What’s New for HAP 2018

Note: Updates effective in 2018 are identified by underlined text throughout this document. Multiple activities include guidance related to the survey of specific elements of performance tied to the Medicare Conditions of Participation. All of this material is highlighted in yellow. If printed in black and white, this content will appear with a grey background.

Changes effective January 1, 2018

Surveyor Arrival and Preliminary Planning – Revised guidance on first day arrival time from 7:30 a.m. to 7:45 a.m. to align with information about arrival time provided to the organization; added guidance to confirm the organization’s scope of services and determine what specifically is included under the hospital CCN

Opening Conference -- Added guidance to confirm the organization’s scope of services and determine what specifically is included under the hospital CCN

Updated survey process related to the revised pain assessment and management standards effective January 1, 2018 – The following activities include additional guidance for surveying these requirements: Orientation to the Organization, Surveyor Planning Session, Individual Tracer, Individual Tracer Addendum, System Tracers – Data Management and Medication Management, Leadership Session, and the Surveyor Worksheet

Individual Tracer Addendum – Contents added related to swing bed survey requirements under topic headings: Care Planning, Dental Services, and Patient Rights

Competence Assessment – Under the section After, added guidance to select personnel files of pharmacy staff who perform and supervise those who perform sterile medication compounding

Appendix C – Surveyor Worksheet – Under the section HAP Survey Process Rules for Surveyor Planning added detailed guidance on what sterile medication compounding locations to visit

Appendix F – Handout for the Hospital – Added an item, number 59, requesting reports of certification/testing for all Primary and Secondary Engineering Controls associated with sterile medication compounding

Appendix K – Medicare Survey Mid-Cycle – Survey Event Guide – New appendix added to explain this event type

Appendix Q – Extension Surveys – Added pre-survey activity guidance to check for notes regarding the arrival location for this survey, which may be different than the main site.

Appendix Y – Evaluating Organizations that Provide Mobile Delivery of Healthcare Services (MDHCS) – New appendix with information about these types of organizations and enhanced guidance on evaluating the care, treatment, and services being provided for compliance with standards

Appendix CC - Immediate Threat to Health or Safety Abatement Survey – Added instructions about the need to enter a note in Central Office comments in WST about what was looked at, and that reflects an affirmative observation of each standard/EP related to the ITL survey; Central Office staff receiving email regarding resolved Immediate Threat to Health or Safety revised

Appendix DD – Life Safety and Environment of Care Document List and Review Tool – Two standards added to the tool; EC.02.04.03 as a reminder of requirements related to occupancies with hyperbaric facilities, and EC.02.05.01 which includes the additional expectations to reduce Legionella risk in healthcare facility water systems which are required of hospitals and critical access hospitals using Joint Commission accreditation for deemed status purposes. References: CMS S&C 17-30-ALL Memo dated June 02, 2017; The Joint Commission EC News September 2017, Volume 20 Issue 9. Also included, as a reminder, checking critical care areas designed to control airborne contaminants.

Appendix FF – Sterile Medication Compounding Survey Guidance – New appendix provides surveyors with more in-depth guidance related to this critical process
Changes effective November 15, 2017

Surveyor Arrival and Preliminary Planning – Revised guidance on first day of event arrival time from 7:30 a.m. to 7:45 a.m. This change is to align with the information about on-site surveys provided to organizations indicating surveyors will arrive between 7:45 and 7:50 a.m. on the first day of the event.

Orientation to the Organization – Includes additional topics for discussion related to cyber emergencies impacting patient care services.

Individual Tracer Activity – Includes additional topics for discussion with staff related to cyber emergencies.

Emergency Management – Includes additional content related to cyber emergencies, and the revised emergency management requirements necessary to align with the final rule from CMS for deemed status.

Program Specific Tracer – Suicide Prevention – Renamed to Suicide Prevention, Including Ligature and Other Self-Harm Risk Assessment; includes expanded guidance related to evaluating organization’s for ligature and other self-harm risks and their risk mitigation efforts. Additional scoring and documentation guidance is provided related to observations of ligature or self-harm risks in the inpatient and psychiatric patient areas.

Report Preparation – Corrected contents to reflect current procedures.

Appendix A – Immediate Threat to Health or Safety – Updated to include additional procedures related to identified ligature and self-harm risks and other identified potential threats to health and safety that require organizations to determine and implement a risk mitigation strategy until the identified deficiency can be resolved, while the surveyor(s) is still on site. Surveyors will need to document the organization’s strategy in the survey report.

Appendix F – Handout for the Organization – Added documentation for review related to the revised Emergency Management requirements applicable to organizations seeking deemed status.

Appendix H - Contingent Accreditation Survey and Accreditation with Follow-up Survey – Removed all references to Contingent Accreditation as this decision level is no longer available.

Appendix V – Evaluating Aspects of Health Information Management Requirements – Updated to include additional emphasis on exploring the topic of cyber emergency preparedness.

Appendix DD – Life Safety and Environment of Care Document List and Review Tool – Correction to EC.02.03.05 – Fire Protection and Suppression Testing and Inspection section. EP 1: Supervisory Signals – removed fire pump running and fire pump failure trouble signals.

Important Phone Numbers – Updated SIG and SIG-Engineering phone numbers.
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# Pre-survey Preparation for all Survey Types

**Applies to:** All accreditation programs

## Participants

<table>
<thead>
<tr>
<th>Surveyors</th>
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<tbody>
<tr>
<td>As needed:</td>
</tr>
<tr>
<td>• Account Executives</td>
</tr>
<tr>
<td>• Field Director</td>
</tr>
</tbody>
</table>

Surveyors do not contact the organization at any time prior to a survey. Work with the Account Executive if you need information from the organization.

### 7 day “short notice” is given to:

- Intracycle Monitoring (ICM) Option 2 and 3 surveys
- Department of Defense facilities

## Before

### Four weeks prior to the survey

- As soon as it is available, review your itinerary and confirm the type of survey (unannounced or announced) and whether one or multiple surveyors are assigned
- Note the Account Executive’s name and extension

### Two to four weeks prior to survey

- Access the following information:
  - Survey agenda
  - E-application data
  - Life Safety Code Specialist should access the report of available Basic Building Information (BBI) through the surveyor itinerary. The report contains sites/buildings information and the history and audit trail.
  - Survey Process Rules for Surveyor Planning (appendix C) and the Guidelines for Conducting EC and EM activities (appendix DD)

- Begin planning activity using above noted documents.
- If this is a team survey and you are the team leader:
  - Review and follow the Team Leader Responsibilities document in Appendix D of this guide. A copy can also be found on the Surveyor Portal in the document library.
  - Coordinate travel arrangements with team members
  - Determine a team meeting place and arrival time for survey day one. **All team members should arrive at the organization together** unless circumstances dictate otherwise.
- If this is a team survey:
  - Note the team leader’s name and extension
  - Coordinate travel arrangements with the team leader (Note: You can make your flight reservations; however, you may want to wait to hear from the team leader to coordinate hotel and car reservations.)

### Two weeks prior to survey

- Check the internet for an organization website. If available, compare the services noted to those reported on the e-application and identify any discrepancies to review with the organization. Search the site for driving directions, campus maps and other useful information.
- Make travel arrangements

### Two weeks prior to survey

- Access the organization’s ICM Profile
- View the list of program risk areas
- View the organization-specific risk areas, when available
- View the Focused Standards Assessment, if the organization has granted surveyor access
• View report(s) from the previous full accreditation cycle(s)
• Note the previous accreditation events/activity
• Access ORYX data
• Review the organization’s historical SAFER™ matrix(s). The purpose of the review is to determine if there are high risk findings that you may want to discuss or touch upon with the organization during the survey.
  o Find the historical SAFER™ matrix(s) by selecting the quick link in WST.
  o You will be taken to a page on the organization’s Extranet site with all SAFER™ matrix(s) for that particular organization from historical onsite survey events.
  o Review the SAFER™ matrix(s) associated with surveys that have occurred since the organization’s last triennial (or initial if applicable) survey.
  o Focus the review on the findings placed in the dark orange or red areas of the SAFER™ matrix (these areas represent higher risk findings) and the Evidence of Standards Compliance corrective action submitted by the organization.
  o Identify the higher risk findings that you would like to include or discuss with the organization during the survey to ensure sustainment has been maintained.
  o Incorporation of the identified findings to review during survey will entail the following:
    ▪ Discuss the finding with the organization
    ▪ Ask if they are still utilizing the corrective action plan outlined within the previously submitted ESC
    ▪ Determine if compliance still remains.
    ▪ If compliance has been sustained, no further action is needed.
    ▪ If compliance has not been sustained, score the same standard and determine if scoring LD.04.01.01 EP 3 is also appropriate.
  o NOTE: Findings of lower risk (light orange and yellow areas of the SAFER™ matrix) will be included in the SAFER™ visual as well for reference, but are NOT required to be reviewed or discussed during the survey.
• Print or copy Appendix F of this guide to give the organization upon arrival
  Any time prior to survey
  • Discuss questions regarding the organization or survey logistics with the Account Executive or your Field Director
  • Call your Field Director with any survey process questions
  • Based on pre-survey analysis of available data about the organization, determine if there is a need to perform program specific or focused tracer activity.
  • Surveyors should follow the data gathering guidelines for Organ Procurement as listed in the Orientation to the Organization, Surveyor Planning Session and Individual Tracer Addendum activities
• Look and listen throughout the survey for organization cues that may be indicative of patient flow concerns and when found, perform the program-specific tracer for Patient Flow.

• Look and listen throughout the survey for cues that would prompt implementing other program-specific tracers or focused tracers, such as Cleaning Disinfection and Sterilization, Focused and Ongoing Professional Practice Evaluation, Laboratory Integration, etc.
Surveyor Arrival & Preliminary Planning Session

 Applies to: All accreditation programs, except Laboratory.

<table>
<thead>
<tr>
<th>Duration</th>
<th>30 – 60 minutes</th>
</tr>
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Participants
The Joint Commission: All surveyors on site.
Organization: survey coordinator, senior leadership

Organizations have been asked to have the following documents available for this session.
See Appendix F for a list of documents that organizations have been asked to have available for this session.

Objectives
1. Announce the start of the survey
2. Allow the organization time to gather documents and staff in order to proceed with the survey.
3. Review, and adjust as necessary, any pre-survey planning. Begin review of documents as they become available.

Beginning
- Surveyors should arrive no earlier than 7:45 a.m. on the first day of an unannounced survey. Reminder: Organizations do not receive the survey announcement until 7:30 a.m. on the first day of the event. Arrival times on subsequent survey days should be negotiated with leaders and staff when discussing the agenda.
- If more than one surveyor is conducting the survey, enter the organization together on the first day of the survey.
- Report to the reception area, security officer, information desk, or administrative office upon arrival and provide your name and the purpose for your visit.
- Display your Joint Commission identification badge.
- Direct the organization to their Joint Commission extranet site accessible through www.jointcommission.org to verify the survey event.
- Note that multiple individuals may have access to the organization’s extranet site based on the request of the organization when completing the e-App. Positions might include the CEO, survey coordinator, billing manager, PI Coordinator etc.
- An individual with access to the organization’s extranet site should click on the “Joint Commission Connect” logo and enter their log-in and password, to access their survey information.
  - Multiple individuals should have access to the organization’s extranet site based on the request of the organization when completing the e-application. Positions might include the CEO, survey coordinator, billing manager, PI Coordinator etc.
- The following survey information is available on the morning of your arrival by 7:30 a.m. local time.
  - Notification of scheduled Joint Commission event authorizing your presence
  - Surveyors’ names, pictures and biographical sketches
  - Scheduled survey dates
  - The survey agenda template that you prepared and posted

NOTE: If the organization is unable to validate the authenticity of the survey via computer: 1) Ask the organization to contact their Account Executive for validation; 2) You should call the Field Director on call with the information; and 3) Do not begin the survey until the organization verifies who you are or until the Central Office directs you to begin

During
Once the organization validates the authenticity of the survey:
• Provide the organization with the list of documents that will be needed during the survey. This list is available in Appendix F of this guide. (Note: The document list was provided to the organization on their Joint Commission Connect extranet site and also appears in the Organization Survey Activity Guide.)

• Ask to be taken to a secure location where you can work and secure your belongings.

• Confirm the organization’s average daily census.

• Confirm the organization’s scope of services to determine what specifically is included under the hospital CCN. Follow the instructions below if you discover significant changes from information reported in e-application. There will be another opportunity to confirm during the Opening Conference/Orientation activities.

• Begin document review activity if the organization has materials readily available.
  o If the organization does not have documents immediately ready for review, ask to begin with an individual tracer. Select this tracer based on the ICM Profile data that you reviewed in preparation for the survey.

• Review medical staff bylaws
  o To verify it is specified who is responsible for the development of policies and procedures that minimize medication errors
  o For criteria to determine privileges to be granted to individual practitioners
  o To verify history and physical examination requirements are specified
  o To verify delineation of duties and privileges related to each category of medical staff
  o To verify that an MD/DO is responsible for the conduct and organization of the medical staff.
  o To verify majority of medical executive committee members are doctors of medicine or osteopathy

If you discover that the organization has had a significant change in volume, sites, and services before or upon your arrival on site:

• Call the Account Executive or the Field Director On-Call immediately. Do not assume new service(s) will be included in the scope of the current survey.

• The organization is required to send updates such as these in writing to the Joint Commission within 30 days. Failure to notify the Central Office may result in:
  o APR.01.03.01 EP 1 being scored (If a discrepancy exists between the organization and central office about whether the organization notified The Joint Commission, score APR.01.03.01 EP 1 and flag it for review.)
  o An extension survey after the full survey
  o Subscription billing fee issues

• If you are on site, gather as much information as possible about the new services or changes to services before phoning the
Account Executive or the Field Director On-Call: Information that is useful includes:

- Date service/program started, expanded or discontinued
- Scope of services, including locations, if applicable
- Volume, ADC
- Exploration of Joint Commission program-specific eligibility criteria
- If eligible contract, have contract available for discussion with Account Executive

**Notification to the Public Requirement—Applies to re-surveys only**

APR. 09.01.01 EP 1 The organization notifies the public it serves about how to contact its organization management or The Joint Commission to report concerns about patient safety and quality of care. Methods of notice may include, but are not limited to, distribution of information about The Joint Commission, including contact information in published materials such as brochures and/or posting this information on the organization’s web site.
# Opening Conference

**Applies to:** All accreditation programs

## Duration
15 minutes

## Participants
All surveyors on site.

**Organization:**
Senior leadership (representing all programs/settings where The Joint Commission has a defined accreditation program in a complex organization).

- Attendees should be able to address leadership’s responsibilities for strategic planning and resource allocation, management, oversight, performance improvement (how expectations are established, planned, prioritized and managed), and support in carrying out the organization’s mission and strategic objectives.

### Attendees may include:
- At least one member of the governing body, or organization trustee.
- Senior organization leaders from all programs/settings. (e.g., CEO, COO, CFO, CIO, VP for clinical services, CNO, laboratory medical director, director of patient services or branch manager, chief administrator/director of each program.)
- Elected and appointed leaders of the medical staff.

**Note:** Participation of senior leadership in all programs in a complex organization that independently would be eligible for an accreditation survey should participate; however, department director participation is not required.

## Objectives
1. Introductions of surveyor(s) and organization leaders
2. Review what will take place over the course of the survey
3. Answer any questions the organization has about the survey.

## Beginning
- Surveyor(s) introduce themselves providing a brief background of relevant experience.
- Thank the organization for participating in accreditation as it is a voluntary commitment to improving quality and safety of health care.
- Explain that the purpose of survey is to provide an external validation of compliance with accreditation requirements and provide education/consultation.
- Ask organization attendees to introduce themselves. Make a note of each person’s name and title/functional responsibility.

## During
- Describe each component of the survey agenda and make any changes, if necessary.
- Remind the organization that the agenda is a template to guide the on-site survey; occasional modifications may be necessary. Agenda changes should be considerate of organization operations and scheduling needs and consistent with guidance provided by The Joint Commission central office.
- Identify the specific data (previous reports, data about their services, risk areas noted in the ICM Profile) that you are using to guide your initial on-site activity, such as locations to visit, people to interview, and documentation that will be reviewed.
- Confirm with the organization the scope of care, treatment, and services they are providing as well as the locations reported in their e-application. **Verify that these are all the services that are included under the hospital CCN.**
- Explain that the majority of survey activity occurs at the point where care, treatment and services are provided. The term “Individual Tracer” denotes the survey method used to evaluate the organization’s compliance with accreditation requirements as it relates to the care and services provided to an individual patient.
- Emphasize with the organization that it is important for surveyors to interact with the direct care givers. Remind leaders that staff members can often become uncomfortable with large numbers of observers.
- Give an example of an Individual Tracer, if the organization is unfamiliar with the on-site survey process.
- Describe the Systems Tracer(s) or other activities you will conduct, if the organization is unfamiliar with the on-site survey process.
• Acknowledge that surveyors, like the organization, are interested in preparing a report that accurately reflects the organization’s compliance with accreditation requirements. Remind the organization representatives that throughout the survey there are multiple opportunities to present documentation and evidence of standards compliance in order to clarify and clear observations before they are committed to the Summary of Survey Findings report. Opportunities include:
  o Daily Briefings
  o Special Issue Resolution
  o Team Meetings
  o Report Preparation Time
  o Other times pre-arranged with the surveyors

Emphasize the importance of the organization using these opportunities to present you with documents and other evidence of compliance that may have previously been missed or overlooked at the time it was requested.

• Take a moment to review with the organization the changes in the scoring and reporting process that implemented June 1, 2016.
  o Explain that due to the complexity of the scoring process (such as A’s, C’s, risk categories, direct vs indirect), a new Survey Analysis for Evaluating Risk (SAFER™) matrix was developed to replace the current process.
  o In the new SAFER™ matrix model, findings are evaluated to determine the likelihood the issue has to harm patients/staff/visitors (low, moderate, high) in addition to the scope of the issue within the organization (limited, pattern, widespread) and are illustrated through a visual matrix.
  o This determination is completed by surveyor(s) onsite and will result in the standard and EP being noted within the matrix
  o As a result of this new model, there will no longer be
    ▪ Category A or C EPs
    ▪ Direct or indirect EPs
    ▪ Requirement for an MOS
    ▪ OFIs included in the report--all findings will generate follow-up
  o All ESCs will be due 60 days after the final survey report is received (there is no longer a 45 day ESC)
  o A SAFER™ matrix generates for each accreditation program if this is a tailored survey

• Explain changes to the Clarification Process as follows:
  o Documents not available at the time of Review: Required documents that are not available at the time of review will no longer be eligible for the Clarification Process. These Requirements for Improvement (RFIs) will become action items in the post-review ESC process.
  o Clerical Errors: During the certification review, reviewers and the organization work together to identify and correct any clerical errors in the report. If clerical errors are identified post-review, The Joint Commission will work with the customer to make the corrections. The organization should submit a Clarification Request for the clerical error(s) to be resolved. The correction will be made as part of the
Clarification Process. The corrected RFI will remain in the report and become an action item for the ESC process.

- Audit Option: The audit process will no longer be a part of the Clarification Process. As noted above, with the implementation of the SAFER matrix, the “C” Element of Performance category has been eliminated. The “C” EPs were the subject of Clarification Audits.

- Note that you will provide more explanation at the Exit Conference, but wanted the organization to be aware of the changes before that time. Provide the organization with the printed informational resource that explains this reporting change and indicate that you are available to answer questions.

- Ask if there are any questions about the survey; provide answers, and indicate that questions may be asked throughout the survey.

- Transition into the Orientation to the Organization session.
# Orientation to the Organization

**Applies to:** All accreditation programs.

## Duration
45 minutes

## Participants
All surveyors on site.

**Organization:**
Senior leadership (representing all programs/settings where The Joint Commission has a defined accreditation manual in a complex organization).

- Attendees should be able to address leadership’s responsibilities for strategic planning and resource allocation, management, oversight, performance improvement (how expectations are established, planned, prioritized and managed), and support in carrying out the organization’s mission and strategic objectives.

## Objectives

1. Learn more about the organization to help focus survey activities
2. Listen and analyze the information being shared for prompts that will guide patient tracer selection or the need for more in-depth evaluation of a particular service, system, or aspect of care, treatment and services.

## During

If an organization leader wants to provide a formal presentation, ask how long the presentation will be and if they would be open to questions being asked throughout as they pertain to topics being reviewed. If a preference for questions at the conclusion of the presentation is expressed, ask if the presentation can be limited to 15 minutes so that you have sufficient time to ask follow-up questions.

- This session addresses all programs and services and, as applicable, the team leader or his/her designee serves as facilitator.
- Suggested discussion topics are governance and operations-related that help you to better understand:
  - The organization’s mission, vision, goals, and strategic initiatives
  - Organization structure, verify that there is a single, organized medical staff
  - Operational management structure
  - Planning, resource allocation, and decision-making processes
  - Information management, especially the format and maintenance of medical records in use, that is, paper, electronic or hybrid
  - Contracted services and monitoring performance, including telemedicine services
  - Organization efforts to reduce health care errors and other patient safety initiatives
  - Organization performance in adhering to National Patient Safety Goals
  - Organ procurement and donation including conversion rates
  - Community involvement initiatives
  - Leaders’ roles and scope of responsibility in emergency management planning
  - Utilization review process if there is no agreement with a QIO
  - The patient population the organization serves, including race, ethnicity, and language/communication needs
- Ask leaders what they are doing to assess the organization’s culture and attention to safety
- Ask leaders what percentage of inpatient admissions come in via a) direct admissions, b) transfers, and c) the emergency department (ED)
- Ask leaders about the volume and types of patients seen in their emergency department and how ED throughput is monitored.

## Other information

In complex organizations, all services should be addressed in this session.
• Ask leaders how they manage the care of patients presenting with conditions outside of their scope of service (i.e., mental health, trauma)

• Ask leaders how they monitor and manage hospital-wide patient flow issues related to medical/surgical and behavioral patients, including a general description of report or dashboard data that they review to support system-wide decision-making and identify cyclical issues or trends

• Ask leaders if boarding occurs. If yes, ask what patient population(s) is boarded

• Ask leaders how they have made pain assessment, pain management, and safe opioid prescribing an organizational priority

• Ask leaders how they provide staff and licensed independent practitioners with educational resources to improve pain assessment, pain management, and the safe use of opioids

• Ask the organization to identify hospital-based physicians, (e.g., intensivists, hospitalists, fellows, residents, etc.). Explain that although physicians are included in individual tracers, the organization is free to ask the hospital-based physicians if they would like to accompany the surveyor on an individual tracer.

• Ask leaders about performance improvement initiatives, projects and program structure, to help you better understand:
  o How they set priorities and expectations, and plan, assess and measure initiatives to improve the quality of care, treatment and services
  o The comprehensiveness of the program (seek evidence that the performance improvement activities reflect the complexity and scope of services provided)
  o Their approach to safety, including selection of proactive risk assessment topics, when required, and resulting improvements
  o Board member involvement in safety issues
  o Licensed independent practitioner involvement in performance improvement projects and initiatives
  o Provision of resources including personnel, information systems, data management, and staff training
  o Their approach to the Focused Standards Assessment and methods used to address areas needing improvement

• Ask how senior hospital leadership (officers and vice presidents) monitors and fosters emergency management preparedness and improvement hospitalwide.

• Review with the organization any activities related to risk awareness, detection and response as it relates to cyber emergencies. Suggested discussion topics include:
  o Identification of any medical equipment and care, treatment, or service devices that connect to the internet.
  o Descriptions of any vendor agreements or contracted services that support internet access for transmitting
clinical information or connecting medical equipment and devices.

- How IT leadership participates in identifying potential risks to care, treatment, or services related to IT systems (critical data and applications, servers, computers, and digitally connected infrastructure).

- Any IT security mechanisms or vendor agreements in place to help during an emergency, for example, Application Support, Forensic Specialists.

- Strategies or resources in place to help facilitate recovery and offset liability following cyber attacks (such as a cybersecurity insurance policy).

- Conclude the session by thanking attendees for their participation in the discussion. Reiterate the agenda activities for the day.

**After**

Take a moment to reflect on what you heard during this activity. Identify additional topics and areas for exploration during the survey based on the information shared by leaders during the orientation.
Surveyor Planning Session – Initial
Applies to: All accreditation programs.

**Duration**
30-60 minutes

**Participants**
All surveyors on site.

**Organization:**
Organization's Survey Coordinator, as requested

**Complex Organizations**
- Surveyors should review data and documents relative to their program(s) and survey activities
- Identify which system tracers will be conducted and by which surveyor
- Identify if possible, which program-specific tracers might need to be performed based on ICM Profile data, including past survey reports and organization-specific risk areas.
- If you are conducting a system tracer for multiple programs, review the necessary information for all programs and seek guidance from the surveyor(s) for that program on discussion topics prior to the activity

**Objectives**
1. Begin the review of requested documentation, especially material that is critical to guiding subsequent onsite survey activity.
2. Begin the selection of patients for tracer activity.

**Before**
- Explain to the organization the purpose of this session and the need for as few interruptions as possible.
- Make sure all necessary documents are available, including patient lists.
- Team Leader Responsibility:
  - Remind team members to record all records reviewed (even if the records reviewed do not generate observations of non-compliance). The sample of records reviewed must reflect 10% of the organization's average daily census or a minimum of 30 records. If the organization is a small general acute care hospital, with an average daily census of 20 patients or less, the sample should not be fewer than 20 inpatient records. This smaller sample size does not apply to surgical or other specialty hospitals (such as a heart hospital).

**During**
- Use approximately 25% of session time for tracer selection
  - Using the ICM Profile data (services, previous RFIs) identify initial program tracers for the day. If a census is not available, select units or programs where you will begin tracer activity. See the Survey Process Rules for Surveyor Planning in Appendix C for guidance.
  - Identify surveyors from each program to conduct the system tracers.
- Use approximately 50% of session time for performance review
  - Complete as much of the review of materials listed in the Surveyor Arrival and Preliminary Planning Session and other documentation that is available as time will allow. Under the direction of the team leader, divide up the review of organization data.
    - **Owned and Contracted Onsite Laboratory Services in a Joint Commission Accredited Hospital:** Surveyors should make note that some hospitals may have a combination of owned and contracted onsite laboratory services. As example, the hospital may operate its own general and point-of-care laboratory services, but engage a local donor center to provide onsite blood bank services. Note that all owned and contracted onsite laboratory services must be accredited by The Joint Commission or one of its cooperative partners, namely the College of American Pathologists (CAP), COLA or ASHI. If you identify an organization with contracted onsite laboratory services that are solely either state inspected or accredited by another laboratory agency (AOA, AABB), thus not meeting the accreditation policy, please notify the Account Executive via the surveyor comments. After survey, the Account Executive will work with the organization on their submission of an application for accreditation.
  - Discuss the scope of the survey and which sessions will be conducted by which surveyors, as applicable.

**Surveyor TIP:**
During performance review, think about the possible relationship of negative data to staffing. Select individual tracers from those areas with negative outcomes to gain a better understanding of performance.
Note: In complex organizations, surveyors should review the data relative to their program(s) and survey activities.

