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| **Organizations must have their Emergency Operations Plan activated to utilize the guidance in this document. The Joint Commission expects healthcare organizations to comply with all Elements of Performance. In view of the circumstances, The Joint Commission will not cite noncompliance with these Elements of Performance for the period of time during any local, state, or federal declared State of Emergency for COVID‐19. The Joint Commission continues to recommend all healthcare organizations use their independent medical judgment on a case by case basis in the best interest of patient safety.** | | | | |
| Chapter | Standard | EP | EP Text | comments |
| EQ | EQ.01.01.01 | 12 | The organization verifies that the patient received the medical equipment and supplies. Verification of delivery is documented. | IdI.iii waiving signature and proof of delivery requirements for DME when a signature cannot be obtained. Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID‐19. |
| HR | HR.01.01.01 | 2 | The organization verifies and documents the following:  ‐ Credentials of care providers using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed.  ‐ Credentials of care providers (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed.  For home health agencies that elect to use The Joint Commission deemed status op on:  The organization maintains current licensure and qualifications in personnel records. | Regarding CPR, ACLS, BLS: The Joint Commission released an FAQ supporting the extension of expiration dates for certifications by **120 days**, in accordance with published guidance by the American Heart Association. |
| HR | HR.01.03.01 | 14 | For hospices that elect to use The Joint Commission deemed status option: In order to assess the quality of care and services provided by the hospice aide and to ensure that services ordered meet the patient’s needs, the registered nurse supervises the hospice aide during an on‐site visit to the patient’s home no less frequently than every 14 days. If nursing services are not provided, a physical or occupational therapist or speech‐language pathologist can supervise the hospice aide.  Note: The aide does not need to be present during the supervisor’s visit. | 418.76(h)(1) waiving the requirement for a nurse to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time. |

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| Chapter | Standard | EP | EP Text | comments |
| HR | HR. 01.03.01 | 25 | For hospices that elect to use The Joint Commission deemed status option: A registered nurse makes an annual on‐site visit to the location where the patient is receiving care in order to observe and assess each aide while he or she is providing care. | 418.76(h)(2) For hospices that elect to use The Joint Commission deemed status option: A registered nurse makes an annual on‐site visit to the location where the patient is receiving care in order to observe and assess each aide while he or she is providing care. |
| HR | HR.01.03.01 | 25 | A registered nurse must make an annual on‐site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care. | 418.76(h)(2) For hospices that elect to use The Joint Commission deemed status option: A registered nurse makes an annual on‐site visit to the location where the patient is receiving care in order to observe and assess each aide while he or she is providing care. |
| HR | HR.01.03.01 | 27 | For home health agencies that elect to use The Joint Commission deemed status option: When home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech‐language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the patient care instructions written by a registered nurse or appropriate skilled professional, must make an on‐site visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit. | 484.80 (h)(1)(i) waiving the requirement for a registered nurse, or other appropriate skilled professional, to conduct an onsite aide supervisory visit every 14 days to evaluate if aides are providing care consistent with the care plan. Virtual supervision is encouraged, but not required, during the period of the waiver. |
| HR | HR.01.03.01 | 29 | For home health agencies that elect to use The Joint Commission deemed status option: A registered nurse or other appropriate skilled professional must make an annual on‐site visit to the location where the patient is receiving care in order to observe and assess each aide while he or she is performing care. | 484.80(h)(1)(iii) CMS has postponed the requirement that a registered nurse or other appropriate skilled professional must make an annual on‐site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care. The direct observation of the aide is postponed until 60 days after the expiration of the public health emergency. |

