Joint Commission International Errata Sheet
JCI Accreditation Standards for Hospitals, 7th Edition
Issued 1 April 2020

This sheet lists errors and their corrections for translations of the *Joint Commission International Accreditation Standards for Hospitals,* 7th Edition. These errors do NOT appear in the English version of the manual. Translations were done using an earlier version of the manual before it was finalized. When in doubt, please use the English version of the manual as the official information.

Page Location (in English version)	Correction Deletions in ~~strikethrough~~. New text is underlined.	Explanation for Correction
vii-xxxi	**Summary of Changes to the Manual**	There are errors in the Summary of Changes to the Manual in the beginning of the 7th Edition. Please view the actual text in the body of the English version manual as the official and correct information.
81 and 101	**AOP.6.2** A radiation and/or diagnostic imaging safety program for patients, staff, and visitors is in place, is followed, and is compliant with applicable professional standards, laws, and regulations. Ⓟ	Added the missing Ⓟ icon to Standard AOP.6.2*
85	**Measurable Elements of AOP.1.3** 4. The findings of all assessments performed outside the hospital are reviewed and/or verified at the time of admission to inpatient status or prior to an outpatient procedure.	Revised AOP.1.3, ME 4 to include outpatient settings
123	**Intent of COP.7** Patients who are dying have unique needs for respectful, compassionate care as indicated by their assessment. The patient assessment may identify symptoms that require management, such as nausea, respiratory distress, and pain; factors that alleviate or exacerbate physical symptoms; and the patient's response to symptom management. Identifying the patient's ~~physician~~ physical needs is just one aspect of determining the patient's end of life care. Patients and families may also have a need for spiritual, psychosocial, and support services, as	Corrected a typo in Intent of COP.7 from "physician" to "physical"

	appropriate to the patient's individual needs and cultural preferences.	
131	**COP.9.2** Transplant programs that perform living donor transplants use clinical and psychological selection criteria to determine the suitability of potential living donors. Ⓟ	Added the missing Ⓟ icon to Standard COP.9.2*
138	**ASC.5** ~~Each patient's anesthesia care is planned and documented, and the anesthesia and technique used are documented in the patient's medical record.~~ Each patient's anesthesia care and, when applicable, postoperative pain management are planned, and the plan as well as the risks, benefits, and alternatives are discussed with the patient and/or those who make decisions for the patient and documented in the patient's medical record. ~~**ASC.5.1** The risks, benefits, and alternatives related to anesthesia and postoperative pain control are discussed with the patient and/or those who make decisions for the patient.~~	Combined Standard ASC.5 and former ASC.5.1 in the Standards list
143-144	**Standard ASC.5** Each patient's anesthesia care ~~is planned and documented, and the anesthesia and technique used are~~ and, when applicable, postoperative pain management are planned; and the plan as well as the risks, benefits, and alternatives are discussed with the patient and/or those who make decisions for the patient and documented in the patient's medical record. **Intent of ASC.5** Anesthesia care is carefully planned ~~and documented in the anesthesia record~~. The plan includes information from other patient assessments and identifies the anesthesia to be used, the method of administration, other medications and fluids, monitoring procedures, and anticipated postanesthesia care. The anesthesia planning process includes educating the patient, his or her family, or decision maker on the risks, benefits, and alternatives related to the planned anesthesia. (*Also see* PCC.4.3) This discussion occurs as part of the process to obtain consent for anesthesia as required in PCC.4.2. An anesthesiologist or a qualified individual provides this education. (*Also see* PCC.5.2) When postoperative pain management is provided by anesthesia services, the postoperative pain	Combined concepts from Standard ASC.5 and former Standard ASC.5.1 in the chapter as well as the Intent and MEs