- Identify which system tracers, and if possible, which program-specific tracers will be conducted using the guidelines in the appendix.
  - Surveyors conducting the Data Management System Tracer should complete a review of performance improvement data including aggregation, analysis and action related reports. Determine if performance improvement projects (e.g., quality indicators) are related to improved health outcomes. Review ORYX data and determine how this should be factored into the discussion.
  - One surveyor from each program responsible for conducting the Medication Management System Tracer should review the program specific medication related performance reports, such as medication errors, adverse drug reactions, and adverse drug events, including those related to opioids.
  - One surveyor from each program responsible for conducting the Infection Control System Tracer should review the program specific infection control plans and performance reports.
  - If you are conducting a system tracer for multiple programs, you must review the necessary information for all programs.

- Use approximately 25% of session time to review and discuss with other surveyors, when applicable, what you have discovered from the review of organization documents
  - Surveyors discuss their findings from the performance review with each other, giving each surveyor time to report what they found, where they would suggest focusing attention during individual tracers, and preliminary comparison of issues that cross the organization.
  - Identify the focus for the Data Management system tracer. The first step in the process that is a problem becomes the focus for the organization. If nothing appears to be a problem, focus on how the organization is using data to improve. Identify participants who are needed at the session.
  - When applicable, identify the focus of the Medication Management and Infection Control system tracers.

After

Communicate information to the organization as a result of the planning session, such as:

- Plans for individual and system tracer activity
- Documentation that needs to remain available for further review
- Suggested organization representatives that surveyors recommend be available during other survey activity
### Individual Tracer

**Applies to:** All accreditation programs

<table>
<thead>
<tr>
<th><strong>Duration</strong></th>
<th>60 – 120 minutes</th>
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<tbody>
<tr>
<td><strong>Participants</strong></td>
<td>Joint Commission: One surveyor per tracer. Organization: Staff and management who have been involved in the individual’s care, treatment, or services.</td>
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**Other information**

There is no mandated order for visits to other care areas/units/departments/programs/services. One approach to conducting the Individual Tracer is to sequentially follow the course of care/services received by the patient.

You may arrive in a setting/unit and need to wait for a particular person to be available. In these cases, use this time productively by talking with other staff, observing Environment of Care issues, etc. Ask available supervisors, or administrative staff about the unit, exploring such topics as data collection and use, improvement initiatives, medication management, infection control activities on the unit.

Meet with, ask questions of, and observe care provided by staff and physicians whenever possible. Be sure to include ancillary department staff in tracer activity. Ask questions of management when questions are appropriate to management. Do not ask questions that might be perceived as peer review.

To the extent possible, coordinate with survey team members to avoid selecting Individual Tracers that may overlap in terms of sites within the organization. If you arrive in an area and your colleague is already there, leave and return at a later time.

Further explore issues identified during other tracer activity (other individual and Systems Tracers.)

If you obtain conflicting information about a policy or process, ask the leader accompanying you on the tracer to obtain the policy or process.

| **Objective** | The objective for this session is to evaluate the organization’s compliance with standards as they relate to the care, treatment and services provided. |

**Before**

Think ahead: Prepare for upcoming system and program specific tracers by identifying patients or equipment to trace. Utilize available data during surveyor planning session to facilitate selection of patients for individual tracers.

- Select Individual Tracer candidates based on the organization’s clinical services, ICM Profile risk areas, and information discovered during the Orientation session. As the survey progresses, you may select:
  - Individuals with more complex situations and more contact with various parts of the organizations to assess continuity of care issues. Example: patient admitted through the ED, who required a procedure/surgery, currently in a critical care unit on a ventilator.
  - Patients related to Systems Tracer topics. Reference planned system tracers for additional detail. Select at least one individual tracer that pertains to the system.
  - Patients receiving opioid medications
  - Patients with infections, including those infections addressed by NPSGs.
  - Patients receiving antimicrobials as follows:
    - Emergency department patients who are prescribed antimicrobials.
    - Ambulatory and clinic patients surveyed under the hospital program who are prescribed antimicrobials.
    - Hospitalized patients who will be discharged on antimicrobials
  - Patients who are scheduled for, or who have had a high risk procedure, such as surgery, cardiac catheterization, spinal injection
  - Select patients who are scheduled for, or who have had a Computerized Tomography (CT) diagnostic imaging exam.
  - Patients with care that crossed programs (e.g., a patient admitted from or discharged to an ambulatory care setting).
  - Patients who have been admitted from or discharged to a hospital-based outpatient service.
  - If conversion data indicates a need--a deceased patient to evaluate for appropriate coordination with the OPO relative to organ donation and other care related issues. (e.g., timeliness of care. DO NOT approach this from a peer review perspective – focus on processes).
  - Potential role of infections in the cause of death, delay in treatment, lack of appropriate follow through with the organ donation guidelines/lack of timely communication with the OPO.
  - You do not need to visit every unit or branch of the organization as long as you follow the Survey Process Rules.
documentation for the next scheduled issue resolution time.

**REMEMBER!**
Surveyors conducting the Individual Infection Control Tracer must trace a patient with an infection.

Surveyors conducting the Individual System Tracer for Medication must trace a patient taking a high risk medication.

for Surveyor Planning located in Appendix C. All important aspects in the Individual Tracer should be addressed.

**During**

**Conducting an Individual Tracer**

- Begin the Individual Tracer in the setting/unit where the patient and the medical record are currently located.
- Start the tracer by reviewing a clinical record with the staff person responsible for the individual’s care, treatment, or testing. If the staff person is not available, the discussion can be held with a clinical supervisor or other staff member. The primary purpose of using a clinical record is not to audit its contents, but to use it as a tool in following care, treatment, and services.
- Evaluate the ease with which staff navigate through the medical record and locate the information you are requesting (assessments, reassessments, involvement of appropriate disciplines in the care planning process).
- Ask staff members about the information that is or is not accessible to them and how this is determined.
- Through discussions with staff, explore how well the record supports and facilitates the care, treatment and services that they are providing to the patient.
- Ask licensed independent practitioners and pharmacists about the Prescription Drug Monitoring Database including how they access this resource and what criteria prompts access.
- Trace the entire care or service process from preadmission through post-discharge. This will involve moving from location to location (depending on the size of the organization).

**Interview staff about:**

- Intradepartmental and interdepartmental communication for coordination of patient care. (Pay particular attention to handoffs – these are critical points in time when errors occur.)
- Accessing medical records information when they need it in order to provide patient care treatment and services; who is called when there is a problem; how responsive is help; how reliable are electronic record-keeping systems
- Address data use —What patient flow processes are being measured? What other PI measures are in use for this unit? What have they learned? How has this unit/department/branch used data to make improvements? How is data circulated?
- Check for variability in workload – during the day and between days of the week
- Ask about data collection in units/ departments, e.g. turnaround time, wait time, boarding patients
- Explore patient flow issues; determine if improvements in patient flow have been made
  - **Emergency services**
  - **Who is responsible for direction of services;**
  - **Who supervises emergency services;**
• How emergency services are integrated with other departments or services of the hospital;
• How the hospital provides for medical and nursing personnel qualified in emergency care to meet the needs anticipated by the facility
• Medical staff involvement in and responsibility for emergency service or department
• Processes and role to minimize risk, such as preventing when possible, and reporting near misses/close calls as well as actual mistakes—medication administration errors, breaks in protocol, adverse events; ask if staff feel safe speaking up in order to avoid situations they consider unsafe
• Hospital processes for collecting patient-level data on race and ethnicity
• Hospital processes that prompt or remind staff to ask patients and families about communication needs; how they identify whether patients have oral or written communication needs and how they address these needs
• The availability of tools and resources to assist with patient communication, such as: Access to language interpreters, access to translated documents, the potential for involvement of interpreter on care team
• Hospital processes for collecting patient-level data on pain assessment, pain management and safe-opioid prescribing
• Hospital process for identifying patients at high risk for adverse outcomes related to opioid treatment
• Hospital process for monitoring patients identified as high risk when receiving opioids
• How they screen, assess, and reassess patients for pain, non-pharmacologic approaches they offer
• National Patient Safety Goals (NPSGs) Reminder: All applicable NPSGs must be evaluated during the course of survey
• Patient education processes
• Discharge planning process on each unit surveyed
• Involvement of patients or legal representatives in decision making
• Obtaining of informed consent in accordance with hospital policy
• Orientation, training and competency testing
• Awareness of content of APR.09.02.01 (Any individual who provides care, treatment, and services can report concerns about safety or the quality of care to The Joint Commission without retaliatory action from the organization.
• Workload issues that may hinder safe patient care. If present, further investigate including a review of staffing plans, variance reports, manager interviews and additional staff interviews.
• Roles and responsibilities related to the Environment of Care, including prevention of, and response to incidents; as well as how to report events that occurred.
• Hospital support of patient’s right to access a support person throughout the stay
• Interview individuals that provide language interpreting and translation services about their training, experience, and qualifications. These individuals may include:
- Hospital-employed interpreters (primary responsibility is to interpret)
- Bilingual staff (clinicians or staff with other responsibilities)
- Volunteers
- IM systems they use for care, treatment and services (paper, fully electronic or a combination of the two) and about any procedures they must take to protect the confidentiality and integrity of the health information they collect.
- Ask staff about any back up procedures they’ve been instructed to use if the primary system is unavailable.
- If internet-connected health information, equipment, or devices are used in care, treatment, or service, ask staff to describe their access procedures (passwords, authentication, etc), confidentiality measures, and instructions on down-time procedures.
- Address with staff during different tracer discussions how they approach risk awareness, detection and/or response as it relates to potential cyber emergencies. Suggested discussion topics include:
  - How would they detect a cyber problem, for example, login issues, missing/modified data; strange message on screen.
  - What do they do if they detect a cyber problem - who do they call?
  - The plan(s) in place to continue care, treatment, and services if all of the IT systems are not available, including training in back up/alternative work procedures.
  - Contingency plans if the following systems are disabled by a cyber emergency:
    - Electronic health record (EHR) (acute and prolonged events)
    - Radiology
    - Laboratory
    - Pharmacy
    - Medical devices
    - Telemedicine care, treatment, or services
- Other issues, relative to care, treatment or services
- Validation of information learned during other survey activity

**Interview licensed independent practitioners:**

Note: This may require planning for a meeting on another day or arranging for a phone call at the convenience of the licensed independent practitioners

- The processes in place and care provided to the patient being traced.
- Communications and coordination with other licensed independent practitioners (Ask about: consulting physicians, attending physicians and others within the organization; ascertain what information is communicated to other hospitals and physicians when the patient is transferred or discharged home to the care of a different physician).
- Explore knowledge of pain assessment, pain management, and safe opioid prescribing initiatives by the hospital and any resources that have been made available.
o Has the hospital provided access to and criteria that prompts accessing the Patient Drug Monitoring Database?

o What non-pharmacologic modalities are available to patients and how were these modalities determined?

o What information has leadership provided on available services for consultation and referral of patients with complex pain management needs?

o What opioid treatment programs are available for patient referrals?

- Explore knowledge of discharge planning resources and processes available through the organization

- Roles and responsibilities related to the Environment of Care, including prevention of, and response to incidents; as well as how to report events that occurred.

Interview patients and when appropriate, family members about:

- How the organization identified and addressed oral and written communication needs with them and, if necessary, how language services were provided

- Staff inquiries regarding his or her race and ethnicity

- Coordination of services including timeliness,

- Their involvement in decision making regarding their care, treatment and services

- Informed consent prior to their non-emergency surgery, as applicable

- How the staff involved them in their pain management, plan of care, what their pain management plan of care includes (non-pharmacologic, pharmacologic or a combination of approaches).

- If an opportunity to identify a support person was offered and if access to the person was allowed throughout hospitalization

- Education provided

- Response time when call bell is initiated or alarms ring

- Perception of services

- When the organization began discussions about discharge

- Understanding of discharge instructions

- Staff compliance with NPSGs

- Other issues, relative to care, treatment or services

- Validation of information learned during other survey activity

Observe:

- Potential environmental issues that might impact individual safety.

- Care planning processes (e.g. timing of patient assessments). If possible, observe discharge planning or care coordination meetings.

- Staff use of available tools and resources to identify and address patient communication needs, such as language identification tools, language interpreter services, communication boards, use of teach back techniques to
address health literacy needs, patient access to the nurse call button.

- Clinicians, including physicians, providing direct patient care. **Note:** Physician observation is required.
- Observation of surgical procedures is permitted from the ante-room provided patient permission has been obtained.
- Surveyors are allowed to enter the surgical suite to observe procedures if acceptable to the organization per a written or unwritten policy. This is an opportune time to evaluate compliance with the NPSGs including time out and hand hygiene guidelines.
- Medication processes (e.g. preparation and administration of medications, storage, and security of medications).
- Infection control processes (e.g. techniques for hand hygiene, sterilization of equipment, disinfection, food sanitation, and housekeeping).
- Identify and evaluate the effectiveness of the organization’s standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.

**After**
- Review pertinent meeting minutes and procedures if needed.
- As necessary, pull additional records to verify standards compliance issues identified during the Individual Tracer. **Keep a record of all patient medical records reviewed for data entry into survey technology.**
- Review written policy for equal visitation rights for all patients.
- Share problematic issues with other team members, if applicable, so they can be further explored in subsequent Individual Tracers.
Individual Tracer - Addendum

Individual Tracers - Important Components

The areas highlighted below are important to address in onsite surveys as they are reflective of deemed status requirements, quality and safety matters from current literature and Joint Commission standards and elements of performance. These suggestions are not all inclusive of the issues and topics that can or should be covered in a tracer.

Let the tracers guide you to the issues noted below. DO NOT over survey in these areas but if issues are identified, follow through with drill down activity.

Alarm Safety
- When visiting units that use medical devices with alarms, discuss with staff issues related to alarm safety such as
  - Whether they are aware of any new initiatives associated with alarms
  - Whether they are aware of efforts to set priorities for addressing alarms

If staff in these areas seem to be unaware of any activity related to alarms, this issue can be raised with leadership to verify that they are addressing the NPSG.

Hospitals have some latitude in identifying those alarms to be managed using the criteria identified in EP 2 of this NPSG as well as any other criteria they may identify. This NPSG focuses on devices that monitor a patient's physiological status, but if the organization decides to include other types of devices as well, that is acceptable.

In some organizations (such as psychiatric hospitals), the NPSG may have limited applicability. Staff in the hospital should be able to indicate that they evaluated the need to manage alarms and why they concluded which alarms should or should not be managed as described by the NPSG.

Note that the first two EP were to be implemented by January 2015. EPs 3 and 4 are to be implemented in 2016.

Autopsy-Retrospective Review
- Review hospital policy regarding autopsies
- Review closed medical records to verify that hospital policy was followed regarding autopsy appropriate deaths

Care Planning
- For swing beds – verify that the hospital coordinates resident assessments with the pre-admission screening and resident review (PASARR) program to the maximum extent practicable to avoid duplicitous testing and effort.

Clinical services
- Discuss and review clinical/medical records:
  - Review the timing of patient care assessments
  - Verify individualization and appropriateness of the plan of care, treatment, and services
- Review and discuss the use of verbal orders (e.g., who can accept and transcribe the order, read back process and authentication)
- Interview staff to validate that an MD/DO is managing and coordinating the care of any Medicare patient with a psychiatric problem that is not within the scope of practice of another practitioner; review patient records to validate care is being managed and coordinated by an MD/DO
- Determine that MD/DO is on duty or call at all times

Complaint Resolution Process
- Discuss
  - Complaint handling/resolution process with staff
  - Complaint review and resolution process with unit leadership
  - Written acknowledgement process with hospital leadership for significant complaints
- Interview
  - Patient to verify receipt of contact information for the organization and the appropriate state agency if there is a complaint
- Review
Complaint policy and procedures to validate stated process and confirm that it includes a statement regarding the patient’s right to report a complaint without negative consequences.

Ask to see a sample of complaint resolution and determine if it includes all required elements.

**Computerized Tomography and other Diagnostic Imaging Modalities**

- Ask about oversight and supervision of imaging activities (who, what, how often).
- Inquire about the roles and responsibilities of staff and licensed independent practitioners providing diagnostic imaging services.
- Ask technologists performing CT exams if they have obtained any certification(s) or licensure related to this work; ask what type of training they have received in the provision of diagnostic CT exams.
- Ask about how the radiation dose is being documented for every CT study, and how incidents would be identified if the dose were to exceed the ranges in the imaging protocols.
- Ask what safety and quality data is being collected and monitored (for example, i.e. dosimetry reports, incident reports (i.e., CT dose being exceeded, MRI burns), preventive maintenance records and quality data) and what is being done with the data.
- Use of orders and/or protocols. What guidelines are the imaging protocols based upon? Who approves them? How does the organization ensure that imaging protocols are kept current?
- Explore the factors the organization considers in introducing new technology or replacement equipment into the organization (such as patient safety and quality of care factors, provider and staff education, environment of care limitations, acceptance testing protocols).
- Explore patient pre-testing/screening activities conducted to determine any risks to the patient including:
  - CT - contrast contraindications (kidney function, creatinine levels, allergies); screening for pregnancy.
  - MRI - pregnancy and patients who may experience claustrophobia or emotional distress during the exam.
  - Nuclear Medicine - pregnancy and patients who are breastfeeding
- Explore processes to assure the right patient is getting the right imaging site, right positioning, with the correct CT imaging protocol and CT scanner parameters.
- Explore processes for the management of patients who have taken sedation/anti-anxiety medications.
- Ask about fall prevention activities during patient transfer onto and off equipment.
- Explore process to restrict access to the MRI scanner room and the area that immediately precedes the entrance to the MRI scanner room.
- Ask about procedures for providing emergency/urgent care if need during an imaging exam
- Ask about the results of the annual performance evaluations of the imaging equipment conducted by agnostic medical physicist (or magnetic resonance imaging (MRI) scientist, as applicable). Appendix X lists those tests and that are found in the EC.02.04.03 EPs.
  - Ask when and by whom the performance evaluations were done
  - Ask to review the reports – this can be held for the Issue Resolution session
  - When reviewing the reports, look to see if all required tests were done
  - Did the report indicate any follow-up was needed? If so, was it done?
  - Review of the actual report (if needed) can be done during Issues Resolution Sessions

**Contract Services**

- Include patient that received care from contracted providers, including telemedicine, in individual tracer selection.
- Interview contracted staff about the scope and nature of services they provide and how they were oriented to the organization’s processes
- Interview organizational leaders about their oversight process for contracted services and contracted individuals. Monitoring of contracted services and individuals is required.
- Review PI for inclusion of contracted services and individuals
- Review contracts
- Validate that reference contract laboratory services meet CLIA regulations

**Dental Services**

- Common risk points include: radiation use, infection control, wrong site surgery, competence assessment, medication management and aspiration prevention during treatments
- Evaluate the integration of dental services with hospitalized patients, e.g. dental complaints by hospitalized patients, laryngoscope complications, oral-mucosal complications of care
- For swing beds – determine that the organization follows its established policy on when it is its responsibility for lost or damaged dentures.
- **For swing beds –** verify that the organization refers residents with lost or damaged dentures for dental services within three days. If it takes longer, organization needs to document reason and make sure resident could adequately eat and drink.

**Discharge Planning – Active Review**
- Ask for a list of patients who are going to be discharged during the survey
- Interview designated discharge planning staff about the discharge plan for several selected patients
- Review the patient’s medical record for the admission assessment and determine if any discharge planning concerns were identified and addressed per organization policy
- Review the patient’s medical/clinical record for discharge orders and determine the patient was provided with geographically appropriate skilled nursing facility and home health care agency lists as applicable; if patient is returning to a SNF or other location determine if the locale has been reassessed for appropriateness to the patient’s ongoing needs
- Discuss with staff the discharge evaluation and planning process and who is qualified to perform evaluation and planning
- Discuss with staff the individualized discharge plan for each patient being traced
- Review the patient’s medical record for documentation of the discharge planning evaluation
- Discuss with staff the process of reassessing the discharge plan based on changes in patient condition, available support, or post-hospital care requirement and environment
- Request that the organization obtain patient permission for observation
- Observe the clinician providing discharge instructions. Components of the discharge instructions include:
  - Activity
  - Diet
  - Medications (post discharge)
    - Opioid medications prescribed for discharge, review for discharge education on safe use, storage, and disposal of opioids
  - Plans for physician follow-up
  - Wound care (if applicable)
  - Signs and symptoms to be aware of (i.e. elevated temperature, medication side effects, etc.)
  - Name and telephone number of a physician to call should a problem or questions arise following discharge.
  - The nurse has the patient repeat back information to confirm the patient’s understanding
- **The surveyor reviews written discharge instructions given to the patient.** The discharge instructions are written in a language the patient can read and understand
- Interview the patient to determine the patient’s level of understanding of discharge instructions. The patient’s level of understanding should include the following:
  - The purpose for taking any new medication
  - How to take the medication including dose and frequency
  - Possible side effects of medication
  - The medication regimen including continuation or discontinuation of those medications taken prior to admission to the hospital
  - Contraindications between prescribed medications and over the counter medications and herbal remedies
  - Changes in diet and dietary restrictions or supplements
  - Pain management plan of care including side effects of pain management treatment, activities of daily living in the home environment that may exacerbate pain including strategies to address these issues
  - Signs and symptoms of problems and who to call with questions and concerns
  - Information regarding continued self-care (wound care, activity, etc.)
  - Follow-up process with physician(s)
  - Arrangements made for home health needs (i.e. oxygen therapy, physical therapy)
- Interview the nurse/clinician to ascertain the origination of discharge information (physician-nurse communication regarding discharge instruction)
- Hand-off communications
- Medication reconciliation
- Review discharge planning policies and procedures
- Determine that the organization reviews the discharge planning process in an ongoing manner
- Interview designated discharge planning staff regarding performance improvement efforts, for example, asking for feedback from post-acute care providers

**Discharge Planning – Retrospective Review**
- Ask for a list of patients who were discharged over the past 48 hours
• Review the patient’s medical record for the admission assessment and determine if any discharge planning concerns were identified.
• Review the patient’s medical record for discharge orders and any written instructions given to the patient.
• Review the patient’s medical record for documentation of the discharge planning evaluation.
• Review the patient’s medical record for results of tests pending at time of discharge and the documentation of those results being communicated to the next provider of care.
• Request that the organization stay with you as you make follow-up phone calls. The organization should first talk with the patient to explain the purpose of your call and obtain permission for a phone interview.
• Interview the patient to determine their understanding of discharge instructions provided. The patient’s level of understanding should include the following:
  o The purpose for taking any new medication
  o How to take the medication including dose and frequency
  o Possible side effects of medication
  o The medication regimen including continuation or discontinuation of those medications taken prior to admission to the hospital
  o Contraindications between prescribed medications and over the counter medications and herbal remedies
  o Changes in diet and dietary restrictions or supplements
  o Proper storage and disposal of pain medications
  o Signs and symptoms of problems and who to call with questions and concerns
  o Information regarding continued self-care (wound care, activity, etc.)
  o Follow-up process with physician(s)
  o Arrangements made for home health needs (i.e. oxygen therapy, physical therapy)
• Explore the patient’s perception of their discharge instructions. Do they believe they were given all of the information needed?
• Review discharge planning policies and procedures.
• Determine that the organization reviews the discharge planning process in an ongoing manner.

Emergency Services
• Discuss:
  o The immediate availability of services, equipment, personnel and resources for providing patient care
  o Whether the hospital goes on diversion and if so, how often and for what reason(s)
  o The integration and communication of emergency services with other departments (e.g., surgery, laboratory, ICU, diagnostic services, etc.)
  o Provisions for follow-up care of emergency services to patients who are not admitted to the hospital or transferred to another hospital
  o The process or length of time it takes to transport emergency patients to another department where needed interventions will be given and the length of time it takes to deliver equipment or supplies to provide needed interventions, tests, care, or services
  o Hospital’s plan for managing behavioral health patients; review documented plan, as available and necessary
  o How patients with psychiatric or substance abuse emergencies are handled in the ED, including frequency of assessments, care provided, use of sitters, items or furnishings that could be used to harm self or others (trace their presence back through the organization’s environmental safety assessment), training of clinical staff or security to manage for such patients, case management or social work services to facilitate transfer, etc.
  o The process for medical staff review of policies and procedures.
• Review:
  o Policies to appraise emergencies, provide initial treatment, and transfer/refer patients when needed in hospitals that do not provide emergency services and policies and procedures for on- and off-campus locations.
  o In organizations who use scribes: Review medical records to determine if the role and signature of the scribe is clearly identifiable and distinguishable from that of the physician or licensed independent practitioner or other staff
  o In organizations who use scribes: Review medical records to determine that physician signature stamps are not being used in the authentication of “scribed” entries. The physician must actually sign or authenticate through the clinical information system. This must take place before the physician and scribe leave the patient care area.
• Identify if boarding of psychiatric patients is a periodic issue. If there are no current boarders to trace, during regular tracer and document review activities, be attentive to the following for potential patterns:
- Data collected and analyzed as indicated in Data Management System tracer (including Focus-Specific Tips)
- Query in Orientation to Organization session regarding how leadership knows if there is a recurring problem
- Review risk assessments conducted related to NPSG.15.01.01 (patient risk for suicide) and query staff regarding impact on boarding
  - Observe physical space where patients are boarded for care and safety accommodations, especially behavioral patients who may have longer lengths of stay
  - Interview staff, (e.g., clinical, security, counselors) and ask about their training and processes relative to caring for patients with psychiatric emergencies

**Environment of Care**
- Observe if the condition of the facility areas is safe, clean, functional, and comfortable *(this includes proper storage and disposal of trash).* Examples of clean areas include those that are free from dirt, grime, spillages, debris, and where trash is properly stored and disposed
  - Discuss:
    - The process for conducting environmental tours to identify environmental deficiencies, hazards, and unsafe practices
    - Management of hazardous materials and waste
    - Staff knowledge and training on how to report problems or incidents
- Verify that documentation from state or local fire inspections is maintained

**Emergency Management**
- Ask various staff members to explain their role in fire management and/or emergency/disaster management
  - Discuss:
    - Staff knowledge and training on roles and responsibilities in the event of an emergency, including any education or training with community response partners or volunteers
    - Supplies, medical equipment, communication equipment, personal protective equipment (PPE), decontamination stations available in emergencies
    - Interview unit/department leadership to evaluate knowledge of chain of command and communication processes in the event of an emergency. Evaluate understanding and planning for emergency incidents that last greater than 96 hours.