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| Chapter | Standard | EP | EP Text | comments |
| HR | HR.01.05.03 | 9 | For home health agencies and hospices that elect to use The Joint Commission deemed status option: Each home health aide or hospice aide participates in at least 12 hours of in‐service training during each 12‐month period.  Note: This in‐service training may be furnished while the aide is providing care to a patient. | 418.76(d). CMS is waiving the requirement that hospices must assure that each hospice aide receives 12 hours of in‐service training in a 12month period. |
|  | HR.01.05.03 | 9 | update to waiver | 418.100(g)(3) As of 4/21 CMS has extended the timeframe for the assessment of the skills and competencies of all individuals furnishing care. The completion has been postponed until the end of the first full quarter post public health emergency. This does not alter the requirements at 418.114. |
| HR | HR.01.05.03 | 9 | For home health agencies and hospices that elect to use The Joint Commission deemed status option:  Each home health aide or hospice aide participates in at least 12 hours of in‐service training during each12‐month period.  Note: This in‐service training may be furnished while the aide is providing care to a patient. | 484.80(d) CMS has postponed the completion of the annual 12 hour Home Health Aide requirement until the first full quarter after the public health emergency. |
| HR | HR.01.06.01 | 9 | For home health agencies and hospices that elect to use The Joint Commission deemed status option: The supervisor evaluates the following areas by observing a home health or hospice aide's performance of the tasks with a patient:  ‐ Appropriate and safe techniques in personal hygiene and grooming that include bed, sponge, tub, or shower bath; sink, tub, or bed shampoo; nail and skin care; oral hygiene; toileting and elimination  ‐ Safe transfer techniques and ambulation  ‐ Normal range of motion and positioning  For home health agencies that elect to use The Joint Commission deemed status: The supervisor evaluating the aide must be a registered nurse. | CMS is modifying the requirement at 418.76(c)(1) that a hospice aide must be evaluated by observing an aide’s performance of certain tasks with a patient. This modification allows hospices to utilize pseudo patients such as a person trained to participate in a role‐play situation or a computer based mannequin device, instead of actual patients, in the competency testing of hospice aides for those tasks that must be observed being performed on a patient. |
| IM | IM.02.02.03 | 9 | status option: Each home health aide or hospice aide participates in at least 12 hours of | 484.45(a) waiving the 30‐day OASIS submission requirement. Delayed submission is permitted. |
| LD | LD.03.07.01 | 8 | For hospices that elect to use The Joint Commission deemed status option: The quality assessment and performance improvement program demonstrates improvement in the indicators related to improved palliative outcomes and hospice services. | §418.58(a) Standard: Program scope for QAPI is narrowed to include IC/adverse events. |

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| Chapter | Standard | EP | EP Text | comments |
| LD | LD.03.07.01 | 9 | For hospices that elect to use The Joint Commission deemed status option: The hospice uses quality indicator data, including patient care and other relevant data, in the design of its quality assessment and improvement program. | 418.58(b) Standard: Program data for QAPI is narrowed to include IC/adverse events. |
| LD | LD.03.07.01 | 8 | For hospices that elect to use The Joint Commission deemed status option: The quality assessment and performance improvement program demonstrates improvement in the indicators related to improved palliative outcomes and hospice services. | 418.58(a) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services. The waiver has now narrowed the scope to IC and adverse events. |
| LD | LD.03.07.01 | 9 | For hospices that elect to use The Joint Commission deemed status option: The hospice uses quality indicator data, including patient care and other relevant data, in the design of its quality assessment and improvement program. | 418.58 (b)(1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program. The waiver has now narrowed the scope to IC and adverse events. |
| LD | LD.03.07.01 | 29 | For home health agencies that elect to use The Joint Commission deemed status option: The home health agency uses quality indicator data, including measures derived from OASIS, when applicable, along with other relevant data in the design of its quality assessment and improvement program. | 484.65 (b)(1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. The waiver has now narrowed the scope to IC and adverse events. |
| LD | LD.04.03.01 | 18 | For hospices that elect to use The Joint Commission deemed status option: Volunteer staff provide administrative or direct patient care in an amount that equals 5% of the total patient care hours of all paid hospice employees and contract staff. The hospice documents the level of volunteer activity and also records any increased care and services achieved through the use of volunteers. Documentation includes the type of volunteer services and time worked. | 418.78(e) waiving the requirement that hospices use volunteers in an amount that equals 5% |
| LD | LD.04.03.03 | 17 | For hospices that elect to use The Joint Commission deemed status option: The hospice provides physical therapy, occupational therapy, and speech‐language pathology services for the purposes of symptom management or to enable the patient to maintain activities of daily living and basic functional skills. | 418.72 waiving requirement for non‐core hospice services (physical, occupational and speech therapy) |