	management plan is reviewed and discussed with the patient by the anesthesiologist or other qualified individual and documented in the patient's medical record. The anesthesia agent, dose (when applicable), ~~and~~ anesthetic technique, and qualified individual administering the anesthesia are documented in the patient's anesthesia record. (*Also see* COP.2.1; QPS.8; and MOI.8.1) **Measurable Elements of ASC.5** 1. The anesthesia care of each patient is planned and documented in the patient's medical record. 2. The patient, family, and/or decision makers are educated on the risks, benefits, and alternatives of anesthesia. 3. When applicable, the patient, family, and/or decision makers are educated prior to the procedure being performed about the options available for postoperative pain management. ~~2~~4. The anesthesia agent, dose (when applicable), and anesthetic technique are documented in the patient's anesthesia record. ~~3~~5. The anesthesiologist and/or nurse anesthetist and anesthesia assistants are identified in the patient's anesthesia record.	
144	~~**Standard ASC.5.1**~~ ~~The risks, benefits, and alternatives related to anesthesia and postoperative pain control are discussed with the patient and/or those who make decisions for the patient.~~ ~~**Intent of ASC.5.1**~~ ~~The anesthesia planning process includes educating the patient, his or her family, or decision maker on the risks, benefits, and alternatives related to the planned anesthesia and postoperative analgesia. (*Also see* PCC.4.3)~~ ~~This discussion occurs as part of the process to obtain consent for anesthesia as required in PCC.4.2. An anesthesiologist or a qualified individual provides this education. (*Also see* PCC.5.2)~~ ~~**Measurable Elements of ASC.5.1**~~ ~~1. The patient, family, and/or decision makers are educated on the risks, benefits, and alternatives of anesthesia.~~	Delete ASC.5.1 as it was merged into ASC.5

	~~2. The patient, family, and/or decision makers are educated, prior to the procedure being performed, about the options available for postoperative pain management.~~ ~~3. The anesthesiologist or another qualified individual provides and documents the education.~~	
174	**QPS.7.1** The hospital uses a defined process for identifying and managing adverse, no-harm, and near miss events. Ⓟ	Revised Standard QPS.7.1 to include no-harm and near miss events in the Standards listing
180	**QPS.7.1** The hospital uses a defined process for identifying and managing adverse, no-harm, and near miss events. Ⓟ	Revised Standard QPS.7.1 to include no-harm and near miss events in the chapter
180	**Intent of QPS.7 and QPS.7.1** ***(first paragraph)*** In order to address system issues that can lead to patient, staff, or visitor harm, the hospital must have a process for identifying and managing ~~both~~ sentinel, adverse, no-harm, and near miss events ~~and adverse events~~. In response to these events ~~a sentinel event or an adverse event~~ it is important that the hospital focuses not on individual error, but on the system factors that contributed to the event.	Revised Intent of QPS.7 and QPS.7.1 to include no-harm and near miss events
182	**Intent of QPS.7 and QPS.7.1** ***(last paragraph)*** While not all patient safety events will meet the definition of a sentinel event, those that meet the definition of an adverse event require analysis in order to identify corrective actions. In addition, in an attempt to proactively learn where systems may be vulnerable, the hospital ~~collects data and information on those events identified as~~ tracks no-harm events, ~~and~~ near misses ~~events, as defined above~~ and hazardous conditions and uses them as opportunities to prevent harm, in accordance with the hospital's process for responding to patient safety events that do not meet the definition of sentinel event. (*Also see* MMU.7.1) The hospital's ~~develops a~~ process for managing these events ~~that~~ includes a mechanism for blame-free reporting. (*Also see* GLD.12.2 and GLD.13.1) The data from these reports are aggregated and analyzed to learn where proactive process changes will reduce or prevent their occurrence.	Expanded Intent to address a wider range of patient safety events beyond just sentinel events
182	**Measurable Elements of QPS.7**	Deleted QPS.7, ME 2 and renumbered the remaining MEs