**Food and Dietetic Services**
- Identify the national standards used for recommended dietary allowances
- Observe hygiene practices and kitchen sanitation
  - Discuss:
    - Safety practices for handling food
    - Assessment process to determine patient dietary needs
    - Process for prescribing and evaluating therapeutic diet orders
    - Who can order patient diets – practitioner responsible for patient care and/or qualified dietitian or nutritional professional authorized by the medical staff and in accordance with law and regulation
    - Process for accommodating special and altered diet schedules
    - Follow-up process when the patient refuses food served
    - Qualifications of dietitian and dietary services director
    - And verify availability of a current therapeutic diet manual for reference

**Hand Hygiene** - Observe clinicians (this includes physicians) as they provide care. Specifically observe all opportunities for hand-washing with antimicrobial soap or alcohol based rub as outlined in the CDC or WHO guidelines:
- **Before**:
  - Having direct contact with patients (e.g. medication administration, bathing, physical exam etc.)
  - Donning sterile gloves when inserting a central intra-vascular catheter
  - Inserting indwelling urinary catheters, peripheral vascular catheters or other invasive devices that do not require a surgical procedure
- **After**:
  - Contact with a patient’s intact skin, e.g. when taking a pulse or blood pressure, administering medications and lifting a patient
  - Contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings
  - Removing gloves
In surgical areas:
  o Before donning sterile gloves when performing surgical procedures

**Infection Control**

- Observe clinicians, including physicians, for compliance with CDC or WHO hand hygiene techniques; observe the environment for accessibility of means to practice hand hygiene
- Observe for availability of personal protective equipment (PPE) to staff
- Observe transmissions based precautions including airborne, droplet, and contact; inquire about respiratory fit testing
- Interview staff about communicating with other providers and staff related to patient infectious disease status and precautions; inquire about transportation process for patients with infections requiring medically necessary care outside of their room
- Inquire about daily monitoring of air pressure with patients on airborne precautions (e.g., airborne isolation infection room requirements)
- Interview staff about, and observe, as appropriate, sterilization of equipment, disinfection, employee health requirements, food sanitation, housekeeping cleaning processes, reporting process for potential HAIs, and other means for limiting the spread of infection
- Observe infection control techniques (e.g., aseptic or sterile techniques, cleaning between surgical cases, surgical attire, sterilization of operating room material, surgical devices and equipment), segregation of clean and dirty items (e.g., laundry, equipment)
- Inquire about employee health screening and health requirements (e.g., vaccinations, immunizations) for working on a unit; ask to see a sample of employee health files to verify compliance through documentation in these records
- Verify that staff are following evidence-based practices, in relation to CLABSI, CAUTI, MDRO, and surgical site infection prevention
- Observe and discuss protective environment
  o Positive air pressure with HEPA filter and 12 air exchanges per hour
  o Review documents to identify sustained performance and correction of failures

**Laboratory Integration**

- **Owned and Contracted Onsite Laboratory Services in a Joint Commission Accredited Hospital:**
  Surveyors should make note that some hospitals may have a combination of owned and contracted onsite laboratory services. As example, the hospital may operate its own general and point-of-care laboratory services, but engage a local donor center to provide onsite blood bank services. Note that all owned and contracted onsite laboratory services must be accredited by The Joint Commission or one of its cooperative partners, namely the College of American Pathologists (CAP), COLA or ASHI. If you identify an organization with contracted onsite laboratory services that are solely either state inspected or accredited by another laboratory agency (AOA, AABB), thus not meeting the accreditation policy, please notify the Account Executive via the surveyor comments. After survey, the Account Executive will work with the organization on their submission of an application for accreditation.
  - The integration of the laboratory must be evaluated in every survey
  - Specific information is available in this section of the SAG with additional evaluative techniques outlined as part of the Infection Control System Tracer. One of the following are reviewed during a review of laboratory integration regardless of which accrediting body the laboratory uses:
  - **Blood Transfusion**
    Trace a patient (active or discharged) who received blood or blood product. **Conduct separate interviews** with:
    - The laboratory personnel, e.g. Med Techs, etc.
    - Non-laboratory personnel who are involved with blood administration e.g. courier of blood/blood products or phlebotomy in preparation for administration.
  - Interview laboratory staff involved in blood bank operations about:
    - Protocol for ordering and issuance, including:
      ▪ communication
      ▪ patient identification
      ▪ blood product identification
      ▪ patient evaluation of adverse reactions – discovery, notification and process
    - protocol for unused blood products
    - evaluation and maintenance of administration equipment
    - data collection – communication and use
    - storage when blood is not being used
• Interview non-laboratory staff, involved in the administration of blood/blood components about:
  o Protocol for ordering and issuance, including:
    • communication
    • patient identification
    • blood product identification
    • patient evaluation for adverse reactions – discovery, notification and process
  o protocol for unused blood products
  o evaluation and maintenance of administration equipment
  o data collection – communication and use
  o storage when blood is not being used

• Review medical record and verify blood transfusions administered in accordance with law and policy and procedure
• Review medical staff policies and procedures to verify blood transfusion is included

Medical Records
• Verify that:
  o Information (e.g., advance directives, laboratory reports, test results, consultations, assessments, etc.) is filed in the patient’s medical record in a timely manner
  o Medical record entries are dated, timed, and authenticated (as required by law)
    o A complete informed consent is obtained, when applicable (Verify through date and time of the informed consent that it was obtained prior to a non-emergency surgery.)
  o Review medical records for:
    o The presence of sufficient information to identify the patient, support the diagnosis, justify continued hospitalization, describe the patient’s progress, and response to care, treatment, and services
    o Authentication of the history and physical exam, operative report, consultation, and discharge summary
    o Verbal order authentication within state law timeframe
    o Validation that history and physical and/or update was completed within appropriate timeframe. (for Medicare deeming the history and physical examination, including updates must be documented within 24 hours of registration or admission and prior to surgery or a procedure requiring anesthesia services)
    o Evidence that emergency laboratory services are provided 24 hours a day/7 days a week
    o Unapproved abbreviations
    o Data on patient communication needs, including preferred language for discussing health care
    o Data on how patient communication needs are being or were addressed, including if a language interpreter was used or translated documents were provided
    o Data on patient race and ethnicity
    o Inclusion of appropriate information for discharge
      o In organizations who use scribes: Review medical records to determine if the role and signature of the scribe is clearly identifiable and distinguishable from that of the physician or licensed independent practitioner or other staff
      o In organization who use scribes: Review medical records to determine that physician signature stamps are not being used in the authentication of "scribed" entries. The physician must actually sign or authenticate through the clinical information system. This must take place before the physician and scribe leave the patient care area.

• Medical Records Department
  o Interview medical records staff to validate process and timeliness to grant access to records
  o Interview patient to validate that requested records were received within hospital defined timeframes
  o Interview medical records supervisor to verify structure of the medical records department
  o Trace medical records system for timely processing of records, coding/indexing of records, retrieval of records, and compiling and retrieval of data for quality assurance activities.
  o Verify that the medical records system allows for timely retrieval of patient information by diagnosis and procedure
  o Review personnel files of medical records employees to verify they are indeed employees of the hospital
  o Verify that medical records are retained for at least 5 years

Medication Management
• Interview the pharmacist responsible for developing, supervising and coordinating all the activities of the pharmacy department or pharmacy services; verify their role and responsibilities
• Verify that the pharmacy and/or medication storage area is directed and supervised by a registered pharmacist and is administered according to professional principles
• Review and discuss how medications are prepared (e.g., using clean or sterile techniques, minimizing contamination, use of laminar airflow hood or other class 100 environment while preparing IV admixture in the pharmacy, etc.)
• Verify:
  o Proper emergency medication storage (sealed or locked containers; in a locked room; or under constant supervision)
  o **Appropriate labeling of medications, including multi-dose vials**
  o The presence of a list of medications approved for dispensing or administering (must be readily available)
  o Safe storage of medications, including controlled substances
  o Practitioner and pharmacist access to the Prescription Drug Monitoring Database
  o Process for clarifying unclear medication orders
  o **Medications are prepared and administered in accordance with orders**
  o Process for reviewing all prescriptions for the following: appropriateness of the drug, dose, frequency, and route of administration; therapeutic duplication, real or potential allergies or sensitivities; real or potential interactions between the prescription and other medications, food, and laboratory values; other contraindications; variation from organizational criteria for use; **for antibiotic orders—do these include an indication for use** and other relevant medication-related issues or concerns
  o Review pharmacy services policy to verify there is a definition of an adverse drug reaction and medication error; determine that there is a procedure for reporting drug administration errors, adverse drug reactions, and drug incompatibilities immediately to the physician
  o Validate that the attending physician was notified of any medication administration errors, adverse drug reactions, or medication incompatibilities when they occurred
  o If used in the organization, appropriate use of insulin pens (e.g., storage, single patient use, disposal)
• Antimicrobial stewardship:
  o Focus on the following three populations only:
    • Emergency department patients who are prescribed antimicrobials.
    • Ambulatory and clinic patients **surveyed under the hospital program** who are prescribed antimicrobials.
    • Hospitalized patients who will be discharged on antimicrobials.
  o **Do not** interview patients or family members for the antimicrobial stewardship standard.
  o Interview select staff involved in dispensing and administering of antimicrobials regarding the education they have been provided on antimicrobial resistance and the organization’s antimicrobial stewardship program.
• Discuss:
  o **Injection practices including preparation, administration and disposal of syringes and needles**
  o Process for ensuring safety with high risk/high alert medications
• Discuss the process for:
  o Dealing with the patient’s own medications
  o Access to medications when the pharmacy is closed
  o Control and transportation of unused, expired, or returned drugs (e.g., is the pharmacy controlling the process)
  o Data collection on medications accessed after hours
• Review medication orders for:
  o Clarity and completeness
  o Adherence to safety standards (e.g., no blanket reinstatement of previous orders)
• Observe:
  o **Medication pass—several, if possible**
  o Preparation of hazardous medication, e.g. chemotherapy
  o Preparation of high risk medications, e.g. intra-thecal, TPN, intravenous
  o **Process for compounding, labeling, and dispensing medication**
  o Process for preparing radiopharmaceuticals, including preparation by trained registered pharmacist or doctor of medicine or osteopathy

**Organ, Tissue, and Eye Procurement**
Inclusion of organ procurement is based on the conversion rate as follows:

For hospitals in Tier 1 (conversion rate ≤50%) / Tier 2 (conversion rate between 51-74%) with more than 150 beds
- Deceased patient that OPO rendered eligible for donation
  o Explore
    ▪ Staff knowledge about identification criteria and process
    ▪ Process for communication and coordination with the OPO (24/7)
    ▪ Associated traceable issues, e.g., Advance Directives, language barriers, spiritual issues, data collection, etc.
    ▪ The organization's position about asystolic recovery of organs

For hospitals in Tier 1 (conversion rate ≤50%) – regardless of size
- ICU and/or ER patient tracer
  o Explore
    ▪ The organization’s communication and coordination with the OPO
    ▪ Discussions about:
      ▪ The organization’s definition of imminent death
      ▪ Roles and responsibilities of different staff relative to the pursuit of organ donation opportunities
      ▪ The organization’s position about asystolic recovery of organs

Outpatient Services
- Verify that inpatient and outpatient services are integrated (e.g., medical records, radiology, laboratory, environment of care, medication management, surgery, anesthesia, infection control, etc.)
- Verify that outpatient services are ordered by a practitioner who is appointed to the medical staff, privileged, and satisfies the following requirements; or who is not appointed to the medical staff but satisfies the following requirements:
  o Is responsible for the care of the patient
  o Is licensed in the state where he or she provides care to the patient
  o Is acting within his or her scope of practice under state law
  o Is authorized in accordance with state law and policies adopted by the medical staff, and approved by the governing body, to order outpatient services

- Explore the mechanisms for communication between inpatient and outpatient services
- Discharge planning process for outpatient services, for example from the ED, same day surgery, observation units
- Review:
  o In organizations who use scribes: Review medical records to determine if the role and signature of the scribe is clearly identifiable and distinguishable from that of the physician or licensed independent practitioner or other staff
  o In organization who use scribes: Review medical records to determine that physician signature stamps are not being used in the authentication of "scribed" entries. The physician must actually sign or authenticate through the clinical information system. This must take place before the physician and scribe leave the patient care area.

Patient Flow
- Ask staff on different units and services (particularly Emergency Department, med/surge units, OR, radiology, laboratory, housekeeping, transportation) what they consider to be the hospital’s most challenging patient flow problem
- Reference the Program Specific Tracer for Patient Flow. This document contains detailed information that should be evaluated in organizations about patient flow.
- Query staff regarding the timing of assessments and reassessments and availability of consulting providers (such as for behavioral health, oncology, surgery, neurology, ob/gyn). Inquire about the availability and rounding of qualified mental health staff or consultants.
- Query staff regarding frequency of boarding patients with behavioral health emergencies.

**Boarding of Patients Presenting to Emergency Department with Psychiatric Emergencies**

- Review medical records of boarded patients for:
  o Assessment and reassessments - include as indicated: medical, mental status, and psychiatric assessments, and consideration of suicide risk and prevention (see also PC.03.03.09 regarding restraint and seclusion).
Care planning process – trace stabilization or therapeutic care, treatment or service; identify any current treatment providers, family members or others with role in care planning.

Continuum of care – evaluate the communication and coordination process with other staff, other units (e.g., psychiatry, social work, case management) and external providers as indicated in planning for transfer or discharge.

Patient Rights
- Staff discussion and observation:
  - Communication between shifts and departments
  - Education within the confines of patient needs, physical and cognitive challenges, culture and language diversity
  - Use of restraint and seclusion
  - Process when a patient refuses care
  - Process to inform family, surrogate, or another physician of admission when requested by patient
  - Swing beds – organization follows its policies and procedures on prevention of abuse, neglect, and exploitation
  - Swing beds – allegations of abuse, neglect, and exploitation are reported within two hours if relate to abuse or serious bodily injury and within 24 hours otherwise
  - Swing beds – results of investigations are reported to the administrator and to others in accordance with law and regulation within five working days

- Interview patient and family to evaluate understanding of:
  - Rights, prior to receiving or discontinuing care, including regarding advanced directive and end of life decisions
  - Patient safety and personal / health information privacy

Performance Improvement
- Discuss, as appropriate, at the unit or branch level:
  - Data collection processes and responsibilities (for example but not limited to: medication management, blood and blood product use, restraints and seclusion, behavior management and treatment, pain assessment, pain management and safe opioid prescribing, other)
    - Staff instructions for documenting and collecting data for performance improvement
  - Inclusion and monitoring of contracted services and individuals
  - Applicable undesirable patterns or trends in performance that are being aggregated and analyzed
  - Use of data analysis in the identification and implementation of process improvements
  - Process for identifying and implementing changes to reduce the risk of sentinel events
  - Evaluation of performance improvement changes are made to ensure that they achieve the expected results
  - Process for taking appropriate actions when planned improvements are not achieved or sustained
  - Inclusion of data from external sources to determine if there is excessive variability or unacceptable levels of performance
  - Changes in PI activities to accommodate urgent events such as patient health outcomes, high-volume, high-risk, or problem prone processes, adequacy of staffing, significant changes in the internal or external environment
  - Core measure implementation and process changes
  - Proactive activities for identifying and reducing unanticipated adverse events and safety risks to patients are being performed

Radiology and Nuclear Medicine Services
- Discuss:
  - Patient and staff safety (e.g., shielding, lead aprons, badges, pregnant patients, radiation safety, chemical storage etc.)
    - Process for assuring shielding equipment is properly maintained
    - Frequency of radiation exposure monitoring
    - Qualifications, role, and responsibility of director –workers must be checked periodically, by the use of exposure meters or badge tests, for amount of radiation exposure
  - Dissemination of reports
  - Maintenance of printouts, films and scans

- Process for annual equipment maintenance and qualifications of staff that perform maintenance
- Identification and follow-up communication about critical results and findings
- Request documentation of annual equipment maintenance
- Observe:
  - Environment of care to assure safety precautions are being followed
o Radiation exposure monitoring equipment
o Access and use of appropriate shielding equipment by staff and patients

Rehabilitation Services
- Review and discuss:
  o Who provides rehabilitation care, treatment, or services and what qualifications are required
  o Documented (Medicare only) plan of treatment prior to the beginning of treatment
  o Process for developing the plan of treatment (e.g., who orders the service, the type and duration of services, the identification of measurable goals and changes in patient’s response to therapeutic intervention, input from the family)
  o Role of the inter-disciplinary team
  o If speech pathology or audiology are part of rehabilitation services, ask these staff if and how they are enlisted by the care team as a resource to communicate with patients
  o In accordance with policies and procedures, documentation of orders in the medical record

Respiratory Care Services
- Discuss:
  o Safety practices, including infection control measures for equipment, sterile supplies, biohazard waste, posting of signs and gas line identification
  o Medication storage, ordering, dispensing, and administration (e.g., who orders the service)
  o Procedure for treatment of adverse reactions
  o Review preventive maintenance logs
- Review and observe:
  o Handling, storage, and dispensing of therapeutic gases
  o Cardiopulmonary resuscitation
  o Respiratory protocols, e.g. pulmonary function testing, bronchopulmonary drainage, mechanical ventilation and oxygenation support, aerosol medication administration, humidification (sterile water use), and therapeutic gas administration
  o Suctioning, equipment cleaning, medication administration, weaning protocols (e.g., sedation reduction, breathing trials), oral hygiene program, bed elevation
  o In accordance with policies and procedures, documentation of orders in the medical records

Restraint and Seclusion
- Review policies on restraint and seclusion related to:
  o Definition of restraint and seclusion
  o Initiation of restraint and seclusion
  o Safe implementation of restraint and seclusion
  o Training of staff and LIPs in restraint and seclusion
  o Ordering of restraint and seclusion
  o One hour face-to-face evaluation
  o Simultaneous use of restraint and seclusion monitoring
  o Reporting of restraint and seclusion deaths to CMS
- Review medical records for:
  o Documentation of restraint and seclusion (PC.03.05.15 EP1)
  o Initiation of restraint and seclusion in accordance with policy
- Interview staff and LIPs and review staff and LIP files to validate training in restraint and seclusion

Staffing
- Interview staff nurses individually about the workload. Elicit information about the work hours, frequency of missed lunch breaks and overtime. Ask about recent weekend or holiday staffing patterns. Find out how the organization addresses staffing needs when someone calls in sick or patient acuity rises or there is a rapid turnover of patients. Validate that there is an RN on duty at all times.
- Follow-up with nurse managers individually. Further explore issues of insufficient staffing, e.g. budgeting process, recruitment and retention processes, etc. Request a random sample of nurse staffing schedules for one week to evaluate staffing adequacy and skill mix.
- Interview the Chief Nursing Officer about staffing problems. Ask to review meeting minutes where this was discussed with hospital administration.
- Look for negative outcomes as a result of staffing and explore this system-wide issue, if found, during the leadership session.
- Verify that an RN assigns nursing care to nursing staff in accordance with patient needs and the qualifications and competence of staff.
Surgery and Anesthesia

- Observe Universal Protocol in action (patient permission required)
- Discuss policies and procedures that are being followed related to:
  - Informed consent process; confirm it is obtained prior to non-emergency surgery
  - Pre-operative care, including responsibilities for staff
  - Procedural monitoring
  - Post operative care including responsibilities of staff, discharge protocols, and patient teaching
  - Who may administer anesthesia and in what settings; do they apply in all hospital locations where anesthesia services are provided
- Observe/discuss with staff infection control processes related to the operating room
  - Surgical scrub
  - Surgical attire (including masks in restricted areas)
  - Establishing sterile field
  - Minimum traffic in and out of the operating room
  - Damp dusting horizontal surfaces prior to first procedure of the day
  - Cleaning and disinfection between patients, including anesthesia equipment
  - Terminal cleaning after last procedure of the day
  - Ventilation requirements (positive pressure 15 air exchanges per hour; 90% filtration; clean and dry air vents and grill work)
- Discuss and review protocols for supportive life functions such as:
  - Cardiac and respiratory emergencies
  - Resuscitative techniques
  - Availability of emergency medications, supplies, and equipment
  - Process for handling a DNR status
- Verify that:
  - A provisional diagnosis is recorded before the operative procedure
  - A current H & P is in the record prior to surgery
  - Pre-sedation or pre-anesthesia assessments are conducted within 48 hours prior to the delivery of the first dose of medication(s) given for the purpose of inducing anesthesia for the surgery or a procedure requiring anesthesia services; verify the pre-anesthesia assessment includes, at a minimum
    - Review of the medical history, including anesthesia, drug and allergy history;
    - Interview and examination of the patient
    - Notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk)
    - Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access)
    - Additional pre-anesthesia evaluation, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation)
    - Development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia
  - Patients are identified as high risk for adverse events related to opioid treatment and how this is accomplished
  - Patients are monitored during and immediately after the administering of moderate to deep sedation or anesthesia; verify that there is an intraoperative anesthesia record or report that includes, at a minimum
    - Name and hospital id number of the patient
    - Name(s) of practitioner who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiology or operating practitioner
    - Name dosage, route and time of administration of drugs and anesthesia agents
    - Technique(s) used and patient position(s), including the insertion/use of any intravascular or airway devices
    - Name and amounts of IV fluids, including blood or blood products, if applicable
    - Timed-based documentation of vital signs as well as oxygenation and ventilation parameters
    - Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment
Supervision by the surgeon/practitioner performing the procedure or the anesthesiologist occurs when anesthesia is administered by someone other than a physician.

Operative reports are dictated or written immediately after the procedure and authenticated by the surgeon.

Postoperative documentation is timely and complete (e.g., vital signs and level of consciousness, medications, unusual events or complications); verify that the post anesthesia evaluation was conducted by a practitioner who is qualified to administer anesthesia, and performed within 48 hours after the surgery or procedure and at a minimum includes:
- Respiratory function including respiratory rate, airway patency, and oxygen saturation
- Cardiovascular function, including pulse rate and blood pressure
- Mental status
- Temperature
- Pain
- Nausea and vomiting
- Postoperative hydration

Documentation supports the protocols described above.

Access to the operative and recovery areas is restrictive to protect the patients.

Resuscitation equipment is available, properly maintained, and staff responsible in the use of the equipment are competent.

Practitioner performing procedure is appropriately privileged.

Appropriate supervision of LPNs and surgical technologists occurs by RNs.

Operating room register information is included in medical record.

Policies and procedures are implemented related to handling and examination of tissue specimens.

Inquire about air exchanges in the OR.

Verify the cleaning, disinfection and sterilization processes in procedural areas (e.g., steam sterilization, endoscopes cleaning and processing procedures).

Determine if organization elects to reuse single use devices; if so, inquire about whether or not a third party re-processor is used.

**Swing Bed Services**

- Verify the following:
  - The hospital has fewer than 100 beds (excluding beds for newborns and beds in intensive care type units).
  - The hospital is located in a rural area.
  - The hospital does not have in effect a 24-hour nursing waiver.
  - The hospital has not had a swing-bed approval terminated within the 2 years previous to application.

- Also verify that:
  - There are discharge orders changing status from acute care services, appropriate progress notes, discharge summary, and subsequent admission orders to swing bed status.
  - There was a 3-day qualifying stay in any hospital prior to admission to a swing bed in any hospital.

**Telehealth**

- Telehealth tracers are individualized to the scope of services. An individual tracer follows the care of the individual patient by following the process for the telephonic care, treatment or service. Guidelines follow:
  - Surveyors must first identify what service(s) is provided telephonically.
  - Identify a variety of individual tele-health tracers. For example, consider pulling patient records for different:
    - Types of tests
    - Patient populations (age, diagnoses, referral sources, etc.)
    - Branch offices, etc.
  - Follow the process from referral through to discontinuation.
  - Evaluate all steps in the process. The following is not all inclusive but provides a sketch of what can be included:
    - Referral – consider communications, orders, validation of physician license, admission criteria (if applicable), organization directed timeframes etc.
    - Equipment – preventive maintenance, transportation and delivery, set-up, removal
    - Patient education – content, format (includes language and diagrams)
    - Coordination – communication of information, liaison between the organization and patient.
• Test results – process for having results read, flow of information to attending physician, communication of critical values (if applicable)
• Competency – staff applying the equipment, staff education about the process, physician evaluation of results (including credentialing when applicable)
• Interviews should be conducted with patients, technicians and clinicians, as appropriate to the tracer records pulled

Tissue Storage and Issuance
Trace a patient (active or discharged) who had tissue transplanted or implanted. Issues to discuss include:
• Review medical record
• Interview laboratory personnel to discuss:
  o Oversight responsibility assignment (TS.03.01.01, EP1)
  o Process for ensuring that the source facility is licensed (state) and/or registered (federal) (TS.03.01.01, EP 3 and EP 11)
  o Coordination of tissue ordering, receipt, storage, handling and issuance – validate that these processes are being done according to manufacturer or source facility written directions (TS.03.01.01, EP 4 and EP 5)
  o Process for logging in all tissues (TS.03.01.01, EP 6 and EP 7)
  o Physical Environment (TS.03.01.01, EP 8, EP 9 and EP 10)
    ▪ Storage – continuous temperature (refrigerator and freezer, not room or ambient storage), functional alarms, emergency backups
    ▪ Documentation of tissue temperatures
    ▪ Acceptance of tissue from source:
      • Process for ensuring package integrity
      • Transportation temperature
        o No thermometer needed but do need to know if shipping containers were validated.
  o Record keeping:
    • Required for 10 years (TS.03.02.01, EP 5 and EP 6)
    • Donor/source facility to final disposition (discarded, returned to source facility or transplanted/implanted to recipient) traceability and vice versa.
      • Source facility information (TS.03.02.01, EP 6)
      • Pre-transplant/implant documentation (TS.03.02.01, EP 2 and EP 3)
      • Post transplant/implant documentation (TS.03.02.01, EP 1 and EP 4)
      • Return information to source facility (TS.03.02.01, EP 7)
  o Adverse events investigation - implementation of procedures (TS.03.03.01, EP 5) for:
    • Tracking and investigation of tissue transplant infections (TS.03.03.01, EP 1) –
    • Reporting of infections to source (TS.03.03.01, EP 3)
    • Sequestering other associated tissue, if contamination is suspected (TS.03.03.01, EP 4)
    • Identification and notification to recipients of suspected infections (TS.03.03.01, EP 5)

Waived lab testing tracer
• During an individual tracer, identify a patient who is undergoing waived lab testing by the organization’s staff. (Note: patients who are self testing are exempt from CLIA regulations)
  o Trace the organization’s process by:
    • Reviewing documentation elements in the patient record (quantitative result and acceptable range)
    • Interviewing clinicians about testing procedures, including:
      • Orientation and training about equipment use and testing process
      • Identification of tests completed by non-laboratorians in the specified location
      • Implementation of a waived testing quality control plan, including responsibilities
      • Validation that the organization completed quality control testing for the patient’s waived tests you are tracing
        ▪ Organizations are no longer required to perform quality control checks on each day of testing. Organizations are now required to perform quality control checks per manufacturers’ instructions.
    • Follow-up process when results are obtained
  o Drilling down as indicated by:
    • Identifying and interviewing the waived testing director and / or supervisor – director name found on the CLIA waiver
    • Reviewing quality control plan and other planning documents, e.g. policies and protocols (reference standard for detailed needs)
• Evaluating personnel files for the presence of staff education and competency for each type of test being traced
• Reviewing additional data and trace where the data flows and its use in organizational performance improvement
• Instrument maintenance

• Point of Care Testing
  o Cleaning and disinfection of devices (According to the CDC: Lancets and lancet holding devices are single patient use equipment)
  o Appropriate use of PPE
Special Issue Resolution
Applies to: All accreditation programs in which the survey lasts more than one day.

Duration
30 minutes

Participants
All surveyors on site available to participate.

Organization: As requested by the surveyor(s) depending on the issue(s) to be discussed.

During one-day surveys, resolve any open issues prior to report preparation.

Objectives
1. Further investigate and resolve any open issues from previous survey activity.

Before
• If necessary, inform your organization contact of staff members you would like to meet with or the area(s) you would like to visit during this time.
• Inform your organization contact of the documentation you would like to have for review during this session.
• Remind the organization of any promised items that you are still waiting for them to provide.