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| Chapter | Standard | EP | EP Text | comments |
| LS | LS.02.01.30 | 24 | Every patient sleeping room has an outside window or outside door except newborn nurseries or rooms intended for less than 24‐hour stays (such as obstetrical labor beds, recovery beds, and observation beds in the emergency department).  Note: Windows in atrium walls are considered outside windows. | 418.11(d)(6) CMS has waived the requirement that buildings must have an outside window or outside door in every sleeping room. This allowance only applies to alternate treatment areas designated for surge patients. |

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| Chapter | Standard | EP | EP Text | comments |
| MC | MC.03.06.01 | 1 | Written policies and procedures (as described in USP chapters <797> and <1116>) include, but are not limited to, the following:  ‐ Maintaining the sterility and cleanliness of critical sites.  ‐ Maintaining certification of primary engineering control (PEC) and secondary engineering control (SEC) at a minimum of every 6 months and when modified, including documentation of the results and measures taken.  ‐ Continuously monitoring pressure differentials between the ante‐area and buffer area and between the ante‐area and the general surrounding area. Results are documented.  ‐ Monitoring air quality via viable air sampling and nonviable air sampling as described in USP chapter <797> at a minimum of every 6 months and when modified.  ‐ Monitoring surface requirements via surface sampling as described in USP chapter <797> including, but not limited to, sampling locations, methods of collection, sampling frequency, time of day as related to compounding activities, and action levels.  ‐ Measures to be taken when action levels based on colony‐forming unit (CFU) counts for microbial contamination are exceeded.  ‐ Measures to be taken when pathogenic organisms are identified during airborne particle and surface sampling.  (See also LD.04.01.01, EPs 1–3)  Note: USP chapter <1116> addresses microbiological control and monitoring of aseptic processes and environments. | USP released guidance which allows for the following extending the testing and certification frequency during the COVID‐19 Pandemic. Organizations may utilize these guidelines and remain in compliance with Joint Commission standards until the state of emergency has been lifted at the regional, state or national level for the organization. Testing and Certification must be completed within 60 days of the end of the declared state of emergency at the regional, state or national level (whichever gives organizations the longest time to complete)  •Primary and secondary engineering controls should not be used without initial (i.e., startup) certification. •Understanding resource constraints during the COVID‐19 pandemic, facilities may consider delaying recertification of primary and secondary engineering controls ONLY if they are served by a continuous monitor for pressure differentials. The continuous monitor may help assure that a state of control is established and maintained from the previous certification.   * The interval between certification shall not exceed 12 months. * Based upon a risk assessment, organizations should consider increased environmental monitoring and applying shorter beyond‐use dates (BUDs) if certification is delayed. |

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| Chapter | Standard | EP | EP Text | comments |
| MC | MC.03.06.01 | 3 | Primary engineering controls (PECs) are required to be certified every 6 months as described in USP chapter <797>.  Note: Primary Engineering Controls (PECs) include biological safety cabinets (BSCs), unidirectional airflow isolators (that is, CAI and CACI), and laminar air flow workbenches (LAFW). | USP released guidance which allows for the following extending the testing and certification frequency during the COVID‐19 Pandemic. Organizations may utilize these guidelines and remain in compliance with Joint Commission standards until the state of emergency has been lifted at the regional, state or national level for the organization. Testing and Certification must be completed within 60 days of the end of the declared state of emergency at the regional, state or national level (whichever gives organizations the longest time to complete)  •Primary and secondary engineering controls should not be used without initial (i.e., startup) certification. •Understanding resource constraints during the COVID‐19 pandemic, facilities may consider delaying recertification of primary and secondary engineering controls ONLY if they are served by a continuous monitor for pressure differentials. The continuous monitor may help assure that a state of control is established and maintained from the previous certification.   * The interval between certification shall not exceed 12 months. * Based upon a risk assessment, organizations should consider increased environmental monitoring and applying shorter beyond‐use dates (BUDs) if certification is delayed. |