	1. Hospital leadership establishes a definition of a sentinel event that includes at least a) through r) found in the intent. ~~2. Hospital leadership establishes a definition of an adverse event as defined in the intent.~~ ~~3~~2. Hospital leaders complete a credible and thorough comprehensive systematic analysis (**for example**, root cause analysis) of all sentinel events within a time period specified by hospital leadership that does not exceed 45 days from the date of the event or when made aware of the event. ~~4~~3. The root cause analysis identifies all system and process origins that may have contributed to the event. ~~5~~4. Hospital leadership considers each identified contributing factor and takes corrective actions for improvement to prevent or reduce the risk of the adverse event from recurring. ~~6~~5. The hospital monitors the implemented corrective actions for potential process failures (unintended consequences), effectiveness, and sustainability over time.	
182	**Measurable Elements of QPS.7.1** 1. Hospital leadership establishes a definition of adverse event, no-harm event, and near miss event as defined in the intent. 2. Hospital leadership has a mechanism for ~~defines a process for managing no-harm events and near miss events that includes a~~ blame-free ~~mechanism for~~ reporting of adverse events, no-harm events, and near miss events. 3. ~~Data from no-harm and near miss events are analyzed and the results are used~~ Hospital leadership defines a process for managing adverse events that includes an analysis of the events to identify corrective actions. 4. Hospital leadership defines a process for managing near miss events and no-harm events that includes an analysis of the events to identify corrective actions. ~~4~~5. Hospital leaders implement corrective actions, when appropriate, on the results of the analysis. ~~5~~6. Hospital leaders monitor the implemented corrective actions for potential process failures (unintended consequences), effectiveness, and sustainability over time.	Revised QPS.7.1 MEs to include adverse events including splitting and revising ME 3 to distinguish process for managing adverse events (ME 3) from managing near miss and no-harm events (ME 4) and renumbered remaining MEs

213	**GLD.3** ~~Hospital leadership identifies and plans for the type of clinical services required to meet the needs of the patients served by the hospital.~~ Hospital leadership is identified and is collectively responsible for defining the hospital's mission and creating the programs and policies needed to fulfill the mission. Ⓟ **GLD.3.1** ~~The governing entity approves the hospital's program for quality and patient safety and regularly receives and acts on reports of the quality and patient safety program.~~ Hospital leadership identifies and plans for the type of clinical services required to meet the needs of the patients served by the hospital. Ⓟ	Revised Standards GLD.3 and GLD.3.1 in the Standards listing to match revisions made in the chapter
214	**GLD.13.1** Hospital leadership implements, monitors, and takes action to improve the program for ~~creates and supports~~ a culture of safety ~~program~~ throughout the hospital. Ⓟ	Revised Standard GLD.13.1 in the Standards listing to match revisions made in the chapter
218	**Intent of GLD.3** Hospital leadership comes from many sources. The governing entity names the chief executive(s). The chief executive(s) may name others to hospital leadership. Hospital leadership may have formal titles, such as Medical Director or Director of Nursing, may be leaders of clinical or nonclinical departments or services, or may be informally recognized for their seniority, stature, or contribution to the hospital. It is important that hospital leadership is recognized and brought into the process of defining the hospital's values and mission. Based on that mission, hospital leadership works collectively and collaboratively to develop the programs, policies, and services needed to fulfill the mission. When the mission and policy framework are set by owners or agencies outside the hospital, hospital leadership works collaboratively to carry out the mission and policies. **Measurable Elements of GLD.3** 2. Hospital leadership is responsible for defining the hospital's values and mission.	Revised Intent of GLD.3 and its ME 2 to include the hospital's values
243, 258, and 259	**FMS.10.1** The utility systems program includes inspection, testing, and maintenance to ensure that utilities operate effectively and efficiently to meet the needs of patients, staff, and visitors. Ⓟ	Added the missing Ⓟ icon to Standards FMS.10.1 and FMS.10.2*