During
• Discuss/clarify with requested attendees any open issues identified during the course of the survey.
• Review documentation pertinent to the issues identified during the survey, such as:
  o Policies, procedures and plans
  o Complaint policy and procedures to validate stated process and confirm that it includes a statement regarding the patient’s right to report a complaint without negative consequences
  o Ask to see a sample of complaint resolution and determine if it includes all required elements
  o Additional patient records, or components of records, to confirm an Individual Tracer observation; keep a list of all the patient records reviewed
  o HR or credentials files
  o Review interpreter services contract(s) to verify that the service provider defines competencies consistent with hospital expectations
  o Review a sample of clinical service contracts to determine if they include performance expectations; request evidence that the contractor’s performance is being evaluated against the expectations
  o Review of data, such as that associated with performance improvement projects
  o Review of medical records delinquency data
Team Meeting / Surveyor Planning – End of Day
Applies to: All accreditation programs.

**Objectives**

1. Capitalize on the value of a team approach to survey.
2. Discuss and plan for subsequent tracer selection and focus.
3. Identify potential system-wide issues, patterns and trends that are emerging in the observations made to date.

**During**

Surveyors should:

- Discuss/review their observations
- Review the National Patient Safety Goals that have been evaluated
- Think about and review/discuss connections between observations and systems. Discuss/review your planned approach to survey activities for the next day
- Establish areas of focus for subsequent tracer activity based on observations and performance patterns
- Look for similar observations and system level issues across programs, units, branches etc. – focus on potential system-wide issues
- Discuss the observations made to date and where the EPs are likely to appear on the SAFER™ matrix as of this point in the survey; consider appropriateness of the potential EP placement on the matrix each day of a multi-day onsite event
  - Each observation entered in WST will require the surveyor to identify the likelihood for harm, as well as the scope of the issue.
    - WST will auto-populate the SAFER™ matrix with standards and EPs based on the surveyor designation of likelihood to harm and scope of the issue identified with each observation entry
      - Note: The organization will not see the identified likelihood to harm and scope of the issue at the observation level. This is only displayed at the EP level based on where it appears in the matrix.
  - Auto-population of the standards and EPs within the matrix is based on the worst-case observation in terms of likelihood to harm and scope of issue designation. For example, if there are multiple observations under one EP, by one or more surveyors, the observation with the most likelihood to harm is used, and the issue with the greatest scope is used to determine where the standard and EP will appear in the matrix.
  - Surveyors are able to override the matrix auto-population of a standard and EP if, based on their expertise, observations and judgment, they disagree with the placement. See Report

**Duration**

30 minutes

**Participants**

All program surveyors, as applicable. Participation may be by phone if a surveyor is at a distant location. The team leader, if applicable, serves as facilitator for this activity.

Organization: None
Preparation section for further information on how to edit the matrix.

- Identify topics for upcoming system tracers
- Review and verify the status of any outstanding requests for information
- Prepare for the Daily Briefing discussion with the organization, including sharing where observations of non-compliance have the potential to appear on the SAFER™ matrix

After
Return organization documents directly to the organization contact / liaison for safe-keeping
Daily Briefing
Applies to: All accreditation programs in which the survey lasts more than one day.

**Duration**
Approximately 30 to 45 minutes per survey day

Note: The briefing is not required on the first day of multi-day surveys; however, it is left to surveyor discretion to determine the need for a briefing at the conclusion of the first day

**Participants**
All surveyors on site available to participate

Organization: Governing Body, CEO/Administrator and other leaders or staff invited to participate.

**Session Guidelines**
- This session is intended as a briefing, not a detailed report out.

- Team Leaders, as applicable, need to serve as time keeper so that all surveyors from all programs have an opportunity to discuss their observations. Other team members should serve in this role when the team leader is briefing the organization.

- When multiple surveyors are on site, this session is conducted jointly. In such cases, team members may take turns presenting observations. Surveyors at distant locations can join the discussion via conference call, whenever possible.

- When joining by conference call is not possible, the surveyor should relay survey activities and observations to another surveyor in advance of the session. The participating surveyors then share this information with attendees on behalf of the absent surveyor.

**Objectives**
- Provide organization representatives with a brief summary of survey activities of the previous day.

- Relay observations according to standards area and note observations related to general program or organization-specific risk areas.

**During**
- Briefly summarize survey activities completed on the previous day. Make general comments regarding significant issues.

- Do not repeat observations made at a previous daily briefing unless it is in the context of identifying systemic performance issues.

- Discuss what occurred to substantiate an observation as needed for organization understanding. Do not discuss in detail each survey activity, specific records, and discussions held with individuals during Individual Tracers.

- Address requests for consultation on observations by scheduling a time for such consultation to take place.

- Emphasize significant observations and performance patterns or trends in a given standards area that could lead to non-compliance determinations.

- Inform attendees that Requirements for Improvement (RFIs) will be available only when all activities are complete and results are aggregated.

- Answer questions and clarify your comments when requested.

- Review the agenda for the day.

- Make necessary adjustments to plans based on organization needs or the need for more intensive assessment of an issue.

- Inform the organization when a system tracer is planned for that day. Note that participants should include management and pertinent program staff.

- Remind the organization of any information that you are still waiting for them to provide or any staff with whom you still wish to speak and when you would like this to occur.

- Arrange a time for staff to provide information that may have been missed during the previous survey day that could clarify an observation or clear an RFI.

**Summary of Clarification Process Changes**
As appropriate and necessary during RFI review, remind the organization of changes to the Clarification Process.

- Documents not available at the time of Review: Required documents that are not available at the time of review will no longer be eligible for the Clarification Process. These Requirements for Improvement (RFIs) will become action items in the post-review ESC process.

- Clerical Errors: During the certification review, reviewers and the organization work together to identify and correct any
clerical errors in the report. If clerical errors are identified post-review, The Joint Commission will work with the customer to make the corrections. The organization should submit a Clarification Request for the clerical error(s) to be resolved. The correction will be made as part of the Clarification Process. The corrected RFI will remain in the report and become an action item for the ESC process.

- Audit Option: The audit process will no longer be a part of the Clarification Process. As noted above, with the implementation of the SAFER matrix, the “C” Element of Performance category has been eliminated. The “C” EPs were the subject of Clarification Audits.

- Surveyors can extend the Daily Briefing if and when necessary. Be considerate of staff time. **Do not** make all organization representatives stay for a discussion that is specific to a small group of individuals.

- At the last Daily Briefing, the organization may provide additional items for review or individuals to interview in an effort to clarify surveyor reported observations. Remind the organization to provide you with access to documents or individuals in sufficient time to complete your review before the start of the Report Preparation session.
Competence Assessment Session

Applies to: All accreditation programs.

Duration
60 minutes

Participants
One surveyor

Organization:
Staff responsible for:
- Aspects of the organization's human resources processes
- Orientation and education of staff
- Assessing staff competency
- Assessing licensed independent practitioner and other credentialed practitioner competency, when applicable.

Staff with authority to access information contained in personnel and, when applicable, credentials files.

File review
While file review is not the primary focus of this session, you may want to use time in this session to confirm or verify process-related information through documentation in personnel or credentials files. You may also elect to review files as part of Individual Tracers or during the Special Issue Resolution session.
- The organization’s process for maintaining competency records should guide your decision on the timing for file review. For example, if files are maintained by supervisors or managers in the area where an individual works, file review is perhaps most easily accommodated during Individual Tracers.

Other information
In multi-program surveys, one surveyor should conduct this activity for all programs.
- Each member of the survey team is responsible for supplying this surveyor with relevant topics and issues for discussion and identifying files for review, or conducting file review during Individual Tracer activity and reporting on their observations.

Objectives
- Learn more about the organization’s competence assessment process for staff.
- Learn more about the organization's orientation, education, and training processes as they relate to staff, licensed independent practitioners, and other credentialed practitioners encountered during Individual Tracers.
- Identify competence assessment process-related strengths and potential risk points.

Discussion
- Using data gathered during Individual Tracer activity, engage attendees in discussion of the following topics:
  - Internal processes for determining compliance with policies and procedures, applicable law and regulation, and Joint Commission standards.
  - Methods used to determine staffing adequacy; frequency of measurement; and what is being done with these results
  - Performance improvement initiatives related to competency assessment for staff, licensed independent practitioners, and other credentialed practitioners
  - Orientation of staff, licensed independent practitioners, and other credentialed practitioners to the organization, job responsibilities, and/or clinical responsibilities. Does the curriculum include:
    - How to identify patient communication needs
    - How to collect and record data on patient communication needs, patient race and ethnicity
    - How to address communication needs, such as accessing interpreter services, accessing translated documents, working with an interpreter as part of the care team, addressing health literacy needs
    - Information on the organization's non-discrimination policy
    - Experience, education, and abilities assessments
    - Ongoing education and training, including

Antimicrobial Stewardship
- Identify how staff are educated on antimicrobial resistance and antimicrobial stewardship
- Determine which staff were provided with antimicrobial resistance and antimicrobial stewardship education.
- Any evidence that staff were educated is acceptable. NOTE: This does not require review of education and training records for individual staff members.
  - Compliance: Acceptable materials and methods of education are determined by the organization and should be based on acceptable practice. Examples can include: written materials, presentations, online education, classes, manager’s minutes from staff meetings, conferences, annual education days, CEUs, etc.
- **Non-compliance**: There is no evidence that any staff have been educated or were provided information on antimicrobial resistance or antimicrobial stewardship.

- Competency assessment, maintenance, and improvement
- Competency assessment process for contracted staff. Unless a concern is identified with a specific individual, focus contract review on contractors that are not Joint Commission accredited or certified.
- Qualifications for individuals that provide interpreting and translation services—does the hospital include any of the following: Language proficiency assessment, education, training, experience
- Qualifications, competence and experience of the medical physicist(s) supporting CT services
- Ongoing education of diagnostic imaging technologists:
  - CT - annual training radiation dose optimization techniques and tools for pediatric and adult patients
  - MRI - annual education on patient screening criteria, patient positioning, MRI safety
- Inquire about employee health screening and health requirements (e.g., vaccinations, immunizations) for working in the organization; ask about the process for monitoring compliance with such requirements
- Other issues discovered during Individual Tracers. For example, if evidence of understaffing exists, discuss staffing plans and variances
- Summarize strengths and potential risk points in the organization’s competency assessment process

**After**

- Review the personnel and credentials files and job descriptions of specific staff and other credentialed practitioners. For example, the director of dietary services, pharmacist responsible for pharmacy services, radiology and nuclear medicine, and therapy staff.
- Verify that the medical staff determines the qualifications of the radiology staff and approves the nuclear services director’s specifications for qualifications of the nuclear medical staff. (It is appropriate to verify this in the Medical Staff Credentialing and Privileging session as well.)
- Do not review human resource records for antimicrobial stewardship education
- Review the personnel and credentials files of the medical physicist(s) supporting CT services
- Review personnel files of technologists responsible for performing diagnostic CT exams. Verify whether they have obtained any certification(s) or licensure that would indicate they are qualified to perform diagnostic CT exams
- Check for documentation indicating that CT technologists have received training in the provision of diagnostic CT exams.
- Verify there is a full time director of dietary services.
• Verify there are one or more individuals responsible for outpatient services.

• Review a sample of personnel files for individuals that provide language interpreting and translation services to verify that job descriptions include defined competencies such as language proficiency, required skills, and training; validate that competency assessment is performed based on the job description.

• Review personnel files for pharmacy staff, one who supervises others as well as performs sterile compounding and one for a staff member who routinely performs sterile compounding.

• Verify through review of a sample of employee health files any documentation that staff has undergone required health screenings.

• Review staff orientation curriculum to determine what hospital policies and procedures are covered; make a note to validate with staff encountered during individual patient tracers.

• Consider the relationship of your observations to system level issues.

• Share with other team members issues that need to be further explored in subsequent tracers.
Medical Staff Credentialing and Privileging
Applies to: Hospital Accreditation Program

**Duration**
60 minutes

**Participants**
Joint Commission: One clinical surveyor (usually the physician member of the team).

Organization: Individuals able to address issues related to medical staff, for example,
- President of medical staff
- Medical director
- Medical staff coordinator
- Medical staff credentials committee representatives

**Resources**
Required:
- Credentials files
- Medical Staff Bylaws

Optional, based on identified issues during survey activity and need for clarification:
- Rules and Regulations
- MEC Minutes
- Peer review and focused monitoring records
- Graduate medical education guidelines

**Objective**
Learn about the processes used to collect data relevant to appointment decisions, the processes for granting and delineating privileges, and the structure that guide consistency of implementation (for example, bylaw requirements).

**Evaluate** (through discussion and review of credentials files) the implementation of the credentialing and privileging process for the medical staff and other licensed independent practitioners who are privileged through the medical staff process.

**Learn** about some of the specific services in the hospital such as emergency services and anesthesia services.

**Explore** how the organization monitors the performance of practitioners on a continuous basis; identifies substandard performance; and, implements interventions to address identified safety and quality of care issues.

**Before**
- Request credentials files, unless you have reviewed them as part of individual tracers.
- Request other documents as needed to validate something heard in discussion or during individual tracers.

**During**
- Ask the organization to begin the discussion by describing its credentialing and privileging processes.
- Ask questions focused on assessing:
  - The design of the medical staff credentialing and privileging process to determine if standard requirements are in place (e.g., verification of credentials including challenges to licensure, voluntary and involuntary relinquishment or limitation, reduction or loss of clinical privileges, involvement in a professional liability action, health status, morbidity and mortality, and peer recommendations)
  - The scope of the medical staff process to determine if all licensed independent practitioners and other practitioners are reviewed.
  - Consistent implementation of the process for all practitioners.
  - If privileges are appropriate to the qualifications and competencies.
  - The link between results of ongoing professional practice evaluation and focused professional performance evaluation and the adherence to criteria.
  - How the organization is monitoring the performance of all licensed independent practitioners on an ongoing basis (Ongoing Professional Practice Evaluation).
  - How the organization is evaluating the performance of licensed independent practitioners who do not have current...
Individual Tracers
OR log
ICU and special procedures unit logs
“Indicator drugs” (e.g., sedation)
Supplies (e.g., S-W catheter)

- performance documentation at the organization (Focused Professional Performance Evaluation).
  - How the organization is evaluating licensed independent practitioners whose performance has raised concerns regarding the provision of safe, quality care (Focused Professional Practice Evaluation).
  - The process for communicating practitioner privileges and ensuring that practitioners practice within the scope of their defined privileges.
- Explore the medical staff's involvement with emergency services and anesthesia services; verify that the medical staff establishes criteria for the qualifications for the director of anesthesia services.
- Determine if the state is an "opt-out state" and therefore permits CRNAs to administer anesthesia without supervision.
- Ask about policies and procedure governing supervision of CRNA's and anesthesiologist's assistants and determine whether they comply with the regulatory requirements.
- Ask about, and review the qualifications of individuals authorized to furnish other anesthesia services, to determine if they are consistent with the hospital's anesthesia service policies.

- Antimicrobial Stewardship
  - Inquire about the types of licensed independent practitioners and prescribers that received antimicrobial resistance and antimicrobial stewardship education
    - Any evidence that prescribers were educated is acceptable. NOTE: This does not require review of individual medical staff credentialing and privileging records.
    - Compliance: Acceptable materials and methods of education are determined by the organization and should be based on acceptable practice. Examples can include: Written materials, presentations, online education, classes, conferences, annual education days, CMEs, etc.
    - Non-compliance: There is no evidence that any licensed independent practitioners or prescribers have been educated on, or were provided information on antimicrobial resistance or antimicrobial stewardship.
  - Verify that the medical staff determines the qualifications of the radiology staff and approves the nuclear services director's specifications for qualifications of the nuclear medical staff. (Appropriate to cover in Medical Staff Credentialing and Privileging as well)
  - Verify that providers of care via a telemedical link are credentialed and privileged in accordance with the written agreement.
  - Review the files of the anesthesia, nuclear medicine, radiology, and respiratory care services directors to verify qualifications and supervision/administration of services.
  - Conclude the session by summarizing identified strengths and areas for improvement.

After
• Antimicrobial Stewardship: Do not review medical staff credentialing and privileging records for this standard.

• Request additional resources for review, if needed, based on issues identified.

• Consider what you have learned relative to the organization’s systems.

• Share with other members of the team issues that need to be further explored in subsequent Individual Tracers.
Emergency Management Session
Applies to: Critical Access Hospital and Hospital Accreditation Programs

**Duration**
Varies per agenda

**Participants**
One surveyor

NOTE: A Life Safety Code Specialist will conduct this session on surveys with a surveyor complement of 6 or fewer surveyor days.

Organization:
- Emergency management coordinator
- Safety
- Security
- Facility manager
- Clinical staff
- Infection Control
- Ancillary staff
- IT representative
- Organization leadership

Give the staff responsible for managing the particular process the opportunity to provide information regarding their role in addressing any vulnerability you observe.

**Objectives**
1. Evaluate how well prepared the organization is for emergencies and disasters
2. Assess the organization’s degree of compliance with relevant emergency management standards
3. Share ideas and address concerns as they relate to the organization’s emergency management activities
4. Assess leadership involvement and support

Note: Specific emergency management evaluation activities related to CMS Deemed Status requirements for hospitals are indicated with appropriate headers.

**Before**
- Review the following documents:
  - Hazard Vulnerability Analysis (EM.01.01.01)
  - Emergency Operations Plan (EM.02.01.01)
  - Annual evaluation of the Emergency Operations Plan (EM.03.01.01)
  - Emergency Management (EM) drills and after action reports (EM.03.01.03) *Not applicable to initial surveys*
  - Most recent (past 12 months) After Action Report for exercise required under the Homeland Security Exercise and Evaluation Program (if HSEEP exercise is required for hospital under federal Hospital Preparedness Program grants)
  - CMS Deemed Status only: Documentation of emergency management training provided to staff, volunteers, and individuals providing on-site services under arrangement. Training is consistent with the individuals’ role in the organization and in emergency response plans, and is conducted at least annually and when these roles change.
    - Volunteers may be individuals in the hospital (patient escort, receptionist, etc.) or may be skilled providers (trauma team from a nearby facility that comes in response to a mass casualty event); contractors may be on-site only sporadically. Training should be consistent with their usual responsibilities and role (if any) in the emergency response plan.
- Review EM-related issues observed in previous survey activities (including those made by other survey team members).
- Document initial impressions on the optional Hospital Emergency Management Data Collection Tool.

**During**
- Ask attendees to describe their titles and roles in Emergency Management.
- Engage attendees in discussion about the organization’s emergency management activities.
- Review the organization’s:
  - Planning
Planning performance using the topics of Hazard Vulnerability Analysis, multidisciplinary involvement, mitigation activities and recovery plans. Review the scope of the risk assessment, including consideration of risks in the community that might impact the hospital’s ability to provide care, treatment, or services.

Collaboration with community partners (EMS, fire, police, vendors, other health care organizations, governmental, Red Cross, etc.)

• CMS Deemed Status only: Documentation of completed and attempted contact with local, state, tribal, regional, and federal emergency preparedness officials in the hospital’s service area. Examples of these contacts may be written or email correspondence, meeting minutes, conference call agendas, drills or exercises, education programs. Which entities the organization contacts should have relevance to the organization’s prioritized risks, response capabilities and needs, patient population, and designated role (if any) in its community disaster response plan.

• Inventory of the assets and resources it has on-site, that would be needed during an emergency, including for sheltering in place.

• CMS Deemed Status only: Leadership succession planning, delegation of authority, and other strategies for continuity of operations.

• CMS Deemed Status only: Determine if the organization participates in an integrated emergency preparedness program in its system. Note: The integrated system evaluation is important in terms of coordination of emergency preparedness efforts and plans, but most time during this session should be devoted to evaluating the individual organization’s preparedness and response capabilities.

• CMS Deemed Status only: If the hospital has one or more transplant centers, discuss with the organization how transplant center representatives participate in emergency management planning, how the safety of transplant patients is addressed in emergency management planning, and how the transplant center(s) and any associated organ procurement organizations are reflected in the emergency management plan or relevant protocols.

Emergency Operations Plan
Planning performance for the six critical functions:

1. Communication

• CMS Deemed Status only: Review the communication plans for the names and contact information of staff, physicians, other hospitals and CAHS, volunteers, entities providing services under contract, relevant federal, state, tribal, and local emergency preparedness personnel, and other sources of information and assistance.

• CMS Deemed Status: Discuss with the organization its process for communicating information (consistent with law and regulation)
  • about the general condition and location of patients under the organization’s care to public and private entities assisting with disaster relief.
• about evacuated patients to family, patient representatives, or others responsible for the patient’s care
  • CMS Deemed Status only: Current Joint Commission standards for hospitals require that the EOP identify alternative sites for care, treatment, and services that meet the needs of the hospital’s patients during emergencies. Determine that the organization has a procedure for addressing 1135 waivers that, at a minimum, describes how to contact the authority responsible for 1135 waivers should such waivers be needed for the organization to provide care at an alternate care site.

2. Resources and assets

3. Safety and Security
  • CMS Deemed Status: Review the emergency plan and any supporting procedures, electronic forms, or other tools that facilitate tracking on-duty staff and sheltered patients.

4. Staff responsibilities (including orientation/competency/training of staff)
  • Discuss with the organization the type of emergency preparedness training provided (for example, classes, webinars, self-study modules, conferences) and how they determine which groups of staff - disciplines, departments, shifts, etc. - receive education and training and why.
  • Review attendance lists for orientation and training activities. Discuss with managers how staff demonstrate knowledge of emergency procedures after training (post training tests, Q&As, drills, tabletops, etc.) During tracer activity, ask staff about any orientation or training they received in emergency preparedness roles or responsibilities; and of any involvement in emergency management exercises or responses to actual emergencies. Review personnel files if necessary to support evaluation of staff involvement.

5. Utilities management
  • During evaluation of Environment of Care requirements, review the organization’s emergency and stand-by power system inspection, testing, and maintenance plans and activities for alignment with current Health Care Facilities Code, NFPA 110 and Life Safety Code requirements, including
    ▪ evaluating the generator location requirements that are reflected in section 7.2 of NFPA 110
    ▪ maintenance of an onsite fuel source to power emergency generators,
    ▪ emergency lighting
    ▪ maintenance of temperatures to protect patient health and safety and storage of provisions

6. Patient and clinical; support activities, including
  • care of vulnerable populations served by the organization.
  • a system of medical documentation that preserves patient information during an emergency; protects confidentiality and availability, and includes back-up systems for mitigating loss of information due to cyber failures or intrusions
  • Capabilities and response efforts when the organization cannot be supported by the local community for at least 96 hours. NOTE: Acceptable response efforts could include: conservation of resources, curtailment of services,
supplementing of resources from outside the local community, staged evacuation, or total evacuation.

- Safe evacuation from the hospital relative to patient needs, transportation, and communication with external sources of assistance. Ask staff to describe or demonstrate the tracking systems in place that document the locations of patients and staff.

- **Disaster Privileging:** Include discussion of the disaster privileging of Licensed Independent Practitioners (EM.02.02.13) and verification of other practitioners who are required to have licensure, certification or registration (EM.02.02.15)

- **Evaluating Exercises and Response:** Based upon past implementations/drills of the emergency operations plan, discuss and assess the organization’s performance in testing and evaluating its plan and making the necessary improvements. Include the following topics:
  - Critique, including lessons learned, strengths and weaknesses
  - Multi-disciplinary evaluation of exercises and actual responses (including licensed independent practitioners and all levels of staff affected)
  - Identify deficiencies and define specific improvements, including measurable objectives where possible
  - Incorporate changes into current and future preparedness activities and emergency operations plan, including interim measures for longer term improvement efforts.

**Risk, Detection and Response – Cyber Emergencies**

- **Discuss with leaders:**
  - IT system integrity support for maintaining high reliability in care, treatment, or services.
  - IT participation in system risk identification and prioritization, and planning for system emergencies that might impact care, treatment, or services.
  - Updates received by leadership on cyber risk analysis or the state of cybersecurity, including who provides the updates and how frequently they are provided.
  - Leadership support for IT system resilience through EM preparedness activities that mitigate risk of cyber attacks that could impact care, treatment, or services.

- **Discuss with staff involved with emergency management planning how they collaborate with other staff to address potential cyber emergencies.** Suggested discussion topics include:
  - How IT is represented in or informs EM activities related to risk identification or development of the organization’s emergency management plan.
  - The organization’s emergency management planning related to information management, primary and back-up communications, and patient care & support.
  - How medical devices, care, treatment or service equipment, and care-related utilities (medical gas, electricity, water, etc) that are connected to the internet are protected from unauthorized access, catastrophic failure, or malicious attack.
o Staff training, drills or exercises that support effective response and recovery relative to cyber emergencies that impact care, treatment, or service.

- Discuss with senior hospital leaders the reports they receive annually regarding the following: the organization's risks, hazards, and emergencies; the objectives and scope of their EM plans; and their inventories. Ask how they use this reporting to inform strategic planning, budgets, policies, and other mechanisms to support emergency preparedness priorities throughout the hospital to enhance the organization's resilience, response, and recovery.

**CMS Deemed Status only: Integrated Healthcare System Member Organization**

If the accredited organization is part of a health care system that has an integrated emergency preparedness program, and if the organization chooses to participate in the system’s integrated emergency preparedness program, the organization is required to participate in specified integrated activities. The purpose of this discussion and document review is to identify the extent to which the organization is involved in the system’s integrated emergency planning and preparedness activities. Depending on the organization’s risks, services, and capabilities, some aspects of integration with the system may be at an early stage rather than an advanced stage. However, because disasters can occur at any time, the organization must actively implement communication channels and procedures with the system in order to actively use and align with the system’s emergency response procedures.

- Review the following materials:
  o Organization chart or similar document describing the system’s integrated emergency preparedness program
  o The system’s integrated emergency preparedness plan

*Note: Where the system is using a formal Incident Command Structure, these materials and reporting structures may be defined in ICS guidance documents.*

- Ask the organization to describe its participation in the system’s integrated emergency preparedness planning processes, plan and preparedness activities. Query about the following:
  o Ask how they were involved in developing the system’s integrated emergency preparedness program.
  o Ask who has been designated to facilitate coordination with the system on integrated emergency preparedness planning.
  o Ask about any unique circumstances, patient populations or services in their organization relevant to emergency preparedness, and how they informed the development of the system’s integrated program. Review supporting documentation.
  o Discuss how the organization participated in risk assessment activities as part of the system’s integrated emergency preparedness program, including prioritization of risk. Review supporting documentation.
  o Ask the organization to talk through the system’s integrated emergency preparedness plan. Discuss how the organization is involved in on-going preparedness activities, especially related to integration of communications, training, and exercises. Review supporting documentation.
  o Ask how the organization participated in the annual review of the system’s integrated emergency management program. Review supporting documentation.
o Ask the organization to discuss the system’s current program status with respect to their organization’s involvement– what integration activities are currently implemented, and what activities are in planning, design, or development phases.

• Conclude the session by summarizing strengths and risks identified.

After

• In the EM chapter as in other chapters, an iterative process of interview, observation, and document review may be utilized where needed to validate that the organization is doing what leaders have described. Throughout the individual tracer, interview staff of different levels regarding:
  o Knowledge/training on roles and responsibilities in the event of an emergency (verify through personnel file review)
  o Supplies, medical equipment, communication equipment, personal protective equipment (PPE)
  o Decontamination stations available in emergencies
  o Interview unit/department leadership regarding chain of command and communication processes in the event of an emergency
  o Understanding and planning for emergency incidents that last longer than 96 hours

• Review pertinent meeting minutes, policies, and procedures if needed, including reports reviewed by senior hospital leadership and their response to these reports.

• Share observations and concerns with other team members, if applicable, so they can be further explored in subsequent Individual Tracers, System Tracers, and the Leadership session.