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| Chapter | Standard | EP | EP Text | comments |
| MC | MC.04.01.01 | 2 | If sterility testing is lacking, low‐risk CSPs are stored for a maximum of 48 hours at a controlled room temperature between 20 and 25 degrees Celsius, 14 days at a cold temperature between 2 and 8 degrees Celsius, and for a maximum of 45 days at a freezing temperature between ‐10 and 25 degrees Celsius. | USP released guidance which allows for the following extending the testing and certification frequency during the COVID‐19 Pandemic. Organizations may utilize these guidelines and |
| PC | PC.01.02.01 | 36 | For hospices that elect to use The Joint Commission deemed status option: The hospice’s interdisciplinary group updates the comprehensive assessment in collaboration with the patient’s attending physician, if any, as frequently as the patient’s condition requires, but no less than every 15 days. | 418.54(d) extending the timeframe requirements for updating the assessment from 15 to 21 days |
| PC | PC.01.02.03 | 12 | For home health agencies that elect to use The Joint Commission deemed status option: The organization completes the comprehensive assessment within time frames that meet the patient’s needs, but no later than five calendar days after the start of care. | 484.55(b)(1) extending the 5‐day completion requirement for the comprehensive assessments to 30 days. |
| PC | PC.01.02.05 | 2 | For home health agencies that elect to use The Joint Commission deemed status option: A registered nurse conducts an initial assessment visit to determine the immediate care and support needs of the patient and determine eligibility for the Medicare home health benefit, including homebound status. (If physical therapy, occupational therapy, or speech‐language pathology are the only services ordered, see also PC.01.02.05, EP 3) | 484.55(a) Allows Home Health Agencies to perform Medicare covered initial assessments and determine patients' homebound status remotely or by record review. |
| PC | PC.01.02.05 | 3 | For home health agencies that elect to use The Joint Commission deemed status option: The initial assessment visit may be made by an appropriate skilled rehabilitation professional (physical therapist, occupational therapist, or speech language pathologist) when rehabilitation therapy service (physical therapy, occupational therapy, or speech therapy) is the only service ordered by the physician responsible for the home health plan of care, and the need for that service establishes program eligibility. (See also PC.01.02.05, EP 2) | 484.55(a) Allows Home Health Agencies to perform Medicare covered initial assessments and determine patients' homebound status remotely or by record review. |
| PC | PC.01.02.05 | 3 | For home health agencies that elect to use The Joint Commission deemed status option: The initial assessment visit may be made by an appropriate skilled rehabilitation professional (physical therapist, occupational therapist, or speech language pathologist) when rehabilitation therapy service (physical therapy, occupational therapy, or speech therapy) is the only service ordered by the physician responsible for the home health plan of care, and the need for that service establishes program eligibility. (See also PC.01.02.05, EP 2) | **Additional Waiver added 4/10/20:**  484.55 (a)(2)(3) Allows occupational therapists (OTs) to perform initial and comprehensive assessments for all patients. This waives the requirement that OTs may only perform the initial and comprehensive assessment if occupational therapy is the service that establishes eligibility. OTs and other therapists would not be permitted to perform assessments in nursing only cases. |

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| Chapter | Standard | EP | EP Text | comments |
| PC | PC.01.02.05 | 5 | For home health agencies that elect to use The Joint Commission deemed status option: When physical therapy, speech‐language pathology, or occupational therapy is the only service ordered by a physician, a physical therapist, speech‐language pathologist or occupational therapist may complete the comprehensive assessment and determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility. | 484.55 (a)(2)(3) Allows occupational therapists (OTs) to perform initial and comprehensive assessments for all patients. This waives the requirement that OTs may only perform the initial and comprehensive assessment if occupational therapy is the service that establishes eligibility. OTs and other therapists would not be permitted to perform assessments in nursing only cases. |
| PC | PC.04.01.05 | 17 | For home health agencies that elect to use The Joint Commission deemed status option: The organization provides patients being transferred to another home health agency or discharged to a skilled nursing facility, inpatient rehabilitation facility, or long‐term care hospital the quality and resource‐use measure data for these settings. The measures pertain to the patient’s goals of care and treatment preferences and are used to assist in selecting the next care provider. | 484.58(a) CMS has waived the requirement that for patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post‐acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient’s goals of care and treatment preferences. |
| RC | RC.01.01.01 | 17 | For home health agencies that elect to use The Joint Commission deemed status option: The patient record (hard copy or electronic form) is available to a patient upon request and free of charge either at the next home visit or within four business days, whichever comes first. | 484.110(e) CMS has waived the requirement that a patient's clinical record (whether hard copy or electronic form) must be made available to a patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first). |