	FMS.10.2 The hospital utility systems program ensures that essential utilities, including power, water and medical gases, are available at all times and alternative sources for essential utilities are established and tested. Ⓟ	
246	**Intent of FMS.2** ***(bullet b)*** b) Facility management and safety programs are planned and developed for the following: safety, security, hazardous materials and waste, fire safety, medical equipment, utility systems, ~~and~~ emergency and disaster management, and construction and renovation.	Expanded bullet b in the Intent of FMS.2 to include construction and renovation in facility management and safety programs
275	**Intent of SQE.3** ***(second bullet)*** • The evaluation of necessary skills, knowledge, and desired work behaviors also includes an assessment of the staff member's ability to operate medical equipment, clinical alarms~~, and~~ clinical alarms and oversee medication management unique to the specific area (for example, staff working in intensive care units should be able to effectively manage ventilators, infusion pumps, and continuous cardiac monitoring, and staff working in labor and delivery should be able to effectively manage fetal monitoring equipment	Clarified in Intent of SQE.3 that a staff member must have ability to oversee medication management
278	**Measurable Elements of SQE.7** 3. ~~Volunteers are oriented to the hospital and assigned responsibilities.~~ Staff who accompany independent practitioners and provide care and services are oriented to the hospital. 4. Students, ~~and~~ trainees, and volunteers are oriented to the hospital and assigned responsibilities.	Moved concept of volunteers from SQE.7, ME 3 to ME 4 and included a new ME 3 to address orientation of staff who accompany licensed independent practitioners
291	**Measurable Elements of SQE.11** 3. The data and information from the ~~monitoring~~ evaluation are reviewed at least every 12 months by the individual's department or service head, senior medical manager, or medical staff body, and the results, conclusions, and any actions taken are documented in the medical staff member's credential file and other relevant files.	Clarified in SQE.11, ME 3 data and information is from evaluations not simply monitoring
325	**Intent of MPE.6** ***(second and third paragraph)*** Also, required clinical practice guidelines, surgical time-out procedures, medication-ordering policies, and other mechanisms to reduce variation in care	Clarified in Intent of MPE.6 applies to ongoing evaluations/evaluation programs

	processes—and thus reduce the risk in those processes—are part of all medical students' and trainees' initial orientation and ongoing training and ~~monitoring~~ evaluation. The orientation for the medical student and trainee includes at least a) hospital quality and patient safety program; (*Also see* GLD.4; GLD.4.1; GLD.5; GLD.11; and GLD.11.2) b) infection prevention and control program; (*Also see* PCI.5) c) medication safety program; (*Also see* MMU.1) d) the International Patient Safety Goals; e) all other required hospital orientation, including at the department and unit level; (*Also see* SQE.7) and f) any ongoing required education. Those persons providing medical student and trainee supervision ensure that all medical students and trainees are knowledgeable about these quality and safety programs and are included in the ~~monitoring~~ evaluation process.	
345	**Appeal of Decisions to Deny or Withdraw Accreditation** Hospitals have the right to appeal adverse accreditation decisions. If, based on a full or ~~focused~~ follow-up survey, or a threat-to-life health and safety situation, there is a decision to deny or to withdraw accreditation, an organization has 10 calendar days from receipt of its Official Survey Findings Report or notice of accreditation withdrawal to notify JCI, in writing or by e-mail, of its intent to appeal the decision.	Changed all references to "focused survey" to the correct term, "follow-up survey" in the "Summary of Key Accreditation Policies" chapter
347	An organization that fails to submit an acceptable SIP within 120 days of the organization's survey is placed At Risk for Denial of Accreditation and a ~~focused~~ follow-up survey is required to verify evidence of compliance. When this occurs, the client organization is notified and the ~~focused~~ follow-up survey protocol is implemented.	Changed all references to "focused survey" to the correct term, "follow-up survey" in the "Summary of Key Accreditation Policies" chapter
359	**Immediate Threat to Health or Safety** A threat that represents immediate risk and has or may potentially have serious adverse effects on the health or safety of the patient, resident, or individual served. These threats are identified on site by the surveyor. Also known as immediate threat to life (ITL).	Add the term "Immediate Threat to Health or Safety" to the Glossary
368	**risk assessment** The identification and evaluation of potential failures and sources of errors	Revised the term "risk assessment" and deleted the

	in a process. This is followed by prioritizing areas for improvement based on the actual or potential impact on care, treatment, or services provided. ~~**risk assessment, proactive** An assessment that examines a process in detail, including sequencing of events; actual and potential risks; and failure or points of vulnerability; and that, through a logical process, prioritizes areas for improvement based on the actual or potential impact (that is, criticality) of care, treatment, or services provided.~~	term “risk assessment, proactive”

*The Ⓟ icon indicates that a standard requires a written policy, procedure, program, or other written document for specific processes.