The Implementation EP in standards EM.02.02.01 through EM.02.02.11

Standards EM.02.02.01 through EM.02.02.11 describe the six critical all-hazards functions for which all organizations must plan and prepare. Most of the elements of performance (EPs) in each of these standards define what the Emergency Operations Plan (EOP) should describe; these EPs are scored based on the scope and quality of the documented EOP.

The last EP in each of these standards requires the organization to actually implement some or all of the activities described in the EOP; it is here that additional drill down may be necessary to validate, for example, that staff were trained, communication equipment purchased, quarterly meetings with alternative utility vendors are scheduled, etc.

A framework for looking at this implementation EP is as follows:

• The EP is fully implemented
  o Based on iterative interviews, document review, and/or observation, the organization has everything in place that they say they do; if an emergency happened tomorrow they would be prepared to respond. The implementation EP would be considered compliant.
  o The organization is actively in the planning stages; for example, they have meetings scheduled; they have budgeted for certain activities; are awaiting delivery of equipment; have trained some percentage of staff; the board has it on their agenda for next quarter; etc. These are acceptable types of responses because realistically it is recognized that
preparedness is costly, time-consuming, and sometimes contentious. As long as the organization can demonstrate that it is moving toward preparedness, this also can be considered compliant.

- **The EP is not implemented** (not even partially) - there is no planning under way, no meetings scheduled, no one has demonstrated any effort to prepare. The implementation EP is non-compliant for that particular activity.
Emergency Management “Data Collection Tool”

Denotes Documentation Requirement

This optional data collection tool is designed to aid in gathering initial impressions made while reviewing EM documents in preparation for the EM session. It can also assist in questioning during the EM session, following up with any issues identified during the EM session, and documenting any observations and findings for determining standard’s compliance.

**EM.01.01.01 - Planning activities prior to developing Emergency Operations Plan (EOP)**

<table>
<thead>
<tr>
<th></th>
<th>EP 1: Hospital leaders (including of Medical Staff) participate in planning prior to EOP development.</th>
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</thead>
<tbody>
<tr>
<td>Y</td>
<td></td>
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<tr>
<td>N</td>
<td></td>
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<tr>
<td>Y</td>
<td>EP 2: A hazard vulnerability analysis (HVA) is conducted and documented.</td>
</tr>
<tr>
<td>N</td>
<td></td>
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<tr>
<td>Y</td>
<td>EP 3: Hospital and community partners prioritize potential emergencies identified in the HVA.</td>
</tr>
<tr>
<td>N</td>
<td></td>
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<tr>
<td>Y</td>
<td>EP 4: Hospital and community agencies communicate about needs and vulnerabilities.</td>
</tr>
<tr>
<td>N</td>
<td></td>
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<tr>
<td>Y</td>
<td>EP 5: The HVA is used as basis for defining mitigation activities.</td>
</tr>
<tr>
<td>N</td>
<td></td>
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<tr>
<td>Y</td>
<td>EP 6: The HVA is used as basis for defining preparedness activities.</td>
</tr>
<tr>
<td>N</td>
<td></td>
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<tr>
<td>Y</td>
<td>EP 7: The Hospital’s Incident Command is integrated with that of the community.</td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td>EP 8: An inventory of assets and supplies that would be needed during an emergency has been completed and includes, at minimum, PPE, water, fuel, and medical, surgical, and medication-related resources.</td>
</tr>
<tr>
<td>N</td>
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</tbody>
</table>

**EM.02.01.01 - Emergency Operations Plan (EOP)**

<table>
<thead>
<tr>
<th></th>
<th>EP 1: Hospital leaders (including of Medical Staff) participate in EOP development.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td>EP 2: An EOP exists that describes an All Hazards approach.</td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td>EP 3: The EOP identifies the hospital’s capabilities &amp; establishes response efforts when the hospital cannot be supported by the local community for at least 96 hours in the six critical areas.</td>
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</table>

**Have capability limitations and response efforts been planned for the 96-hour absence of community support?** See EM.02.01, EP 3 above.

It is not required that hospitals have a 96-hour supply inventory on hand. However, it is critical that they determine how long they can provide safe patient care and treatment and how patients will have their care needs met for the initial 96 hours, especially as relates to high risk situations identified on the HVA. **Note: An acceptable response effort would be to temporarily close or evacuate the facility, consistent with their designated role in their community response plan.**

**Projected Hrs. of Operation (circle response):**

- **Communications:** 12 24 36 48 60 72 84 96
- **Resources & Assets:** 12 24 36 48 60 72 84 96
- **Safety & Security:** 12 24 36 48 60 72 84 96
- **Staff Responsibilities:** 12 24 36 48 60 72 84 96
- **Utilities Management:** 12 24 36 48 60 72 84 96
- **Patient & Clinical Support Activities:** 12 24 36 48 60 72 84 96

<table>
<thead>
<tr>
<th></th>
<th>EP 4: The EOP describes recovery strategies and actions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
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</tbody>
</table>
EM.02.02.01 through EM.02.02.11 - EOP addresses all six (6) critical functions

1. **Communication (see EM.02.02.01).** In the event that community infrastructure is damaged and/or a hospital’s power or facilities experience debilitation, communication pathways, whether dependent on fiber optic cables, electricity, satellite, or other conduits, are likely to fail. Hospitals must develop a plan to maintain communication pathways both within the hospital and to critical community resources.

   - Have system failure contingency plans been developed for hospital-specific systems and equipment? Contingency plans may be established for and are not limited to:
     - Telephone
     - Nurse call
     - Overhead paging
     - Radio (Fire, EMS, police, etc.)

2. **Resources and assets (see EM.02.02.03).** A solid understanding of the scope and availability of a hospital’s resources and assets is as important - and perhaps more important - during an emergency than during times of normal operation. Materials and supplies, vendor and community services, as well as state and federal programs, are some of the essential resources that hospitals must know how to access in times of crisis in order to ensure patient safety and sustain care, treatment, and services.

   - Has consideration been given to determining the duration of operational sustainability of medical services, food service, etc? HVA-identified risks may include and are not limited to:
     - Patient treatment supplies
     - Medication supplies
     - Food supplies
     - Sanitation supplies
     - Laboratory supplies
     - Medical equipment & associated supplies
     - Contracted services

3. **Safety and security (see EM.02.02.05).** The safety and security of patients is the prime responsibility of the hospital during an emergency. As emergency situations develop and parameters of operability shift, hospitals must provide a safe and secure environment for their patients and staff.

   - Have safety and security arrangements been established? Protection of patients and staff is contingent upon measures that operate internally and externally. Safety and security plans may include and are not limited to:
     - Total building lockdown
     - Ingress and egress identification
     - Establishing restricted areas
     - Internal movement of patient supplies & waste
     - External traffic flow into & away from the hospital
     - Decontamination location security
     - Hazardous waste management

4. **Staff responsibilities (see EM.02.02.07).** During an emergency, the probability that staff responsibilities will change is high. As new risks develop along with changing conditions, staff will need to adapt their roles to meet new demands on their ability to care for patients. If staff cannot anticipate how they may be called on to perform during an emergency, the likelihood that the hospital will not sustain itself during an emergency increases.

   - Are staff roles and responsibilities identified for job-specific flexibility and for need-specific responsibilities? There are certain tasks that are only accomplished by certified or licensed
     - Patient transportation
     - Supply distribution
     - Security access control
     - Traffic control
to defining responsibilities for duties not requiring a license. In addition, cross-trained tasks should be defined and practiced during an emergency exercise and may include and are not limited to:

5. Utilities management (see EM.02.02.09). A hospital is dependent on the uninterrupted function of its utilities during an emergency. The supply of key utilities, such as power or potable water, ventilation, and fuel must not be disrupted or adverse events may occur as a result.

Are utility systems and equipment clearly identified for use and function? Are contingency plans practiced to the degree practical? Have written agreements been established, wherever possible, with supply and equipment vendors, including address and after hours telephone contact? The operational duration of systems and equipment should be defined with and without community support (96 hours) as described in EM.02.01.01, EP3. Systems and equipment evaluation may be conducted for and are not limited to the following:

| Y N | Hazardous materials & waste handling |
| Y N | Communication runners |
| Y N | Guest and visitor management |
| Y N | Decontamination duties |
| Y N | Emergency power and fuel |
| Y N | Medical gas and vacuum |
| Y N | Ventilation including positive and negative pressure requirements |
| Y N | Potable water |
| Y N | Sanitation system |
| Y N | Heating and cooling |
| Y N | Elevator operation |

6. Patient clinical and support activities (see EM.02.02.11). The clinical needs of patients during an emergency are of prime importance. The hospital must have clear, reasonable plans in place to address the needs of patients during extreme conditions when the hospital’s infrastructure and resources are taxed.

Clinical conditions will vary during the course of an emergency. Patient care and treatment triage become essential to maximizing staff resources, environmental integrity and effective utilization of supplies and equipment. Some issues to consider:

- Has consideration been given as to the potential need for alternative care sites for patient treatment?
- Is an effective patient identification and tracking system practiced during emergency exercises?
- Are patient transportation options identified with respect to accessing specific equipment or services needed by the patient for the duration of the trip?
- Given that various patient populations will be served during an emergency, has the hospital reviewed its capabilities and limitations associated with these various populations; e.g., infants and children, elderly, non-ambulatory or limited ambulatory patients, behavioral patients, hearing impaired, and the blind? The hospital should be encouraged to consider community patient populations such as assisted and Nursing Care Center populations in the area when developing an effective HVA.

**EM.02.02.13 and EM.02.02.15 - Disaster Volunteer credentialing and privileging**

**About Disaster Privileging**

When the hospital activates its Emergency Operations Plan in response to a disaster and the immediate needs of its patients cannot be met, it can choose to rely on volunteer practitioners to meet these needs. These practitioners may be volunteer licensed independent practitioners (EM.02.02.13) or volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification, or registration to meet these needs (EM.02.02.15).

Under these circumstances, if the usual credentialing and privileging processes cannot be performed because of the disaster, the organization may use a modified credentialing and privileging process on a case-by-case basis for eligible volunteer practitioners. While these standards allow for a method to streamline the process for determining qualifications and competence, safeguards must be in place to assure that the volunteer practitioners are competent to provide safe and adequate care, treatment, or services. Even in a disaster, the integrity of two specific parts of the usual process for determining qualifications and competence must be maintained:

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

A number of state and federal systems engaged in pre-event verification of qualifications can help facilitate the assigning of disaster privileges to volunteer licensed independent practitioners at the time of a disaster. Examples of
such systems include the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and the Medical Reserve Corps (MRC). The ESAR-VHP, created by the Health Resources and Services Administration (HRSA), allows for the advance registration and credentialing of healthcare professionals needed to augment a hospital or other medical facility to meet increased patient/victim care and increased surge capacity needs. MRC units are comprised of locally based medical and public health volunteers who can assist their communities during emergencies, such as an influenza epidemic, a chemical spill, or an act of terrorism.

Standards EM.02.02.13 and EM.02.02.15 are surveyed primarily as part of the Emergency Management Session. Recognizing that hospitals are not required to utilize volunteers during a disaster, and may make a policy decision regarding their emergency response strategy that they will not seek or utilize such volunteers:

- Query leaders regarding how the organization might determine that volunteer practitioners will be necessary. This might include a discussion of the planning expectations in EM.02.01.01 EPs 2, 3, 4, 7.
- Query hospital leaders, the incident commander, and other staff leading key response functions regarding how such volunteers would be distinguished from other staff and how they would be monitored during the disaster. These discussions can take place in the EM discussion session or during interviews with staff and licensed independent practitioners as part of individual tracer activities.

### Disaster Volunteer Credentialing and Privileging Requirements Table

<table>
<thead>
<tr>
<th>Determination that volunteer practitioners will be used?</th>
<th>EM.02.02.13 Volunteer licensed independent practitioners</th>
<th>EM.02.02.15 Volunteer practitioners who are not licensed independent practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>If not used, EPs 1-4 are not applicable.</td>
<td></td>
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</tr>
<tr>
<td>EP1: Disaster privileges only when EOP has been activated.</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>EP2: Who can grant disaster privileges is defined in writing (in medical staff bylaws for licensed independent practitioners).</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>EP3: Determine how to distinguish volunteer practitioners and licensed independent practitioners from other practitioners and licensed independent practitioners.</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>EP4: Oversight method described in writing.</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

### Volunteer practitioners actually used during a disaster?

EPs 5 through 9 are implementation EPs that can only be surveyed if an organization experienced a disaster for which volunteer practitioners were utilized. Review of After Action reports and EM discussion session will provide key information, including whether such volunteers were used even if the organization had not planned in advance to do so.

Staff responsible for HR and medical staff functions will be able to address through discussion or other evidence how identification and oversight were handled. EP8 requires documentation related to verification of licensure.

| EP5: Obtain two forms of identification. | Y | N |
| EP6: Oversee performance. | Y | N |
| EP7: Determine within 72 hours if privileges/clinical responsibilities should continue. | Y | N |
**EM.03.01.01 – Annual Evaluations**

Date of most recent evaluation

<table>
<thead>
<tr>
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</table>

**EM.03.01.03 – EOP Implementations and Evaluations**

<table>
<thead>
<tr>
<th>EP 1: EOP activated twice a year for all sites included in plan? Sites classified as business occupancy, need to conduct only one exercise annually.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of main site:</td>
</tr>
<tr>
<td>Date of secondary site #2:</td>
</tr>
<tr>
<td>Date of tertiary site #3:</td>
</tr>
<tr>
<td>Date of alternate site #4:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EP 2: One exercise/year included influx of simulated patients? May be combined with EP 3 or 4.</th>
</tr>
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<tbody>
<tr>
<td>Date: Community involvement?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EP 3: One exercise/year with an escalating event and no community support? May be combined with EP 2 or 4. Tabletop sessions are acceptable in meeting the community portion of the exercise.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>EP 4: One exercise/year included community involvement? May be combined with EP 2 or 3. Tabletop sessions are acceptable in meeting the community portion of the exercise.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: Community involvement?</td>
</tr>
</tbody>
</table>

| EP 5: Exercises are realistic and HVA-related. |
| EP 6: A qualified person(s) is solely responsible for observations. |
| EPs 7-12: The Six Critical functions are monitored. |
| EP 13: A multi-disciplinary process is used to evaluate exercises. |
| EP 14: Exercises are evaluated. |
| EP 15: Exercise strengths and weaknesses are communicated to the EC multi-disciplinary improvement team. |
Y  N  EP 16: The EOP is modified based upon evaluations.

Y  N  EP 18: Exercises evaluate the effectiveness of EOP modifications from previous evaluations.
## Emergency Management Lessons Learned

### Tips and Examples

<table>
<thead>
<tr>
<th>Topics</th>
</tr>
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<tbody>
<tr>
<td><strong>Planning</strong></td>
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<tr>
<td>Planning</td>
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<tr>
<td>Planning</td>
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</table>

| **Response** |
| Volunteers | Spontaneous volunteers from the community may converge on the organization to provide assistance during a community disaster. This may be welcome, or it may distract staff and leaders or create congestion and confusion. The organization can plan to direct such volunteers away from the active response area to be screened by designated staff. Alternatively, to mitigate such arrivals, the organization can plan to communicate through its EOC (including incorporation of traditional and social media) to the community regarding the type of volunteers it needs and where they should report, or convey that no volunteers are needed and where to call or check if the situation changes. |

| **Communication** |
| Communication Systems | Organizations have found it useful in planning and response to: |
| | • establish a line of communication solely for command/control and a separate channel for communication with staff |
| | • switch to satellite phones, if necessary; and employ two-way radio communication via walkie-talkies, which can be more reliable devices in stormy conditions |
| | • contact government agencies in their area to request access to backup telecommunications towers. |
| Communication with physicians | Prepare for proactive communication with physicians at the start of an emergency response. Physicians often spontaneously report to a scene or multiple scenes, which can result in too many or too few physicians, or a mismatch of specialties to immediate patient needs. |
| Communication via social media | Informally, many staff became aware of incidents in the organization via social media before receiving official notification from their managers. Many organizations found social media to be more effective than their mass communication plans and have incorporated it in various ways to communicate with staff, patients, the community, and traditional media. In one emergency where there was an explosion in the community: |
| | • One hospital developed a ‘disaster blog’ to keep internal staff apprised of information from the command center. |
| | • Another hospital began sending out regular updates on the number of patients treated, types of injuries, etc., and media outlets stopped inundating them with phone calls. |
| | • Another hospital requested blood donors on its Facebook site, and over 250 people came to donate. |
Communication via Media - national and international
Hospitals often have established relationships with local media, but a high level of interest from national
and international media can consume a great deal of executive time and attention. In high profile
emergencies, some organizations utilize a proactive media outreach plan in which leadership:
- Provides media some access to facilitate accuracy of reporting and mitigate excessive distraction
  in and around the facility
- Decides (in advance to the extent possible) the type of circumstances and conditions under which
  media can be allowed access to patients for interviews with patient consent; hospital can then aid
  patients or family members in the interaction with local, national, or international media

Security
Security during Community Threat/Attack/Unrest
Health care organizations can work in advance with public safety providers when there are known or
perceived safety risks; and should be prepared to be proactive and nimble when the unexpected happens.
During a bomb attack in one community that resulted in multiple casualties and involvement of local, state,
and federal authorities:
- Security forces had a different understanding of what it meant to lock down a facility than did staff
  and physicians in the hospitals - what was lock down at some hospitals was just limited access in
  others. Hospitals should work with other health care facilities and local law enforcement (especially
  if served by overlapping authorities, such as campus and city police, or city police and county
  sheriff) to synchronize key terms and definitions essential in emergency response.
- When all vehicles were ordered to stay off the streets and trains/buses ceased operations, it was
difficult for health care staff to get to work. Health care organizations can contact local authorities in
advance to discuss ways to facilitate access of essential staff to their organizations during a
community disaster (identification cards, transport, escort, etc.)

Security – Staff caring for forensic patients
Planning for the safety of staff who are caring for suspects or prisoners should consider the potential for a)
harm carried out by the patient; b) harm carried out by visitors against the patient; c) harm carried out by
visitors against the staff caring for the patient.

Staff
Staff Support
In planning for community disasters where staff’s homes may be compromised (such as tornados or
hurricanes), create a plan for staff sheltering, meals, and transportation. Determine staff rotations and shift
reliefs, and designate sleeping areas for men and women who are able to report for work. Provide
adequate meals for employees and set up a shuttle system to transport staff to and from their homes.

Staff Planning
Communicate proactively with staff at the start of response and throughout so that a sufficient number and
type of staff deploy to the right location when needed. In a community explosion, each of the three local
hospitals had 250-300 off duty employees report for work unsolicited when the explosion was reported
through the media; there were so many staff that the hospital had to send many home because it was too
crowded in the ED.

Patient Care
Patient care – OME SAG
Home health organizations are not consistently included in the community EOC; they can plan internally for
notification, situational awareness and response, but may need to reach out proactively to other providers
and authorities in the community throughout the incident. In one community disaster, home health and
DME organizations were alerted of community water disaster in the evening primarily through media
reports. No notification or instructions were received from local authorities, organizations activated their
own emergency plans. The organizations:
- Contacted staff that evening, and all patients that evening and the next morning
- Prioritized patients with O2 concentrators and CPAP machines
- Instructed all other patients of precautions for humidifiers, face washing, etc.
- Advised patients to follow public health guidance
- Delivered water to patients where necessary or informed patients of where to get it
- Sent letters to those patients they were unable to reach by telephone
- Provided additional follow-up to those most medically compromised, including home visits

**Patient tracking**
In mass casualty events, information on the location of patients across hospitals and within hospitals can be difficult to track. In such emergencies, some organizations have shared the names of patients they've received with other facilities so that accurate information can be shared with families, especially if family members were taken to different organizations for care.

**INFECTIOUS DISEASE**

**Emerging infectious diseases: training and exercises**
- Training and simulations should encompass critical aspects of care, treatment and service – initial patient screening, use of PPE, safe patient flow from entry point(s) to isolation, iterative training of care teams, dedicated equipment, safe transfer of patients, safe conveyance of samples to external laboratories, disposal and transport of waste, etc.
- Exercises should not just repeat the same scenarios if there is a new threat in the environment; the organization should update its preparation for new threats or risks where needed (for example, in terms of mitigation, community planning, use of social media, etc.)

**Infection Control: Cleaning and sterilizing**
A hospital had drilled for not using potable water, but following contamination of municipal water source was not able to clean and sterilize surgical instrument trays. The hospital worked with partners to transport trays to another hospital for sterilization there and transport back; enhanced surveillance was used to track loaned equipment and the trays that were sent out and returned.

**UTILITIES**

**Utilities**
When loss of water (potable and/or non-potable) is considered a risk, the organization should not only know its actual usage in gallons per day, but how that usage may vary by time of day, or day of the week.

**EXERCISES**

**Exercises**
The organization should vary its exercises to surface hidden weaknesses or gaps in its plans. Stress and test the system, staff and leadership with escalating complications and different patient populations, such as those with special functional needs or communication challenges.

**HEALTH CARE PARTNERS**

**Health care partners – mass casualty event**
Organizations can consider how nursing homes, behavioral health providers, physician practices and home care agencies can partner with inpatient settings to support response. Following an explosion in which local hospitals received patients from the community and a nursing home fire:
- Local nursing homes coordinated among themselves and contacted the hospitals to let them know how many displaced nursing home residents they could take from each hospital.
- Hospitals utilized in-house behavioral health staff, employee assistance programs, pastoral services and grief counselors to support patients, first responders, staff and community.
- Local ENT specialists were mobilized for care in the community via the state’s Regional Advisory Council (RAC).
- Hospital case managers helped with patient placement for two weeks post event, including coordination with affiliated home care providers.

**Health care partners - utilities**
Organizations can consider how ambulatory providers can partner with inpatient settings to share information, maintain situational awareness, and support response. Following a contamination of the community water supply, the local ambulatory dialysis company:
• mobilized its biomedical engineer, and maintained contact with its regional director and the command center at its affiliated hospital throughout the incident.
• through its national contract, acquired a 6000 gallon tanker truck within 4 hours, rigged up a distribution center, and worked with hospital building engineers and local fire department to provide for proper pressurization to operate hospital equipment and services until community water services were restored.
• kept in touch with the CDC and the EPA in an attempt to identify the specific contaminant. Because clear information was not available and it was difficult to measure the contaminant in the field, they worked with a competitor dialysis provider to share information, sampled water at the hospital, and contracted with an independent laboratory.
• Improved its preparedness going forward by mapping the water sources for each of its sites; and including review of the EM plan as a standing agenda item in its monthly meetings with its affiliated hospitals.

Health Care Partners – infectious disease outbreak
When implementing screening questions, isolation procedures and other infectious disease precautions in the organization, include free-standing physician offices and other affiliated providers to mitigate risk in all potential patient care locations.

Evacuation
Where the need to evacuate is identified as a potential risk, the organization can rehearse evacuations during drills. Many organizations don’t keep evacuation equipment on site, so it’s important to consider in advance how they will evacuate patients and to practice that strategy to identify weaknesses and make adjustments. How much equipment will be sufficient, where it will need to be deployed (which units, floors, etc.) who needs to be trained to use it are all important considerations.

Recovery
Recovery can takes months and sometimes years; long term psychological impacts on staff to consider include:
  • need for ongoing empathy
  • identifying and mitigating triggers of overreaction, fear, etc.
  • role of leadership in seeing battle fatigue in self and others
  • impact of long recovery on ancillary/offsite/support departments that were peripherally impacted
Environment of Care Session
Applies to: Critical Access Hospital and Hospital Accreditation Programs

Duration
Varies per agenda

Participants
One surveyor
NOTE: A Life Safety Code Specialist will conduct this session on surveys with a surveyor complement of 6 or fewer surveyor days and all psychiatric hospitals.

Organization:
Individuals able to address issues related to the management of the EC
• Safety management coordinator
• Security management coordinator
• Facility manager(s)
• Building utility systems manager
• Responsible person for medical/laboratory maintenance
• EC team or safety committee leader
• Organizational leadership
• Clinical Staff

Give the staff responsible for managing the particular process or risk reviewed opportunity to provide information regarding their role in addressing any vulnerability you observe.

In the EC chapter as in other chapters, an iterative process of interview, observation, and document review may be utilized where needed to validate that the organization is doing what leaders have described. This may involve interviews with staff of different levels in the organization or from different shifts.

Objectives
• Assess the organization's degree of compliance with relevant standards and identify vulnerabilities and strengths in the organization's environment of care management processes.
• Evaluate staff knowledge of procedures and technology in place to prevent environment of care incidents, what is their expected response if an incident occurs, how to obtain additional resources if needed, and how to report the incident when it occurs.

Before
• Review the following documents:
  • Annual evaluations of the Environment of Care (EC) management plans (EC.04.01.03) *Not applicable to initial surveys*
  • EC multidisciplinary team meeting minutes for the previous 12 months (EC.04.01.03) *Not applicable to initial surveys*
  • Review EC-related issues observed in previous survey activities (including those made by other survey team members). Use identified risk points to select tracer for observation phase of session.

During
Environment of Care Discussion (70% of the session time)
• Engage attendees in discussion about the following aspects of their environment of care management processes:
  • PLAN – What specific risks related to its environment of care have been identified by the organization
  • TEACH – How roles/responsibilities of staff/volunteers have been communicated by the organization
  • IMPLEMENT – What procedures and controls (both human and physical components) the organization has implemented to minimize the impact of risk to patients, visitors, and staff
  • RESPOND – What procedures the organization implements to respond to an EC incident/failure. How, when, and to whom are EC problems, incidents, and/or failures reported within the organization
  • MONITOR – How the organization monitors EC performance (both human activities and physical components). What monitoring activities have taken place within the last 12 months
  • IMPROVE – What environment of care issues are currently being analyzed? What actions have been taken as a result of EC monitoring activities?

• Medical Equipment and Utility System Components – When evaluating a hospital’s equipment maintenance activities, pay particular attention to high risk equipment for which there is a risk of serious injury/harm or death to a patient or staff member should the equipment fail. If an alternative equipment maintenance (AEM) program is in use, evaluate the following:
  • The process and criteria that the hospital uses for including equipment in the program
The qualifications/competency of those individuals making the determination for including equipment in the program

The factors and evidence considered in developing the AEM strategies for the equipment in the program

- Diagnostic Imaging:
  - The results of quarterly staff dosimetry monitoring
  - Structural shielding design assessment and radiation protection surveys for new or replacement CT, NM, or PET installations by physicists

Environment of Care Tracer (30% of session time)

- Determine which risk category to trace (safety, security, HAZMAT, fire safety, medical equipment, utilities, construction) based on the organization’s services, RFIs from previous survey activity, tracer observations and Environment of Care session discussion. If a risk category is not identified, select an appropriate area based on high risk areas specific to the type of organization.

- To conduct the tracer, start at the physical location where the risk occurs, or has the potential to occur. Interview staff to evaluate the following:
  - Knowledge of processes to eliminate/minimize the risk
  - Technology utilized to eliminate/minimize and to assist with responding to an incident (spill kits, fume hoods, fire fighting equipment, decontamination equipment, alarms, storage spaces, locks, shut off valves)
  - Knowledge of how technology is maintained, who is responsible for maintaining the technology, and what to do if the technology fails
  - Knowledge of how to respond when an incident occurs
  - Knowledge of process to report incident

- Continue the tracer to support departments to assess staff knowledge of their roles in prevention and expected response during an incident.

