available to perform the full appropriateness review, a trained individual conducts and documents a review of critical elements h) through k) in the intent for the first dose and a full appropriateness review is conducted by the designated licensed professional within 24 hours. (*Also see* SQE.5 ME 4; SQE.10, ME 3; SQE.14, ME 1; and SQE.16, ME 1)	Added text to clarify expectation
Pages 192 and 197 **PCI.7**	**Standard PCI.7** The hospital reduces the risk of infections associated with medical/surgical equipment, devices, and supplies by ensuring adequate cleaning, disinfection, sterilization, and storage; and implements a process for managing expired supplies. Ⓟ	Added missing policy symbol
Page 198 **PCI.7, ME 3**	**Measurable Elements of PCI.7** ❑ 3. Staff processing medical/surgical equipment, devices, and supplies are oriented, trained, and competent in cleaning, disinfection, and sterilization and receive proper supervision. (*Also see* ~~GLD.4, ME 1~~ SQE.4, ME 1)	Corrected typo in cross-reference
Pages 210 and 219 **GLD.6**	**Standard GLD.6** Hospital leadership is accountable for the review, selection, and monitoring of clinical ~~or~~ and nonclinical contracts. Ⓟ	Edited text to clarify expectation
Page 214 **GLD.2, ME 4**	**Measurable Elements of GLD.2** ❑ 4. The chief executive(s) ensures compliance with approved policies. (*Also see* MOI.8.1, ME 3)	Added missing cross-reference

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Page 218 **GLD.4.1, ME 3**	**Measurable Elements of GLD.4.1** ❑ 3. Information on the quality improvement and patient safety program is regularly communicated to staff, including progress on meeting the International Patient Safety Goals. (*Also see* ~~QPS.5, ME 5)~~ QPS.1, ME 5)	Corrected typo in cross-reference
Page 231 **"Note" under the header *Health Professional Education***	**Note:** ~~This standard applies to hospitals that provide health professional education but do not~~ For hospitals that meet the eligibility criteria for Academic Medical Center (AMC) hospital accreditation, GLD.14 applies to education provided to nursing students and/or other non-medical, health professional students. For non-AMC hospitals, GLD.14 applies to education provided to medical trainees, nursing students, and/or other health professional students.	Edited text to clarify when GLD.14 is applicable to hospitals and academic medical centers
Page 250 **FMS.8.1, ME 1**	**Measurable Elements of FMS.8.1** ❑ 1. The hospital has a system in place for monitoring and acting on medical equipment and implantable device hazard notices, recalls, reportable incidents, problems, and failures. (*Also see* ~~AOP.5.6, ME 6~~ AOP.5.5, ME 6; AOP.6.5, ME 6; and ASC.7.4, ME 3)	Corrected typo in cross-reference
Pages 258 and 278 **SQE.13**	**Standard SQE.13** The hospital has a uniform process to gather, to verify, and to evaluate the nursing staff's credentials (license, education, training, and experience). Ⓟ	Added missing policy symbol
Page 288 **MOI.2** **Intent**	**Intent of MOI.2** **…** Maintaining data integrity is an important aspect of information management. The information contained in a database must be accurate in order to ensure that the interpretation of results from data analysis is meaningful. In addition, data integrity is maintained during planned and unplanned ~~downtown~~ downtime of data systems. This is accomplished through implementation of downtime recovery tactics and ongoing data backup processes. (*Also see* MOI.14)	Corrected typo in intent
Page 288 **MOI.2, ME 1**	**Measurable Elements of MOI.2** ❑ 1. The hospital has a written process that protects the confidentiality, security, and integrity of data and information. (*Also see* COP.2.2, ~~ME 6~~ ME 5, SQE.5, ME 1; and MOI.3, MEs 2 and 3)	Corrected typo in cross-reference
Page 292 **MOI.8.1, ME 3**	**Measurable Elements of MOI.8.1** ❑ 3. The requirements of the policies, procedures, and plans are fully implemented and evident in the actions of individual staff members. (*Also see* COP.3, ME 2 and GLD.2, ME 4)	Added missing cross-reference

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Pages 318–319
***Summary of Key Accreditation Policies* section**
	Types of Surveys
	
	Full Survey
	The survey of all the hospital standards throughout an entire organization. This may be the initial survey, triennial survey, or validation survey. Definition of each follows.
	• *Initial Survey*—The first full on-site survey of a hospital
	  ○ *Follow-up Survey*—An on-site evaluation scheduled at least 120 days after the date the hospital received the Preliminary Survey Findings Report following an initial survey to evaluate those measurable elements (MEs) scored "not met" or "partially met" that resulted in the hospital's failure to meet the accreditation decision rules.
	• *Triennial Survey*—The survey of a hospital after a three-year cycle of accreditation
	  ○ *Follow-up Survey*—An on-site evaluation scheduled at least 120 days after the date the hospital received the Preliminary Survey Findings Report following a triennial survey to evaluate those MEs scored "not met" or "partially met" that resulted in the hospital's failure to meet the accreditation decision rules.
	• *Validation Survey*—JCI may conduct a second full survey in volunteer organizations as a component of JCI's internal quality improvement monitoring processes. This survey has no impact on the hospital's accreditation status and is conducted at no charge to the hospital.
		Added text to clarify the timing for follow-up surveys