- Conclude the session by summarizing strengths and risks identified.

***Please see the two examples and grid for additional information on conducting the Environment of Care tracer.***

After

- Share with other team members, if applicable, any issues that need to be further explored in subsequent survey activities.
- Review pertinent meeting minutes and procedures if needed.
Conducting the Environment of Care Tracer-- Examples

The following are examples of how to conduct the environment of care tracer for two risk categories. These are just guides to conducting the tracer. Surveyors are not required to interview all the following people and are not required to ask all the following questions. These suggestions are not all inclusive of the issues and topics that can or should be covered.

Example 1: Safety Risk Category (Patient falls)

Initial tracer location: Patient Care unit with higher than expected falls per inpatient day data.

Interview: Direct care staff

- What is the process to assess a patient for fall risk and procedure when a patient is determined to be a fall risk
- What technology (if any) is used to prevent falls (assistive devices, etc.)
- Who is responsible for maintaining and monitoring the technology
- What do you do if technology fails
- What is the expected response when a patient falls
- How is the fall reported for medical record and data tracking
- What orientation and/or education did you receive regarding the patient fall prevention program

Interview: Transport staff

- How are you informed that a patient is at risk for a fall
- What is the process to prevent a fall while the patient is being transported
- What is the expected response when a patient falls
- What orientation and/or education did you receive regarding preventing patient falls

Observe:

- Implementation of fall risk process
- Utilization of preventive/assistive technology
- Communication among care providers regarding patient’s identified as high fall risk

Second tracer location: Patient diagnostic testing area

Interview: Diagnostic testing staff

- How are you informed that a patient is at risk for a fall
- What is the process to prevent a patient fall while the patient is undergoing testing
- What is the expected response when a patient falls
- What orientation and/or education did you receive regarding preventing patient falls

Observe:

- Communication among care providers regarding patient’s identified as high fall risk
- Implementation of process to prevent patient falls

Example 2: HAZMAT Risk Category (Radiation Therapy-Tandem and Ovoids Treatment)

Initial tracer location: Nuclear Medicine preparation area

Interview: Physicist

- What is the process for preparing radioactive source material
- What technology is utilized to minimize exposure risk to staff
- What is the process for responding to radioactive material exposure
- Who is responsible for maintaining the lead aprons and other shielding devices
- Who is responsible to monitor the proper use of the shielding devices
- What is the process for reporting the radioactive exposure
- What orientation and education is required regarding the safe preparation of radioactive source material

Observe:

- Radioactive material preparation area
- Radioactive material disposal area
- Proper personal dosimeter exposure counter usage by staff

Second Tracer Location: Patient care unit

Interview: Physician/Physicist/Radiation Therapist

- What is the process for handling radioactive source material from the time/place of delivery, patient administration, through source retraction and removal from inpatient unit
- What is the process for responding to a source retraction failure or other treatment emergency
- What is the process for reporting an emergency related to tandem and ovoid treatment
- What orientation and/or education did you receive regarding the safe handling of the radioactive source
Interview: Nursing Staff
- What is the process for radioactive material safety, including while providing direct patient care
- What is the process for responding to radioactive material exposure
- What is the process for responding to a treatment emergency
- What is the process for reporting an emergency related to tandem and ovoid treatment
- What orientation and/or education did you receive regarding the safe handling of radioactive patient waste material

Interview: Patient receiving tandem and ovoid treatment
- What education did you receive regarding your treatment and safety precautions
- What does the clinical staff do and wear when they start your tandem and ovoid treatment
- What does the nursing staff do and wear when they stop your tandem and ovoid treatment

Interview: Housekeeping Staff
- What is the process for removing radioactive waste from the patient care unit to final disposal
- What is the process for responding to a radioactive waste spill or staff exposure
- What is the process for reporting a spill or exposure
- What orientation and/or education did you receive regarding the safe handling of radioactive waste

Observe:
- Process for handling, and disposing of radioactive waste
- Process for transporting radioactive waste to final disposal area
- Proper personal dosimeter exposure counter usage

The following grids provide examples of different items to trace based on the identified risk areas of safety, security, HAZMAT, fire safety, medical equipment, utilities, or construction.

<table>
<thead>
<tr>
<th>Safety</th>
<th>EC.02.01.01 EP1 and EP3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Falls</td>
<td>Worker Injuries (i.e., Ergonomics)</td>
</tr>
<tr>
<td>People</td>
<td></td>
</tr>
<tr>
<td>Clinical Staff that assess patients</td>
<td>Clinical Staff</td>
</tr>
<tr>
<td>Safety Officer/ Committee</td>
<td>Safety Officer/ Committee</td>
</tr>
<tr>
<td>Employee Health</td>
<td>Equipment Operator</td>
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<tr>
<td>Technology and Buildings</td>
<td></td>
</tr>
<tr>
<td>Handrails</td>
<td>Patient Lifting Hoists</td>
</tr>
<tr>
<td>Lighting</td>
<td>Patient Lifting Belts</td>
</tr>
<tr>
<td>Bed Alarms</td>
<td>Mattress Assistive Lifting Surfaces</td>
</tr>
<tr>
<td>Management Processes (action to minimize the likelihood of an incident occurring)</td>
<td></td>
</tr>
<tr>
<td>Staff Orientation and Education</td>
<td>Orientation and Education</td>
</tr>
<tr>
<td>Environmental Tours to identify Hazards</td>
<td>Environmental Tours to identify Hazards</td>
</tr>
<tr>
<td>Incident Reports and Investigations</td>
<td>Incident Reports and Investigations</td>
</tr>
<tr>
<td>Incident Response Procedures</td>
<td>Incident Response Procedures</td>
</tr>
</tbody>
</table>
### Security

**EC.02.01.01 EP1 and EP3**

<table>
<thead>
<tr>
<th>People</th>
<th>Infant Abduction and Elopement</th>
<th>Violence</th>
<th>Controlling Contraband in Behavioral Health Care and Emergency Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Staff</td>
<td></td>
<td>ER Staff</td>
<td>Clinical Staff</td>
</tr>
<tr>
<td>BHC Staff</td>
<td></td>
<td></td>
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<tr>
<td>L &amp; D Staff</td>
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<tr>
<td>Security Staff</td>
<td></td>
<td>Security Staff</td>
<td>Security Staff</td>
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<tr>
<td>Support Staff (Housekeeping, food service)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Technology and Buildings</th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Locks</td>
<td>Locks, Controlling access</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alarms</td>
<td>Alarms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Surveillance equipment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management Processes (action to minimize the likelihood of an incident occurring)</th>
<th>Staff Orientation and Education</th>
<th>Staff Orientation and Education, including de-escalation techniques</th>
<th>Staff Orientation and Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Education</td>
<td>Weapons Policy</td>
<td>Controls for new/returning patients</td>
<td></td>
</tr>
<tr>
<td>Method for contacting police</td>
<td>Controls for visitors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident response procedures</td>
<td>Controls for staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HAZMAT

**EC.02.02.01 EP6 and EP7**

<table>
<thead>
<tr>
<th>People</th>
<th>Radiation</th>
<th>Hazardous Vapors (glutaraldehyde, ethylene oxide, cauterizing vapors)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Officer/Committee</td>
<td>Clinical Staff</td>
<td>Clinical Staff</td>
</tr>
<tr>
<td>Safety Officer/Committee</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technology and Buildings</th>
<th>Personal Protective Equipment (PPE) (i.e. lead aprons)</th>
<th>Specialized exhaust systems including fume hoods</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lead shielding</td>
<td>Vapor alarms</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management Processes (action to minimize the likelihood of an incident occurring)</th>
<th>Staff orientation and education</th>
<th>Staff orientation and education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation monitoring procedures</td>
<td>Monitoring procedures</td>
<td></td>
</tr>
<tr>
<td>Incident response procedures</td>
<td>Incident response procedures</td>
<td></td>
</tr>
</tbody>
</table>
## Fire Safety

<table>
<thead>
<tr>
<th>People</th>
<th>Operating Room laser fires</th>
<th>Fire hazards during construction</th>
<th>Patient smoking (if permitted)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EC.02.03.01, EP1</td>
<td></td>
<td>EC.02.01.03, EC.02.03.01, EP1</td>
</tr>
<tr>
<td>OR staff</td>
<td>Clinical staff adjacent to construction areas</td>
<td>Staff in BHC unit</td>
<td></td>
</tr>
<tr>
<td>Safety Officer/Committee</td>
<td>Safety Officer/Committee</td>
<td>Safety Officer/Committee</td>
<td></td>
</tr>
<tr>
<td>Construction personnel</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technology and Buildings</th>
<th>Temporary hard wired smoke detector system</th>
<th>Non-combustible ashtrays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-combustible partitions separating the construction area from the remainder of the hospital</td>
<td>Separate room with dedicated ventilation system</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management Processes (action to minimize the likelihood of an incident occurring)</th>
<th>Staff orientation and education</th>
<th>Incident response procedures</th>
<th>ILSMs (LS.01.02.01)</th>
<th>Contractor orientation</th>
<th>Regular monitoring of smoking policy implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff orientation and education</td>
<td>Staff orientation and education</td>
<td>Incident response procedures</td>
<td>ILSMs (LS.01.02.01)</td>
<td>Contractor orientation</td>
<td>Regular monitoring of smoking policy implementation</td>
</tr>
<tr>
<td>Incident response procedures</td>
<td>Incident response procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LIP orientation and education</td>
<td>ILSMs (LS.01.02.01)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

## Medical Equipment

<table>
<thead>
<tr>
<th>People</th>
<th>Medical equipment failure</th>
<th>Water used in hemodialysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EC.02.04.01 EP6</td>
<td>EC.02.04.03 EP5</td>
</tr>
<tr>
<td>Equipment operator staff</td>
<td>Equipment operator staff</td>
<td>Maintenance staff</td>
</tr>
<tr>
<td>Maintenance Staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technology and Buildings</th>
<th>Failure alarms</th>
<th>Failure alarms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Backup equipment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management Processes (action to minimize the likelihood of an incident occurring)</th>
<th>Staff orientation and education</th>
<th>Equipment testing, inspection, and maintenance</th>
<th>Incident response procedures, including any clinical interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff orientation and education</td>
<td>Staff orientation and education</td>
<td>Equipment testing, inspection, and maintenance</td>
<td>Incident response procedures, including any clinical interventions</td>
</tr>
<tr>
<td>Utilities</td>
<td>Isolation rooms</td>
<td>Utility disruption (i.e., generator, medical gas, water)</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
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<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Personnel</strong></td>
<td>Clinical staff to verify room pressure</td>
<td>Maintenance staff</td>
<td></td>
</tr>
<tr>
<td><strong>Technology and Buildings</strong></td>
<td>Room pressure gauges</td>
<td>Failure alarms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Room pressure alarms</td>
<td>Shut-off controls</td>
<td></td>
</tr>
<tr>
<td><strong>Management Processes</strong> (action to minimize the likelihood of an incident occurring)</td>
<td>Staff orientation and education</td>
<td>Staff orientation and education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Equipment testing, inspection, and maintenance</td>
<td>Equipment testing, inspection, and maintenance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incident response procedures</td>
<td>Incident response procedures, including any clinical interventions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Construction</th>
<th>Bariatric patients</th>
<th>Infection control during construction projects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personnel</strong></td>
<td>Clinical staff</td>
<td>Clinical staff</td>
</tr>
<tr>
<td></td>
<td>Facility staff</td>
<td>Facility staff</td>
</tr>
<tr>
<td><strong>Technology and Buildings</strong></td>
<td>Bathroom accommodations (Handrails, appropriate weight toilet seats, built-in shower chairs)</td>
<td>Temporary barriers to prevent spread of infection</td>
</tr>
<tr>
<td></td>
<td>Patient hoist/lifting equipment</td>
<td>Controlling building ventilation system so construction area is not circulated throughout the building</td>
</tr>
<tr>
<td></td>
<td>Access through ER to patient room including imaging equipment</td>
<td></td>
</tr>
<tr>
<td><strong>Management Processes</strong> (action to minimize the likelihood of an incident occurring)</td>
<td>Staff orientation and education including safe lifting techniques</td>
<td>Staff orientation and education</td>
</tr>
<tr>
<td></td>
<td>Contractor education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regular inspection rounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incident response procedures</td>
<td>Preconstruction infection risk assessment</td>
</tr>
</tbody>
</table>
Facility Orientation – Life Safety Surveyor
Applies to: Critical Access Hospital and Hospital accreditation programs

<table>
<thead>
<tr>
<th>Duration</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| Approximately 90-120 minutes | - Become familiar with the building and plan an efficient survey of Life Safety and selected Environment of Care standards
| | - Review documentation reflecting organization performance of building feature inspections, testing, and maintenance as required by Life Safety and selected Environment of Care standards

<table>
<thead>
<tr>
<th>Participants</th>
<th>Before</th>
</tr>
</thead>
</table>
| | - Review the History Audit Trail for evidence of equivalencies that have been granted
| Organization: | - Meet with the survey team to plan interaction and communication during survey and review any LSC issues or unusual observations identified by team members
| Facility manager(s) Safety Management Coordinator | |

Questions should be reviewed with the Standards Interpretation Group Engineers at: 1-800-965-5888, Option 2, and Option 4

<table>
<thead>
<tr>
<th>Duration</th>
<th>During</th>
</tr>
</thead>
</table>
| | - Ask for an escort to take you promptly to the main fire alarm panel to verify it is functional (10-15 minute activity)
| | - Meet with appropriate organization staff to become oriented to the building through an interactive review of the following items:
| | o Written fire response plan
| | o ILSM policy and procedures
| | o Verify that any granted equivalency conditions align with the information submitted by the organization as reflected in the History Audit Trail
| | o Building plans and drawings to:
| | ▪ Identify fire separations and smoke barriers
| | ▪ Identify arrangement of smoke compartments
| | ▪ Identify arrangement of exiting
| | ▪ Identify location of any suites
| | ▪ Identify areas with automatic sprinklers
| | ▪ Identify any laundry and trash chutes
| | ▪ Identify areas under construction
| | ▪ Assist in mapping a path for the building tour that visits all required areas and avoids retracing steps as much as possible

Facility Maintenance Document Review
- Assess maintenance evidence of performance related to standards EC.02.03.05, EC.02.05.07, EC.02.05.09 through use of the Life Safety and Environment of Care Document List and Review Tool found in Appendix DD

<table>
<thead>
<tr>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>- At the end of this activity, briefly summarize your observations with organization staff, including any IOU documents that need to be reviewed later during the survey.</td>
</tr>
</tbody>
</table>
Life Safety Code® Building Assessment -- Hospital
Applies to:  Critical Access Hospital and Hospital accreditation programs

### Duration
8 hours depending on the total square footage of the building(s)

### Critical Access Hospital Activity Timing
On Critical Access Hospital surveys, the LSC Building Assessment will be conducted in a compressed timeframe. The LSC Specialist will also conduct the Environment of Care and Emergency Management Sessions.

### Participants
Life Safety Code® Surveyor
Organization:
- Facility manager(s)
- Safety Management Coordinator

### Reminder:
When documenting any LSC observations, note if the observation is because an item is lacking or is not functional due to improper maintenance.

### Objectives
- Evaluate the effectiveness of the organization’s processes for designing and maintaining buildings to Life Safety Code (LSC) requirements.
- Evaluate the effectiveness of the organization’s processes for identifying and resolving LSC problems.
- Determine the organization's degree of compliance with relevant LSC requirements.
- Educate attendees on potential actions to take to address any identified LSC vulnerabilities.

### Before
- Inform the organization contact that you will need the following items for this session:
  - Ladder
  - Flashlight
  - Keys or tools necessary to gain access to all locked areas and spaces above ceilings in each location visited during the building tour.
  - Meet with the survey team to plan interaction and communication during survey and review any LSC issues or unusual observations identified by the survey team.
  - Review the History Audit Trail for evidence of equivalencies that have been granted.

### During LSC Building Tour
- Review the objectives for this session with the participants
- Assess operating room(s) for proper pressure relationships. Do this early in the survey to allow the organization time to correct while on site. The review of the corrective action must include documentation that other areas supplied by the same air handler were not negatively impacted by the corrective work.
- Using the Building Tour Guidance Document found in Appendix EE complete the following activities to evaluate organizational compliance with the LSC, based upon occupancy requirements:
  - Assess required fire separations.
  - Assess required smoke separations.
  - Assess hazardous areas, such as soiled linen rooms, trash collection rooms, and oxygen storage rooms.
  - Verify that required exit stairs are continuous from the highest level they serve to the outside of the building.
  - Assess the kitchen and any kitchen grease producing cooking devices.
  - Assess any laundry and trash chutes (including the terminal ends).
  - Assess the automatic sprinkler pump if applicable.
  - Assess the condition of all emergency power systems and equipment.
  - Assess other areas listed on the Building Tour Guidance Document found in Appendix EE.

### Guidance for Surveying a Hospital within a Hospital (HWH)
All EPs in the Environment of Care, Emergency Management and Life Safety standards chapters will be evaluated for compliance. Some EPs may be dependent on the Host, such as the fire alarm and emergency generator inspection, testing and maintenance, as well as ensuring all egress passageways to the public way are clear and unobstructed.
Usually the HWH has established by contract that the Host will provide, upon request, information that confirms compliance.

During survey of a HWH located in a Host that is NOT Joint Commission accredited (i.e., state surveyed) Environment of Care, Emergency Management and Life Safety will be surveyed by a Life Safety Code Specialist.

An HWH that is located within a Host accredited by The Joint Commission will not be assigned a Life Safety Code Specialist, as the Host would have been determined to be compliant during its own full survey.

Clear and unobstructed egress passageways will be confirmed regardless of Host status.

Questions should be reviewed with the Standards Interpretation Group Engineers at: 1-800-965-5888, Option 2, and Option 4.

- Verify that there is a reliable emergency power system that supplies electricity when normal electricity is interrupted to the following areas: exit route illumination, emergency/urgent care areas, areas where electrically powered life-support equipment is used, operating rooms, and postoperative recovery rooms.
- Assess medical gas and vacuum system components including master signal panels, area alarms, automatic pressure switches, shutoff valves flexible connectors, and outlets.

**Life Safety Code findings for deemed hospitals:** If any RFIs related to building deficiencies are identified during the building tour, discuss the deficiency and the impact on patient safety with the organization. Then discuss the life safety deficiency with the organization and determine which of the below ILSMs will be implemented until the deficiency has been resolved.

**ILSMS: LS.01.02.01**

- Fire watch (EP-2)
- Post signage if exit compromised (EP-3)
- Inspect exits (EP-4)
- Temporary fire alarm and detection systems (EP-5)
- Additional firefighting equipment (EP-6)
- Temporary construction partitions (EP-7)
- Increase surveillance (EP-8)
- Enforce practices to reduce building flammable and combustible fire load (EP-9)
- Provide additional training on use of firefighting equipment (EP-10)
- Conduct additional fire drill per quarter (EP-11)
- Inspect and test temporary systems monthly (EP-12)
- Conduct education promoting awareness of deficiencies (EP-13)
- Train staff on fire safety features (EP-14)
- Other (EP-15)

Include the following language in each finding:

- The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization’s ILSM policy: (list all applicable EP numbers).
- Note: If the organization is using an ILSM that is not addressed in EPs 2-14 the surveyor will document what “other” risk-mitigating factor is/are being utilized when citing EP 15.

**After**

- At the end of the day, review and enter your observations into your laptop computer. Note if the observation is because an item is lacking or is not functional due to improper maintenance.
- With a member(s) of the survey team, conduct a verbal interim exit briefing with staff designated by the organization to review your observations.
- Meet with the survey team, if applicable, to review any observations that need further exploration during subsequent survey activities.
Leave your contact information with the team leader in case any questions come up later in the survey.

**LSCS Guidelines on use of “Observed in survey activity but corrected onsite pending acceptable Evidence of Standards Compliance”**

The “Observed, but Corrected On-Site” provision impacts only a limited number of requirements in the Life Safety (LS) chapter, focusing on “operational type” deficiencies. Required repair and/or replacement deficiencies may be corrected while the LSC Surveyor is on-site; however, these types of deficiencies will still appear in the Summary of Survey Findings report, and the organization is still required to submit an acceptable Evidence of Standards Compliance. When you write an RFI for a situation in which the “Corrected On-site” provision applies, the last sentence of the RFI should be: This finding was observed during survey activity, but corrected onsite prior to the surveyor’s departure. The corrective action taken needs to be included in the organization’s Evidence of Standards Compliance submission. You may include additional information if warranted. The following examples will help you determine when and when not to apply the provision. If you have any questions on applying this provision, contact your Field Director for further guidance.

**Situations in which the “Observed, but Corrected On-Site” provision APPLIES:**

- Gap in ceiling tile that is repositioned
- Stretcher or gurney blocking medical gas shut-off valves that can easily be moved
- Food cart parked in front of a fire extinguisher but can easily be moved
- Partially burned out exit light that is corrected on discovery.
- Storage issues
- Failed Door Latch
- Leaky ABHR unit that is repaired/replaced
- ABHR over outlet that is moved immediately
- Missing Fire Extinguisher or signs – immediately replaced
- Fire alarm breaker designation (red)
- Corridor clutter that can be moved immediately
- Unsealed penetrations in walls and smoke/fire barriers that are repaired and shown to inspector while on survey.
- Door problems, minor (e.g., latching and automatic closer problems), demonstrated as repaired during survey.

**Situations when the “Observed, but Corrected On-Site” provision DOES NOT APPLY:**

- Unsealed penetrations in walls and smoke/fire barriers
- Door problems (e.g., improper fire rating, latching and automatic closer problems)
- Non-functioning fire alarm
- Missing smoke detector
- Missing fire damper
- Missing handrail in stairwell
- Remote shut off for generator set missing
- Missing sprinkler spares
Program Specific Tracer - Laboratory Integration

Applies to: Critical Access Hospital and Hospital accreditation programs – Conducted regardless of whether laboratory services are accredited by the Joint Commission or CAP

<table>
<thead>
<tr>
<th>Duration</th>
<th>60 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>One Surveyor</td>
</tr>
<tr>
<td>Organization:</td>
<td>Laboratory and hospital staff</td>
</tr>
</tbody>
</table>

Rationale:
A review of hospital sentinel events involving laboratory services demonstrates that frequently the causative factor is a lack of collaboration between laboratory and non-laboratory staff. The laboratory integration survey process provides surveyors with time to focus on the level of cooperation between the hospital and laboratory.

Objectives
1. To evaluate the consistent application of processes related to laboratory testing throughout the hospital.
2. To evaluate the exchange of information (specimen collection, test results including critical test results, specimen collection and handling, specimen identification) and integration of the laboratory processes in the hospital setting.
3. To identify hospital processes and possibly system issues contributing to a lack of integration.

Before
Select a patient who:
- Is receiving services across the laboratory clinical service groups of blood bank, chemistry, hematology, microbiology. Select a patient receiving as many of these services as possible in the order listed.
- Has had critical laboratory results, and ask the organization for the list of critical test values.

(Tip: Patients meeting these criteria are commonly found in the ICU.)

During
Conducting a Laboratory Integration Tracer
- Trace the laboratory component of the patient’s experience by visiting each area where activities took place and talking with those involved in the activities.
- Interview laboratory and non-laboratory staff in their respective work areas. At a minimum, these interviews should involve:
  - Laboratory staff members, e.g. individuals who perform phlebotomy, conduct laboratory testing, and are responsible for reporting results.
  - Non-laboratory staff members, e.g. individuals who perform phlebotomy, administer blood, transport blood/blood products and are responsible for receiving or using laboratory results.

If tracing a patient with a critical laboratory result:
- Interview non-laboratory staff members about:
  - Test ordering processes
  - Communication to laboratory about the need for testing
  - Obtaining results, including critical values
  - Turn-around time - including communications (phone, fax, IT interface, etc.)
  - As applicable to the role of non-laboratory staff members and location:

Please Note:
This tracer is about:
- Communication and integration between the hospital and laboratory

This tracer is not about:
- Laboratory functioning
- Quality control
- Proficiency testing
- Technical competence

Other

Owned and Contracted Onsite Laboratory Services in a Joint Commission Accredited Hospital:
Surveys should make note that some hospitals may have a combination of owned and contracted onsite laboratory services. As example, the hospital may operate its own general and point-of-care laboratory services, but engage a local donor center to provide onsite blood bank services. Note that all owned and contracted onsite laboratory services must be accredited by The Joint Commission or one of its cooperative partners, namely the College of American Pathologists (CAP), COLA or ASHI. If you identify an organization with contracted onsite laboratory
services that are solely either state inspected or accredited by another laboratory agency (AOA, AABB), thus not meeting the accreditation policy, please notify the Account Executive via the surveyor comments. After survey, the Account Executive will work with the organization on their submission of an application for accreditation.

- specimen collection
- patient identification process
- transportation and storage of lab specimens

- Interview laboratory staff members about:
  - Test ordering processes
  - Communication to laboratory about the need for testing
  - Specimen collection
  - Patient identification process
  - Transportation and storage of lab specimens
  - Obtaining results, including critical values
  - Turn-around time – including process for communications (phone, fax, IT interface, etc.)
  - Laboratory performance improvement data

**If tracing blood and/or blood product administration:**

- Interview non-laboratory staff members about:
  - Protocol for ordering and issuance
  - Communication to laboratory about the need for blood/blood products
  - Patient and blood/blood product identification
  - Transportation and storage of blood collection specimens and blood/blood products
  - Storage when blood/blood product is not being used
  - Protocol for unused blood products
  - Evaluation and maintenance of blood administration equipment
  - Data collection – communication and use
  - Evaluation of adverse reactions – discovery, notification and process
  - Adverse event reporting
  - IT interface between the patient care area and laboratory

- Interview laboratory staff members about:
  - Protocol for ordering and issuance
  - Communication from hospital about the need for blood/blood products
  - Patient and blood/blood product identification
  - Transportation and storage of blood collection specimens and blood/blood products
  - Evaluation of adverse reactions – discovery, notification and process
  - Protocol for unused blood products
  - Evaluation and maintenance of blood administration equipment
Data collection – communication and use
- Storage when blood is not being used
- Adverse event reporting
- IT interface between the patient care area and laboratory
  - Process for notifying recipients of infectious or potentially infectious blood and/or blood components
  - Review agreement with outside blood supply agency

After
- Trace other patients receiving similar services
- Validate contradictory responses by:
  - Interviewing additional staff
  - Reviewing policies, as indicated
  - Interviewing leaders
- Consider the relationship of your observations to system level issues
- Share issues with other team members, if applicable, so they can be further explored in subsequent survey activities
- Discuss observations with the organization at the conclusion of the tracer activity and/or at the next daily briefing
Program Specific Tracer – Patient Flow

Applies to: Critical Access Hospital and Hospital accreditation programs

<table>
<thead>
<tr>
<th>Duration</th>
<th>60-90 minutes (takes place as part of an individual tracer)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>One surveyor</td>
</tr>
<tr>
<td>Organization:</td>
<td></td>
</tr>
<tr>
<td>o Staff involved in the patient’s care, treatment, and services from hospital entry to current location</td>
<td></td>
</tr>
<tr>
<td>o Front line managers</td>
<td></td>
</tr>
</tbody>
</table>

Rationale:
Growing concerns from the health care field about increasing patient congestion continue. Poorly managed patient flow most often impacts vulnerable areas in the hospital first, such as the emergency department, critical care units and surgical areas; but these are not always the causative factors and answers lie throughout the hospital. Treatment delays, medical errors and generally, unsafe practices thrive in the presence of patient congestion; these are precursors to and contributing factors in sentinel events. Many hospitals have improved their flow of patients through due diligence. Joint Commission accredited hospitals are required to identify and correct patient flow issues throughout their organization. While evidence of patient flow issues surface in the emergency department, post anesthesia care unit or other patient care units, corrective improvements may be necessary organization-wide.

Objectives
1. To identify evidence of patient flow problems.
2. To evaluate process issues throughout the hospital contributing to patient flow issues.

Complete this tracer when
- Triggers (listed on the next page in the grey bar) are identified in an organization. Some triggers will be detected via direct observation; other triggers will become evident through querying staff and/or reviewing reports (see Data Management System Tracer) regarding the components of the patient flow process that the hospital has been measuring over time.

Conducting a patient flow system tracer
- Select a patient/client who is experiencing or did experience an extended wait or delay. This information can be gleaned from department logs, staff and patient interviews. Most commonly, patients in the emergency department or surgical units experience delays in transfer to beds in inpatient care areas. You may select patients admitted through the emergency department and begin a tracer there; for example, a medical patient, or a behavioral patient in need of long term placement. Request the ED census from the previous week and choose a patient to trace from the peak period.
- Using the experience of this patient, trace the flow of the patient to various units and through the discharge process where applicable. Note locations, times and details of delays.
- Review the patient’s record looking for detail of delays. If the diagnosis is associated with a core measure the hospital is using, look for variances from the expected.

AMI:
- aspirin and beta blockers on arrival
- fibrinolytic treatment within 30 minutes of arrival
- primary percutaneous coronary intervention (PCI) within 90 minutes of arrival

Pneumonia
- blood cultures prior to first antibiotic
- initial antibiotic received within 6 hours of hospital arrival

Surgical Care Infection Prevention
- prophylactic antibiotic received within 1 hour prior to surgical incision (CABG, other cardiac, colon, hip arthroplasty, knee arthroplasty, hysterectomy, vascular)
- prophylactic antibiotic discontinued within 24 hours post op (colon, hip arthroplasty, knee arthroplasty, hysterectomy, vascular)
- prophylactic antibiotic discontinued within 48 hours post op (CABG, other cardiac)

- Interview staff about patient flow issues, such as patient flow measures for their area and what they have been learning from the data. Inquire if the measures have revealed any delays in care, treatment or services, waits for surgery, diagnostic testing, transfers to
Triggers indicative of patient flow problems:
(Note: this list is not all inclusive and hospitals with patient flow issues may exhibit one or more of these triggers)

- Assessment delays / process
- Delay in blood draws
- Delay in radiological exams
- Delays in communication / reporting from one area handing the patient off to another
- Delays in discharge due to discharge processing
- Delays in OR schedules
- Hospital processes that stop the flow of patient movement, e.g. work up in ED, housekeeping protocols
- Increase length of stay (per literature - directly related to time spent in ED)
- Insufficient support and ancillary staffing levels
- Misuse of ED (Low Acuity Patients, for direct admits)
- Patients experiencing delays with transfers
- Reports of similar issues, specific days of the week or times of the day
- Other units, delays in discharges to home, interdepartmental communication issues, staffing, or other processes that inhibit patient flow, etc. Ascertain how key goals were determined and how patient safety and quality are sustained in situations when goals are not met.

- Interview medical staff, including surgeons and hospitalists about patient flow issues. Inquire about rounding times, surgery schedules, and discharge processes. Discuss relationship with emergency department and participation on PI projects or strategic initiatives related to patient flow. Ascertain the processes put in place to support efficient patient flow. Explore impact of hospital or medical staff structure (e.g., teaching or safety net hospital, use of hospitalists, contracted or employed ED physicians, etc.) on patient flow initiatives.

- Interview staff about the patient flow experience of patients with psychiatric or substance abuse crises who come to the emergency department. Ascertain the staffing, assessment and care, and space considerations taken for safe management of these patients throughout their length of stay.

- When issues are identified, interview leaders about actions they have taken to mitigate consequences of patient flow problems, how they have shared accountability with medical staff, evidence of their shared accountability, what indicators exist throughout the hospital, how indicator results are reported to leadership and how this information has been used to improve patient flow.

- Visit the emergency department more than once to assess hospital-wide impacts and responses related to changes in ED flow at different times of the day.

After

- Discuss issues with survey team during the next surveyor planning session, if applicable.
- Consider the pervasiveness of identified issues. Evaluate possible systems issues.
- Seek additional information, such as assessments of other high risk patients, if necessary during an Issue Resolution session.
- Consider the relationship of your observations to system level issues, such as staffing and planning.
- Query leadership regarding how they use patient flow dashboards or other reports to monitor performance and manage trends over time.
- Discuss observations with the organization at the conclusion of the tracer activity and, when applicable, at the next daily briefing or at the leadership session, if systems related.
Patient Flow Indicators

How to use this diagram
While surveying hospitals surveyors should look for the noted indicators of patient flow concerns while moving throughout the organization. The indicators may be discovered through direct observation, through interviews with patients, staff, or leaders, or reported as part of the organization's analysis of data related to patient backflow. This diagram represents the indicators that may be present at various points of care. When an indicator is identified, surveyors must conduct a patient flow tracer. These indicators also serve as issues for additional exploration when conducting a Patient Flow Tracer.

Standards to consider: LD.04.03.11, NR.02.02.01, PC.01.02.03, PC.02.02.01, RI.01.01.01, MS.03.01.03, HR.01.02.01, HR.01.06.01
Patient Flow through the Emergency Department - Exploratory Queries

Because patient flow through the emergency department can significantly impact or be impacted by throughput in other areas of the hospital, the queries below can be used as needed to help enhance survey of ED operations in order to more fully explore potential system-wide patient flow issues.

<table>
<thead>
<tr>
<th>If you see, hear, or read the following…</th>
<th>Follow-up by asking or doing the following… (potential data elements or sources that might indicate underlying issues or patterns over time are underlined)</th>
</tr>
</thead>
</table>
| The ED goes on diversion frequently     | • In ED, ask to see staffing plan for period they were on diversion, also ask for mitigation plan – who was involved in deciding to divert? What triggers a mitigation response to anticipate or prevent diversion.  
  • Ask if there’s a plan to intervene when census meets a certain threshold?  
  • How does the OR handle elective surgeries pre-diversion? Is there an impact on elective surgeries?  
  • How does the hospital modify surgery scheduling?  
  • When/how does the hospital decide to convert other areas into patient rooms (PACU; GI lab)? How do you staff? |
| Ask during the planning session for metrics regarding LD.04.03.11 EP5 (supply of patient beds, efficiency/safety of patient care areas, access to support services) | Determine if the organization has set performance goals and incremental targets for each of these components of the patient flow process. Ask the organization about the measures they have in place and how they use the data to monitor their performance against the goals and ultimately to improve. Ask if they are benchmarking themselves against external associations, collaborative, or research initiatives. |
| • Delayed turnaround times for labs, beds, etc. in data review during planning session  
  • Patients waiting in diagnostic areas (x-ray or CT) to move through | Ask about wait times and turnaround times for tests. Ask how the hospital sets priorities (among ED patients and inpatients), identifies occurrences and/or patterns of bottlenecks, and mitigates (e.g., call floors to stop more patients from coming to area)? |
<p>| Little data being collected related to patient flow or just beginning to collect, or note no data related to patient flow during first day preparation session. | Ask how the hospital knows what its baseline/current performance is on key areas of patient flow. Request their existing data related to patient flow collected for last 12 months related to LD.04.03.11 EP5 (supply of patient beds, efficiency/safety of patient care areas, access to support services); query who reviews the data, how is it used, does it go to leadership- (can be explored in data session). |
| Full waiting room and ED logs indicate long delays in arrival to screening/assessment | Ask about data on ‘wait time to be seen by provider’ and whether it indicates a pattern of delays over time. |
| Non-acute patients using the ED | Ask number of these types of visits per year, how does the ED triage, how do they prioritize which patients are seen first. Is there a separate area or process for low acuity patients? |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Hospital has no inpatient psychiatric unit but has psychiatric patients</td>
<td>Ask what NPSG suicide risk reduction actions were taken. Ask what contracts with community services, if any, are in place? Ask about case management and social worker service availability.</td>
</tr>
<tr>
<td>No designated area for behavioral patients in ED</td>
<td>Assess area where behavioral health patients are held for safety issues; inquire about staff training. Talk with staff regarding training specific to behavioral health patient needs and safety issues, competencies/training required. Include medical staff in exploring these issues and any specialty training required of ED medical staff.</td>
</tr>
<tr>
<td>Lack of community resources for behavioral health patients</td>
<td>Consider pulling a record of a behavioral health patient seen in ED and trace that patient to disposition. Evaluate compliance with the NPSG, completion of assessments, ask about activities, if any, related to reaching out to community providers/leaders, social work or case managers in the ED. Ask about how these patients are managed and how care is provided until disposition.</td>
</tr>
<tr>
<td>Gap in patient record between arrival time in ED and transfer to unit</td>
<td>Ask how hospital tracks time intervals and time stamps, especially related to CMS inpatient ED measures. Are they comparing targeted times to actual times – from arrival time to time to admit decision, time to get patient to floor, time to conduct diagnostic tests, time to get test results, etc.</td>
</tr>
<tr>
<td>In units:</td>
<td><strong>How often</strong> do they place and provide patient care, treatment and services to patients in hallways due to full ED bays? Explore issues of security, confidentiality, privacy and other patient rights.</td>
</tr>
</tbody>
</table>
| • Patient carts in hallway  
• Privacy screens in hall/cubby  
• Call lights or curtains drawn | |
| Practice of using sitters | When was last time you used sitters? What circumstances in your ED prompt the use of patient sitters? How often do you use sitters? What are their competencies? What type of training does a sitter receive? |
| Sitter used in ED with a patient | Trace the patient if possible, explore the area where patient is held for safety issues, observe location of sitter in relation to patient, explore training of sitters, competency assessment processes, patient/staff safety processes, pull sitter HR file for review later, ask about data collection related to use of sitters (frequency, reason, etc.), |
| See delay in stat orders for diagnostic testing (won’t always see in PI data in planning session as not all hospitals compile this data; | Target time frames for routine & stat orders – ask in diagnostic area about policies related to turnaround times; ask for data for last 12 months if available – may be pattern of delays in patient flow. If stat orders are used frequently, explore reasons. |
## Patient Flow through the Emergency Department - Exploratory Queries

Because patient flow through the emergency department can significantly impact or be impacted by throughput in other areas of the hospital, the queries below can be used as needed to help enhance survey of ED operations in order to more fully explore potential system-wide patient flow issues.

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<tr>
<td>more likely to see them in tracer or during staff interviews</td>
<td></td>
</tr>
<tr>
<td>Patients with psychiatric issues emerge frequently in ED data on ‘chief health complaint upon arrival’</td>
<td>Ask to review the record of a patient with a psychiatric issue currently in the ED or who was recently seen in the ED.</td>
</tr>
<tr>
<td>Many patients in the hall in hallway beds</td>
<td>Review the assessment and triage process; note when the RN and physician evaluate the patient. <strong>What is the turn-around time from the time seen by provider and disposition of the patient?</strong> <strong>Review lab and diagnostic time and response time – does the hospital collect data on critical lab values and tests?</strong> Explore issues of security, confidentiality, privacy and other patient rights.</td>
</tr>
</tbody>
</table>
| Back-ups in getting patients transported to diagnostic areas, to OR, to units | • Ask transporters how long they wait to move patient / what is reason for wait? What happens at end of shift or during breaks?  
• More sophisticated hospitals may be able to produce data on wait/transport times, less sophisticated may not; or nurse may be transporting patients.  
• Ask about circumstances that would find a nurse transporting a patient from the ED to another location. |
| Beds only become available at change of shift, or delay of handoff of patients from ED to floor | Review processes with housekeeping/environmental services for clearing and cleaning rooms. When/how are notifications sent to housekeeping? When/how does housekeeping give notification that a room is clean and ready? What **metrics** are actually being monitored to manage bed turnaround? Talk to Environmental Services, review Bed Board, query Nursing Supervisor. |
| Staff complaining of not enough staff | Talk to Nursing, review nursing staffing patterns. Is a union present in the facility – assess impact on job descriptions, duties, hours, etc. Does the state have mandated staffing? What disciplines are in the Emergency Department? What job duties can each discipline perform? |
Program Specific Tracer – Suicide Prevention, including Ligature and Other Self-Harm Risk Assessment

Applies to: Hospital accreditation program, including psychiatric hospitals

Duration
60 minutes (takes place as part of an individual tracer)

Participants
Clinical surveyors
Life Safety Code® Surveyor

Organization:
- Staff who have been involved in the individual’s care, treatment, or services
- Facility manager(s)
- Safety Management Coordinator
- Nurse Leader or chief nursing officer
- Medical Director or chief medical officer

Rationale:
The rate of suicide is increasing in America.¹ Now the 10th leading cause of death,² suicide claims more lives than traffic accidents³ and more than twice as many as homicides.⁴ At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,⁵ usually for reasons unrelated to suicide or mental health.⁶,⁷ Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.⁸

Above excerpt is from Sentinel Event Alert Issue 56 February 24, 2016. Click on the following link to see the entire issue, https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf

Objectives
- Evaluate the effectiveness of the organization’s suicide prevention strategy.
- Identify process and system level issues contributing to suicide attempts.
- Evaluate the effectiveness of the organization’s processes for designing and maintaining buildings and the patient care environment in a manner to prevent suicides and self-harm behaviors.
- Evaluate the effectiveness of the organization’s processes for identifying, assessing, and resolving ligature, suicide, and self-harm risks present in the environment.
- Assess the organization’s ability to maintain activities to mitigate against environmental risks prior to resolving them, through clinical program activities such as suicide risk assessment, precautions, one-to-one monitoring when appropriate, contraband searches, patient observation checks, etc.
- Educate the organization on potential actions to take to address any identified ligature or suicide and self-harm vulnerabilities. (Resources include “Design Guide for the Built Environment of Behavioral Health Facilities” Ed 7, Revised 7/17/2015)

Before
If you have not already done so as part of the Surveyor Planning Session, take a few moments to meet as a survey team before the clinical surveyor(s) plans to conduct this patient tracer activity.

- Determine where patients are being treated for psychiatric conditions or may be at risk for suicide or self-harm within the hospital. Note: This may include Psychiatric Inpatient Units, and temporary housing in the Emergency Department or other inpatient care areas.
- Inform the organization contact that you will need the following items for this activity:
  - Risk assessment(s) for environment and existing mitigation plans
  - Related policies on patient safety and suicide risk assessment and treatment
  - Any state or national guidelines they are using in the risk assessment process
- Review the Statement of Conditions History Audit Trail for evidence of equivalencies that have been granted previously.
- Together, identify any questions the team needs answers to, based on review of the risk assessment(s), mitigation plans, policies on patient safety and suicide risk assessment, and state or national guidelines the organization is using. Determine a strategy to gather the needed information.
- Plan interaction and communication with the entire team during survey to review any ligature, suicide, or self-harm issues or unusual observations identified.
What does the organization mean by suicide precautions?

**NPSG.15.01.01, EPs**

1. The risk assessment includes identification of specific patient factors and environmental features that may increase or decrease the risk for suicide.

2. The hospital addresses the patient’s immediate safety needs and most appropriate setting for treatment.

3. The hospital provides information such as a crisis hotline to individuals at risk for suicide and their family members.

**Sentinel Event Statistics:** The most common root causes of inpatient suicides are:

- Patient/individual served assessment
- Environmental Security and Safety
- Communication
- Orientation and training

**During**

Life Safety and clinical surveyors will split up at this point to explore these issues in an individual tracer and during the continuing building tour.

**Life Safety Surveyor**

Assess ligature, suicide, and self-harm risks during the building tour activity.

**Clinical Surveyor**

- Select a patient/individual served who is a high risk for suicide:
  - Currently receiving services AND
  - has a diagnosis of depression with or without suicide ideation OR
  - is identified as a high risk for suicide OR
  - had a failed attempt at suicide

- Review the patient record to attain an understanding of services provided and patient specific issues.

- Interview the clinical staff working with the patient and explore the following issues:
  - Crisis process – trace this patient from the time the organization is first involved with the crisis team.
  - Initial Assessment process – comprehensively trace from the initial risk assessment through to treatment planning with a focus on suicide risk and prevention.
  - Reassessment process – trace the triggers for and frequency of reassessment of the risk for suicide and implementation of same.
  - Care planning process – trace from the assessment through to the individualization of care planning relative to suicide risk and preventative care.
  - Continuum of care – evaluate the communication and coordination process with other staff, family, and significant others involved with care relative to the patient’s level of suicide risk.

- Education - evaluate education provided to the patient and family about ongoing care with respect to the suicide risk, including information for crisis situations (Reference NPSG.15.01.01).

- Human Resource components – evaluate orientation, training and competency of clinicians relative to evaluating the potential for risk including self-inflicted harm or suicide, and coexisting behavioral health problems.

- Staffing – trace from staffing levels through to implementation of the organization’s safety checks to evaluate adequacy of staffing patterns to support mitigation plans. Evaluate training and competency.

- Information management – evaluate how timely and accessible information is to individuals with a need to know.

- Interview other staff, (e.g. security, counselors) and ask about their training and processes relative to caring for suicidal patients.

- Assess the environment for the presence or absence of items that would prevent suicide, (e.g. break away bars, no locks on doors etc.) Assess ligature, suicide and other self-harm risks while moving throughout care, treatment and service areas. Trace their presence back through the organization’s environmental safety assessment.
• Assess plans and policies on mitigation of harm posed by environmental risks while removal occurs.

After
• Consider the pervasiveness of identified issues and evaluate possible systems issues.
• Trace specific aspects of care, treatment and services for other patients/individuals served, as applicable, to evaluate extensiveness of identified problems.
• Seek additional information, such as assessments of other high-risk patients, the organization’s history of patient safety events and the process for root cause analysis, or the process for monitoring compliance with its own policies, if necessary, during an Issue Resolution session.
• Discuss findings with the organization at the conclusion of the tracer activity and/or at the next daily briefing.

Scoring and Documentation Instructions
• Document all observations of ligature or self-harm risks in the inpatient psychiatric patient areas at EC.02.06.01, EP 1 following the standard procedure using quantification, precise description, and all required elements of documentation.
• Clinical and Life Safety surveyors collaborate on an analysis of ligature, suicide, and self-harm risks observed during the survey. Note: This analysis must be completed while the team is present on-site.
  o Determine if the organization has previously identified these risks.
  o Evaluate existing plans the facility has for removing these risks.
  o Evaluate the organization’s environmental risk assessment process.
• If the organization attempts to correct findings during the survey, review of the corrective action must include:
  o The actions taken to remove risks in total, or
  o Interim measures the organization is implementing until risks are resolved.
• Note the organization will have 60 days to resolve or they will be required to apply for a survey-related waiver.
• Findings of ligature, suicide, or self-harm will be evaluated according to the SAFER rating methodology in terms of Likelihood to Harm and Scope. Possible findings might include:
  o Ligature, suicide, and self-harm risks have been identified and resolved.
  o Risks have been identified, but not yet mitigated, and what actions have been implemented to operationally mitigate the risk until ultimately resolved.
  o Stratify level of risk based on identifying high, moderate, and low hazardous areas, such as private rooms, and out of sight areas such as stair enclosures, and places where patients may be alone, versus common use areas where staff are present. (The “Design Guide” may be a useful resource to this stratification).
• **Ligature/suicide and self-harm risks for deemed hospitals:** If there are any RFIs related to risks identified during the building tour or tracer activity, discuss the deficiency and the impact on patient safety with the organization. Clinical surveyors will assess effectiveness of
clinical and program activities to identify patients at risk and the implementation of appropriate safety plans.

- The survey team and organization will discuss all the mitigating efforts available and determine which will be implemented until the deficiency has been resolved. This plan for mitigation of the risks on an interim basis must be documented as part of the RFI.

- **Condition-Level Deficiencies:** Given the high level of risk presented by ligature points in psychiatric hospitals or inpatient psychiatric units, observations of such will be made at EC.02.06.01, EP 1, crosswalked to the CMS Condition of Participation at 482.41, and elevated to a condition-level deficiency.

  When psychiatric patients are being held in the emergency room or other hospital patient care area where ligature and self-harm risks are identified, this would be discussed with the organization and their mitigating efforts such as 1:1 observation clarified. Safer ratings and level of deficiency will be determined through the team and SIG on-site reviews.

- **Immediate Threat to Life Consideration:** If the survey team has concerns about the organization’s ability to put effective clinical or environmental mitigation in place, then the process for evaluating an ITL should be initiated.

**Survey guidance on use of “Observed in survey activity but corrected on-site pending acceptable Evidence of Standards Compliance”**

The “Observed, but Corrected On-Site” provision impacts only a limited number of requirements focusing on “operational type” deficiencies. Required repair and/or replacement deficiencies may be corrected while the surveyors are on-site; however, these types of deficiencies will still appear in the Summary of Survey Findings report, and the organization is still required to submit an acceptable Evidence of Standards Compliance.

When you write an RFI for a situation in which the “Corrected On-site” provision applies, the last sentence of the RFI should be: This finding was observed during survey activity, but corrected onsite prior to the surveyor’s departure. The corrective action taken needs to be included in the organization’s Evidence of Standards Compliance submission. You may include additional information if warranted.

**Situations in which the “Observed, but Corrected On-Site” provision APPLIES:**

- Cord removed and wireless phone put into place
- Plastic Bags Removed
- Shower curtain rod removed and rehung by non-weight bearing means
- Beds with ligature attachments removed from rooms
- Doors removed from closets and cupboards

**Situations when the “Observed, but Corrected On-Site” provision DOES NOT APPLY:**

- Door problems in private patient areas and requires new hardware to be ordered and installed
- Windows not made with shatter proof glass
- Exposed plumbing
- Grab bars not flush with wall
Program Specific Tracer - Special Psychiatric Hospital CoPs (482.60 - 482.62)

Applies to: Psychiatric Hospitals participating in Medicare and Medicaid with distinct part certified programs

Duration
Approximately 8 hours per surveyor.

Participants
Psychiatrist and/or nurse surveyors with psychiatric experience

Organization:
Hospital staff

Objectives
1. Evaluate the special psychiatric hospital conditions of participation.
2. Evaluate the degree and intensity of treatment and confirm documentation in the clinical record.
3. Collect and document required information related to nurse staffing and physician coverage in specified sessions.
4. Collect and document required information related to discharge planning and death record review.

Before
- Confirm the applicable distinct part certified programs
- Review the State Operations Manual
- Review the following forms CMS-724, 725, 726, 727, 728, and 729 in survey technology to prepare for collecting the necessary data for completion

During

Individual Tracer
In addition to activities conducted during the Individual Tracer, use the additional tracer time to evaluate the degree and intensity of treatment provided.

- Interview patients to determine if treatment plan goals are consistent with the psychiatric condition the patient is being treated for.
- Short-term and long-term goals, along with projected outcomes, are developed and documented.
- The plan of care includes the responsibilities of each member of the treatment team.
- Interview staff to assess how they determine the patient’s response to treatment modalities.
- Determine the patient’s contribution to formulation of the treatment plan and plan of care.
- Evaluate therapeutic activities and rehabilitative services to confirm the activities and services are individualized based on the goals set in the patient’s treatment plan.
- Assess the patient’s level of participation in the activities.
- Interview the patient to determine his or her participation in the discharge planning process.
- Interview staff to confirm their participation in the discharge planning process, and assess their knowledge of the plan for the patient’s discharge.
• Interview staff to learn about physician participation in treatment planning and physician availability.

• Review medical records to confirm that documentation requirements are met (use form CMS-725) and assess compliance with B-tags (B-105 through B-128 and B-132).

• Confirm that progress notes are recorded at least weekly for the first 2 months and at least once a month thereafter.

• Please note that the following patient tracer grid and the guidelines below it are used to determine the number of patient records surveyors must review for the purpose of completing the CMS-725 forms. The overall sample of patient records needs to be 10% of the organization’s average daily census or a minimum of 30 inpatient records or, otherwise, 20 records for small psychiatric hospitals with an average daily census of 20 patients or fewer.

**Patient Tracer Selection Guidelines**

<table>
<thead>
<tr>
<th>Number of Patients in Hospital</th>
<th>Patient Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up-100</td>
<td>8-10</td>
</tr>
<tr>
<td>101-250</td>
<td>10-12</td>
</tr>
<tr>
<td>251-400</td>
<td>13-15</td>
</tr>
<tr>
<td>401-500</td>
<td>16-18</td>
</tr>
<tr>
<td>&gt;500</td>
<td>18-20</td>
</tr>
</tbody>
</table>

Draw a representative sample number of patients from each distinct program area based on the size of that program. Each patient’s record in the selected sample needs to be reviewed for compliance with the condition of participation titled “Special Medical Record Requirements for Psychiatric Hospitals” (482.61).

**Staffing Review Session**

• During this 60 minute session, discuss with care staff and managers how units are staffed based on qualifications and mix in order to deliver the following activities in a timely manner:
  o admission assessments
  o formulation of individualized treatment plans
  o providing intensive and comprehensive active treatment programs
  o therapeutic activities, rehabilitative services, psychiatric nursing, psychological services, and social services

• Confirm a registered nurse is available 24 hours a day.

• Collect data on nursing complement on at least 25% of the certified units and document on form CMS-727.

• Collect data on direct nursing care staff for the total number of certified beds and document on form CMS-728.
• Verify that there is a director of social work services who monitors and evaluates the social work services furnished. Also, verify that these services are furnished in accordance with acceptable standards of practice and established policies and procedures.

Credentialing and Privileging Session

• In addition to activities conducted during the Credentialing and Privileging Session, use the additional time to focus on qualifications of the clinical director and other physicians who provide psychiatric services
• Discuss physician coverage on evening, nights, and weekends
• Discuss roles and responsibilities of the clinical director
• Discuss the clinical director’s role in monitoring and evaluating the quality, safety, and appropriateness of the services and treatments provided by the medical staff
• Review the credentials file of the clinical director to confirm the individual is board certified
• Review documents to confirm adequate medical staff coverage
• Complete form CMS-729

Discharge Planning/Death Record Review

During this 60-90 minute session, review discharge records representative of the certified programs to evaluate compliance with the discharge planning requirements. Additionally, request a list of all patient deaths that resulted from suicide, homicide, or other unexpected conditions since the last survey.

• Identify 5-10 discharge records representative of the certified programs. Review the discharge summaries and plans for the following:

<table>
<thead>
<tr>
<th>B-tag</th>
<th>The discharge summary includes the reasons for admission; treatment achieved; a baseline of the psychiatric; physical and social functioning of the patient at the time of discharge; and evidence of the patient and/or family response to the treatment interventions.</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-133</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>B-134</td>
<td>The discharge summary includes recommendations from appropriate services for follow-up or after-care</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>B-135</td>
<td>The discharge summary includes a brief summary of the patient’s condition on the day of discharge, including psychiatric, physical, and functional condition</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

If patient deaths occurred since the last survey, request all death records and review conclusions and recommendations of the Mortality Review Board, determine of proper treatment was provided, and review the autopsy report (if available). Complete Form CMS-726.

Documentation in Survey Technology
- Enter observations at the appropriate requirements cross walked to the special psychiatric hospital conditions (482.60-482.62)
- A note (Note 2) has been added at PC.04.01.03 EP 3 related to social service staff responsibilities; non-compliance with this requirement is scored at this EP
- The forms (CMS-724, 725, 726, 727, 728, and 729) are available for completion in survey technology and will transmit with your Summary of Survey Findings Report
# System Tracer – Data Management

**Applies to:** All accreditation programs

<table>
<thead>
<tr>
<th><strong>Duration</strong></th>
<th>60 minutes</th>
</tr>
</thead>
</table>

## Participants

One surveyor (at minimum). All surveyors available to participate should do so.

## Organization

Participants vary depending on the focus of the tracer.

### Objectives

- To learn how the organization is using data to evaluate the safety and quality of care being provided to patients
- To understand and assess the organization’s performance improvement process

### Before

- Discuss and confirm the planned focus for this System Tracer with survey team members and obtain additional input for use at the session
- Review performance improvement data and construct system-level questions as appropriate
- Review antimicrobial stewardship data and construct system-level questions as appropriate (refer to the antimicrobial stewardship education module for EP 7)
- Review pain assessment, pain management and safe use of opioid data and construct system-level questions as appropriate
- Inform the organization about who should attend as active participants

### During

- With the organization, identify the fundamental principles of performance improvement that need strengthening and enhancement within their operations. These principles include:
  - Planning - selection of measures: Understand the organization’s planning process for data use including how your organization identifies and prioritizes measures.
  - Data collection: Understand the organization’s methodology for ensuring that all data is collected as planned.
  - Data Aggregation and Analysis: Understand the organization’s processes for turning data into useful information.
  - Data use: Understand how the organization uses the information obtained from data analysis.
  - Reference the “general tips” and “tips for focus” for recommendations on planning a discussion of the principles. These are located at the end of this section.
  - Explore medical staff involvement in performance improvement projects and initiatives
  - Verify that the governing body specifies the frequency and detail of data collection
  - Determine if the organization is using quality indicators related to improved health outcomes (e.g., based on QIO, guidelines from a nationally recognized organization, hospital specific evidence, peer-reviewed research, etc.)
- Ask the organization representatives how they identify:
Patient Flow Goals defined in law, regulation, and hospital policy must be implemented, but goals set higher or lower than external guidelines (including boarding limit suggested in Leadership standard) may be acceptable in light of hospitals’ internal or external drivers.

Examples of typical patient flow metrics include:
1. Length of stay for all ED patients (and for the subgroup of admitted patients)
2. Length of stay for ED patients with psychiatric and substance abuse emergencies
3. Length of time from presentation until practitioner evaluation (‘door to provider’ time)
4. Patients waiting for bed placement (e.g., pediatric, ICU) – aka, admitting decision time to bed assignment
5. Boarding time for patients with psychiatric and substance abuse emergencies
6. Left without being seen (aka, ‘left before treatment complete’)
7. Emergency department census over time (aka, annual ED volume)
8. Emergency department diversions in hours

- the performance improvement projects that will be undertaken (e.g., high risk, high volume, problem prone, other rationale)
- the performance improvement projects underway cover the scope and complexity of hospital operations

- Explore how the organization knows that the scope of data collection for each indicator is appropriate, that is, that data is being collected in all parts of the hospital where it applies

- Ask the organization representatives to describe how they determine that data is being collected at the appropriate frequency and according to the prescribed method; what is the process used to check collected data for inaccuracy, timeliness

- Determine what type of data the organization is collecting on pain assessment, pain management, and safe opioid use including:
  - Types of interventions and effectiveness, and data to monitor that opioids are being used safely

- Antimicrobial Stewardship:
  - Determine what type of data the organization is collecting on its antimicrobial stewardship data. Note: data may be basic or complex depending on the type of hospital and the duration of their antimicrobial stewardship program. Examples can include an antibiogram, prescribing practices, use of protocols etc.
  - Determine how the antimicrobial stewardship data is collected and analyzed.
  - Determine any antimicrobial stewardship improvement opportunities identified by the organization.
  - Determine if actions resulted in improvements. Note: For some organizations that have sound antimicrobial stewardship data with no opportunities for improvement, EP 8 may be non-applicable.

- Antimicrobial Stewardship: Evidence of non-Compliance:
  - No evidence of collecting any type of antimicrobial stewardship data.
  - No evidence of reporting antimicrobial stewardship data within the organization.
  - For organizations with an opportunity(s) for improvement, they are unable to demonstrate that improvement actions have been taken.

- Determine if the organization is collecting data related to its organ procurement efforts, specifically is the conversion rate being collected and monitored

- Seek out evidence that the organization is collecting and analyzing data related to blood transfusion reactions

- Other data related issues for discussion include:

- Medication Management
  - Review controlled substance loss data and verify it was reported to the pharmacy director and chief executive officer if determined to be appropriate
  - Drug reactions, adverse drug events, other medication management monitoring data
- Infection Prevention and Control
  - Collection and use of surveillance data
    - Discuss use of collected data; corrective action plans recently implemented; measuring for sustained performance
    - Efforts to monitor front-line staff implementation of evidence-based practices related to CLABSIs, CAUTIs, MDROs, and surgical site infection prevention
- Readmission rates and how this data is being used to monitor and improve discharge planning processes
- The methods used throughout the hospital to identify errors, close calls and actual adverse events (e.g., incident reporting, claims data review, retrospective medical record reviews)
  - Determine if
    - The infection control plan includes a goal of improving influenza vaccination rates
    - The plan includes incremental influenza vaccination goals with a focus on reaching the 90% target in 2020
  - Inquire about the influenza vaccination program for staff and licensed independent practitioners. Seek specifics about:
    - The education provided to staff and licensed independent practitioners about the influenza vaccine, non-vaccine control and prevention measures and the diagnosis, transmission, and impact of influenza
    - Organization offering of influenza vaccinations on-site or facilitation of off-site vaccinations
    - The organization has a written description of the methodology used to determine influenza vaccination rates for licensed independent practitioners and staff
    - The organization's process for evaluating licensed independent practitioner and staff reasons for declining the influenza vaccination
    - Improvement in rates of vaccination
    - Dissemination of influenza vaccination rate data throughout the organization
- Pro-active risk assessment (may be known as Failure Mode and Effects Analysis)
- National Patient Safety Goals– including monitoring of CDC or WHO hand hygiene compliance
- Patient flow
  - Data collected on the general issues of patient bed availability, throughput of patient care areas, safety of patient care areas, and access to support areas
  - Hospital preparations to provide patient flow data to CMS on its inpatient emergency department measures
Data collected on typical issues that hospitals measure to monitor patient flow in the ED
- Prioritizing and setting goals for improving patient flow issues
- The goals hospital has set for mitigating and managing patient boarding, both medical and behavioral

- Contracted clinical services and methods for monitoring performance of these services including quality indicators, reporting to leadership and providing feedback to contractor(s) on any needed improvement

- Monitoring staff compliance with employee health screening requirements

- Patient satisfaction data -
  - Is data collected related to how well patient/family communication needs were met
  - Is data collected related to the provision of language interpreting and translation services
  - Is data collected related to the issue of discrimination
  - What aggregation and analysis of these data is being performed
  - Has the organization identified any health disparities or patterns in the data that could be used in service planning
  - Have any improvements been implemented

- Ask the organization for evidence of actions (intervention activities or projects are implemented) taken when quality indicator data analysis reveals a need for improvement (intervention activities or projects are implemented); determine if the interventions are evaluated for effectiveness and sustainability

- Determine if the organization has conducted root cause analysis of all serious, preventable, adverse events

- In complex organizations, additional items for focus include:
  - NCC - MDS outcomes, infection control and medication use
  - OME - OASIS (HC), Med Errors (Home Pharmacy) Equipment maintenance (HME), Incidents (PC)
  - BHC – safety of staff and individuals served, incident tracking, and for Community Mental Health Centers – medication management and infection control
  - AHC - infection rates (surgical), pain management (medical) and quality control related, such as retake rates or walk offs (diagnostic/therapeutic)
  - LAB - quality control related

- Conclude the session by asking attendees if they have any questions and if there is anything else they would like to add.

- Summarize strengths and areas of concern.

**After**

- Discuss the results of this session with other survey team members, as applicable, and identify any needed follow-up.

- Consider and review the relationship of your observations to system level issues.
• Follow-up on any identified issues or remaining topics during subsequent survey activity.

• At the next available Issue Resolution session, verify through review of a sample of employee health files, documentation that staff has undergone required health screenings.
General Tips for Conducting the Data Management Session

1. Success with the Data Management System Tracer is contingent upon the availability of organization data and the surveyors’ good use of time in the Surveyor Planning Session.

2. When there is a team on the survey, more than one surveyor should conduct the tracer. When possible, it is helpful to have different program perspectives during the session. This applies to complex surveys and single-program surveys.

3. The focus of the data system tracer is based on a post data review analysis of the logical sequence of events in the process:
   - Planning
   - Collecting
   - Aggregation and Analysis
   - Use of data.

4. The focus of this session is on the first step in the process where the organization has not demonstrated compliance. Guiding principles follow.
   - If the organization did not collect all required data, then the assigned surveyor should request the plan(s) to review during issue resolution time at the end of the first day. (On one day surveys, the surveyor should ask for and review the plan(s) during the Surveyor Planning Session.) If the organization’s plan does not address the missing data, then the focus of the session is on planning.
   - If the organization has data but the amount of data is questionable or partially missing, the focus of the session is on data collection.
   - If the organization is data rich but has no evidence of aggregation and analysis (reports, charts etc.), then the focus of the session is on aggregation and analysis.
   - If the organization has data which is aggregated and analyzed but problem areas are unchanged, then the focus of the session is on use of data.

5. When possible, subsequent steps in the data management process are addressed during the session. For example, when the focus of the session is on data collection, once data collection has been thoroughly discussed, the focus can move on to aggregation and analysis and use of data as time permits. Subsequent processes will most likely need to be further addressed during an upcoming issues resolution session.

6. Identification and scoring of problem areas is the only way to help an organization succeed with effective data use.

7. Make sure the organization is monitoring the quality and performance of contracted services and individuals. This can be done through contract review or through an integrated approach with their PI process.
Data Management - Focus Specific Tips

Focus: Planning – Selection of Measures

Objective:
Understand the organization’s planning process for data use including how the organization identifies and prioritizes measures, performance improvement projects.

Key Points

- The Joint Commission requires specific elements of data collection based on published literature about critical processes that have the potential of leading an organization to adverse outcomes.
- By planning, tracking, trending and analyzing this data, organizations are guided to making the right decision for the right reasons. Without good information, leaders are forced to make important decisions based on intuition and subjectivity.
- Only clean data leads to good information. Good information brings credibility and reality into the decision making process.
- Organizations need to focus on aspects of quality and safety relative to their services and the populations served in order to identify suitable measures. For example:
  - Quality issues for a chronic diabetic population will be different than pediatric asthma.
  - Interventions to control pain for the patient with neurogenic pain will be different than interventions to control bone pain.
  - Ask the organization to describe exactly what aspect of the issue they are addressing. Do they need to develop a process measure or an outcome measure?
- The selection of suitable measures is proportionate to the understanding of the expected outcome of the process. The measure selected should be specific enough to tell the organization how the process is working.
- A uniform definition of terms is important and allows for a common understanding of what is included in the collection. For example, data collection would be different for the organization that defines a medication error as “a deviation from the norm during administration that results in the patient actually receiving the incorrect medication, dosage, or at the wrong time” versus “a deviation from the norm during administration that results in the patient actually receiving or the potential to have received the incorrect medication, dosage, or at the wrong time.”

Key Standards

- PC.03.03.01 (restraint and seclusion)
- PI.01.01.01 (patient perception of care, high risk processes, planning for the collection and prioritization of data)
- PI.02.01.01 (benchmarking Internal and External database, adequacy of staffing )
- TS.01.01.01 (organ donation)
- LD.04.04.01 (re prioritization of data collection)
- LD.04.03.11 (patient flow)
- IM.01.01.01 (thorough analysis of data needs)
- IM.02.02.01 (uniform data definitions)
- MS.08.01.03 (practitioner specific data)
Data Management - Focus Specific Tips

Focus: Data Collection

Objective:
Understand the organization’s methodology for ensuring that all data is collected as planned.

Key Points
- Ensuring thorough data collection requires checks and balances. Ascertain how the organization knows that they have collected all of the data. (Note: if you suspect that data is being missed, look for examples in individual patient tracers as you continue with the survey. This will demonstrate to the organization that they are not collecting all of the data that meets their definition.)
- Elicit input from the organization about benchmarks. This is a potential source of information that would reflect that the organization is not collecting all of the data.
- There are technical issues associated with data collection, such as sample sizes, biases, etc.
  Sampling Criteria
  • For a population size of 30 or fewer ADC, sample 100% of the applicable medical records
  • For a population size of 31 to 100 ADC, sample 30 medical records
  • For a population size of 101 to 500 ADC, sample 50 medical records
  • For a population size of more than 500 ADC, sample 70 medical records
- Engage in a facilitated discussion centered on simple issues, such as data sources being used (e.g., billing data, satisfaction surveys, record abstraction, observation) and whether the needed data are available.

Key Standards
- PC.03.03.01 (restraint and seclusion)
- PI.01.01.01 (data collection)
- LD.04.03.11 (patient flow)
- IM.02.01.03 (data integrity)
- IM.04.01.01 (use of quality control measures to obtain accurate and complete data)
- RC.01.01.01 (able to collect data to support care)
- RC.01.02.01 (authentication of data in the clinical/medical record)
- MS.08.01.03 (practitioner specific data)
Data Management - Focus Specific Tips

Focus: Data Aggregation and Analysis

Objective:
- Understand the organization’s processes for turning data into useful information.

Key Points
- Reinforce the importance of displaying data so that patterns and the effect of interventions can be readily identified.
- Different types of data displays can be used depending on the issue being addressed. For example, if you are looking at the performance of a process over time, a run chart or a control chart is more useful than a Pareto chart.
- Pareto charts and fishbone diagrams are helpful for understanding the potential causes of a problem. There are a number of resources available that describe these tools in simple terms.
- It is important that data be analyzed with sufficient frequency so that potential problems are caught in time.
- Data analysis will not necessarily involve complex statistical tests. Analysis can be discussed in relatively simple terms. For example, analysis might involve the review of variances—that is, occurrences that don’t meet expectations or trends that may be emerging.
- It is important that the right people be involved in data analysis—not just the Quality Improvement staff. It should include individuals involved in the process or topic being studied. Ask the organization about staff involvement in analysis.
- In some cases, external comparative data can be useful. When relevant, benchmarking can be explored.

Key Standards
- PC.03.03.01 (restraint and seclusion frequency of analysis)
- PI.02.01.01 (systematic aggregation and analysis)
- LD.04.03.11 (patient flow)
- IM.02.02.03 (displaying and dissemination of clinical and non-clinical data / available expertise and tools / timely and accurate dissemination / standardized formats)
- IM.02.02.03 (able to analyze data to support care)
- MS.08.01.03 (comparison of practitioner specific data against the aggregate)
Data Management - Focus Specific Tips

Focus: Data Use

Objective:
Understand how the organization uses the information obtained from data analysis.

Key Points
- Actually using data for improvements and in decision making is one of the most important elements of the data management process. In many cases this may be the primary focus of the discussion during the data session.
- It is very common to see organizations that collect lots of data but do not use it. Collecting data for collection’s sake uses resources needlessly and is a waste of time.
- Ask leaders how they use data to make decisions. Decisions are making choices among different options. Ask leaders how data has helped them make choices.
- Ask the organization how they evaluate improvements, and ask them to provide examples.
- Organizations need to monitor improvements to make sure changes or interventions are successful and that the success is maintained.

Key Standards
- IC.01.03.01 (infection prevention and control)
- IC.01.05.01 (infection prevention and control plan implementation)
- LD.04.04.05 (information used to make changes)
- LD.04.04.11 (patient flow)
- IM.02.01.03 (data security and integrity)
- IM.02.02.03 (data retention for quality control purposes / displayed for use by decision makers)
- IM.02.02.03 (data organization and availability - easily retrievable for decision making)
- MS.08.01.03 (use of practitioner specific data in privileging)
System Tracer – Infection Control
Applies to: All accreditation programs except LAB

<table>
<thead>
<tr>
<th>Duration</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 minutes (A patient with an infectious disease is identified during an individual tracer and the record is reviewed.)</td>
<td>1. Learn about the planning, implementation and evaluation of the organization’s infection control program.</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
<td>2. Evaluate the organization’s process for developing the Infection Control plan; review and discuss the outcome of the annual infection control evaluation; and discuss oversight of opportunities for improvement.</td>
</tr>
<tr>
<td><strong>Joint Commission:</strong> Selected surveyor <em>(with input from other programs if conducting a complex organization survey)</em></td>
<td>3. Learn how the organization identifies and manages outbreaks.</td>
</tr>
<tr>
<td><strong>Organization:</strong></td>
<td>4. Understand the processes employed throughout the organization to reduce infection.</td>
</tr>
<tr>
<td>• Infection control coordinators and staff</td>
<td>5. Learn about the role of the individual responsible for the program and verify that he/she is responsible for developing and implementing infection prevention and control policies and systems.</td>
</tr>
<tr>
<td>• Physician member of the Infection Control committee</td>
<td><strong>Before</strong></td>
</tr>
<tr>
<td>• Individual staff members at various locations encountered during tracer activity</td>
<td><strong>While conducting individual tracers</strong></td>
</tr>
<tr>
<td>• Individuals able to address issues related to the infection control program in all major departments or areas within the organization</td>
<td>• Identify a patient that is being treated for an infection, such as a Healthcare Associated Infection (HAI), a multi-drug resistant organism or other communicable disease</td>
</tr>
<tr>
<td>o Clinicians knowledgeable about the selection of medications available for use and pharmacokinetic monitoring</td>
<td>• Review the record. Note any opportunities to trace a related laboratory testing process through the organization</td>
</tr>
<tr>
<td>o Clinicians from the laboratory knowledgeable about microbiology</td>
<td><strong>During</strong></td>
</tr>
<tr>
<td>• Physical plant staff</td>
<td><strong>Discussion (20 minutes)</strong></td>
</tr>
<tr>
<td>• Organization leadership</td>
<td>Conduct this activity with representatives from all programs being surveyed. If not possible, due to distance constraints, the survey team has the option of conducting this discussion telephonically or delegating an individual tracer to infection control in each program. In any case, it is important for the team to discuss findings at the next planning session to look for common issues across programs.</td>
</tr>
</tbody>
</table>

**Individual Tracer Selection Tips**

In settings where there are no patients being treated for an infection, pull a discharge record of a patient with an infection. Review the record and use this patient’s experience as your scenario for the individual IC system tracer.

If the organization cannot identify an individual that they are actively treating or have treated in the past, or are monitoring for an infection, create a realistic scenario for this activity.
Potentially Problematic Areas

- Local and regional outbreaks – ask the organization, reference current literature and websites, for example, [www.dcd.gov/mmwr](http://www.dcd.gov/mmwr)
- Hazard Vulnerability Analysis regarding bioterrorism or local industry
- Governing Body involvement and accountability
- Hand hygiene
- Medication administration
- PPE availability/use
- Equipment cleaning – between patient use, floating equipment
- Housekeeping processes
- Sterilization – reuse of disposable instruments, use of immediate use steam sterilization (IUSS)
- Reusing single use devices
- Cleaning and disinfecting
- Influenza vaccination of staff and licensed independent practitioners

- Determine if
  - The infection control plan includes a goal of improving influenza vaccination rates
  - The plan includes incremental influenza vaccination goals with a focus on reaching the 90% target in 2020

- Inquire about the influenza vaccination program for staff and licensed independent practitioners. Seek specifics about:
  - The education provided to staff and licensed independent practitioners about, the influenza vaccine, non-vaccine control and prevention measures and the diagnosis, transmission, and impact of influenza
  - Organization offering of influenza vaccinations on-site or facilitation of off-site vaccinations
  - The organization’s written description of the methodology used to determine influenza vaccination rates for licensed independent practitioners and staff
  - The organization’s process for evaluating licensed independent practitioner and staff reasons for declining the influenza vaccination
  - Improvement in rates of vaccination
  - Dissemination of influenza vaccination rate data throughout the organization

Tracing (40-45 minutes)

- Conduct this tracer on units and in departments throughout the organization. Don’t forget ambulatory sites.

- Using a patient experience, engage staff from units, various departments, the laboratory and infection control committee members in separate discussions and explorations about the following:
  - Identification process for this patient’s infection, for example, surveillance (consider other infections)
  - Laboratory testing/confirmation – trace the process for this patient by looking at what actually happened, review physician orders, communication to the lab about the need for testing, collection of specimens, transportation to the lab, turn-around time for results, communication of results from the lab to the organization and to the physician, follow-up actions and monitoring (consider other patients as needed to confirm findings)
  - Staff orientation and training activities – investigate the orientation and training activities provided to the staff involved in the care of this tracer patient. Explore patient rights issues that would be exhibited through staff attitudes and behaviors
  - Reporting of infection control data – evaluate how this patient’s infection will be incorporated into reporting (flow of information for reporting, timing of the report, etc.)
evaluate the responsibility, methodology and flow information gleaned from infection control – state and federal reporting of communicable disease

- Prevention and control activities – housekeeping procedures, organization-wide hand hygiene, food sanitation, and the appropriate storage, cleaning, disinfection, sterilization (should include a visit to central sterile processing), and/or other disposal of supplies and equipment

- Staff exposure – interventions for licensed independent practitioners, staff, students/trainees, independent practitioners, and volunteers that include screening for exposure and/or immunity to infectious diseases they come in contact with, the referral for assessment, potential testing, immunization and/or prophylaxis treatment, and counseling to those who have potentially been identified with an infectious disease

- Planning and resource allocation – drill down with staff about resource appropriations for infection control activities, and explore plans for an influx of patients

- Observe physical facility for issues that may have an impact on infection control. Investigation the process for communicating with the department responsible for correcting any concerns.

  - Inform organization participants about observations that need to be further explored in subsequent tracer activity

After

- Discuss issues with survey team during the next surveyor planning session. Share observations and performance concerns so that they may be further explored in subsequent survey activities

- Seek additional information, if necessary, during an Issue Resolution session

- Consider the relationship of your observations to system level issues that cross programs, as applicable
System Tracer – Medication Management

Applies to: All accreditation programs except LAB

Duration
60 minutes

Participants
All surveyors available to participate.

Organization:
- Clinical and support staff involved in medication management
- Antimicrobial stewardship team members

Planning:
- Planning for this tracer begins at the Surveyor Planning Session. Consider the organization’s programs and high risk services.
- Identify a patient receiving a medication on the organization’s high risk medication list.
- As part of the individual tracer activity, review the record of care, treatment and services.
- Collect necessary data using the work tool. The organization should assist in this process, if possible.

For Multi-Program Surveys
- When multiple programs are being surveyed and a medication management system tracer is selected by more than one program, select a high risk medication for a patient who moved across those programs, or has the potential of moving across those programs. (If a program is not involved in the selected high risk medication, the surveyor from that program should select a medication from that program’s high risk list.)
- Surveyors from each program where a medication management system tracer is being conducted, should trace the high risk medication through their program during the tracer time.
- All surveyors should engage in the conference room “wrap-up” discussion either in person or telephonically for the last 10 minutes of the session. Survey team discretion can be used to move this “wrap up” to an upcoming Issue Resolution time. If the agenda does not include a

Objectives
1. Learn about the organization’s medication management processes.
2. Evaluate the continuity of medication management from procurement of medications through monitoring.
3. Evaluate the medication reconciliation process during hand offs.

Before
- Collect data from a high risk medication while conducting an individual patient tracer. You can use the attached medication management work-tool to help track medications.
- Seek an understanding of the medication management sub-processes (patient specific information, selection/procurement, storage, ordering/transcribing, preparing/dispensacing, administration, monitoring and evaluation). This discussion should include pharmacy review, use of NPSG requirements, and assimilation of pertinent literature.
- Review organization documentation that describes how they use the CDC’s Core Elements of a Hospital Antibiotic Stewardship Program. Note: The documentation needs to describe how the core elements are addressed in the organization’s antimicrobial stewardship program. Core elements include:
  - Leadership commitment
  - Accountability
  - Drug expertise
  - Action
  - Tracking
  - Reporting
  - Education
- Review organization antimicrobial stewardship protocols (e.g., policies, procedures or order sets)
- Check the FDA website for safety alerts and recall notices www.fda.gov/medwatch

During

Tracing (40-45 minutes)
Using the patient’s experience on a high risk medication, trace the processes for managing that medication through the organization’s systems. This should include, when applicable, visits to:

- The unit where the patient is located
  - Ask about the last time the unit was informed of a drug recall; can the manager or staff remember how they were notified; ask to see any recent recall notices
  - Ask staff how patients who are being discharged on opioids are being educated on safe use, storage, and disposal of opioids, when prescribed
- The pharmacy
medication management tracer in some programs, cover the standards during individual tracer activity. Whenever possible though, these surveyors should engage in the "wrap-up" discussion with the team.

If this organization didn’t identify any high risk medications, some high risk medications, supported by literature, include:
- heparin, insulin, coumadin or antibiotics
- sedatives and hypnotics
- intravenous or intrathecal medication
- TPN

Antimicrobial Stewardship Standards

Evidence of non-compliance:
- There is no evidence that any staff have been educated or were provided information on antimicrobial resistance and antimicrobial stewardship.
- There is no evidence that any licensed independent practitioners have been educated on or were provided information on antimicrobial resistance and antimicrobial stewardship.
- Multidisciplinary team:
  - Evidence that the team is composed of one person.
  - Evidence that the team is composed of 2 people but does not include a licensed independent practitioner.
  - Evidence that the team is inactive.
- Core elements of an antimicrobial stewardship program:
  - No written document explaining how the core elements of EP 5 are addressed in the antimicrobial stewardship program.
- Protocols:
  - Staff and prescribers cannot identify antimicrobial stewardship protocols associated with their patient population.
  - Explore the high risk medication’s procurement, storage and dispensing, investigating important issues, such as drug security, look-alike/sound-alike issues, collaboration with other disciplines/departments.
  - Ascertain the process for pharmacy review of this specific medication.
  - Evaluate the oversight of this drug – formulary, P&T committee reviews etc.
  - Ask how the pharmacy keeps current on medication recalls; review the process for implementing drug recalls (e.g., recalled heparin); request a description of recall notifications to leaders, licensed independent practitioners and staff.
  - Review the pharmacy after-hours processes including observation of a night cabinet, if applicable.
  - The lab, if applicable
    - Explore the role of the laboratory in evaluation of the medication.
    - Identify the organization’s triggers for lab testing relative to medication being used.
    - Learn about inter-departmental communication processes and documentation of same.
    - Review of applicable dietary restrictions, dietary interactions with medications, and processes in place to educate the patient.
    - Review of equipment or devices, if used for administration of the medication being traced.
  - Other important considerations for this tracer
    - Explore different high risk medications as you evaluate the medication management processes.
    - Talk with the prescribing physician or any physician you encounter about prescribing issues in the organization.
    - Explore communication exchange during hand-offs from one level of care to the next.

Conference Room Discussion (15 minutes, if needed)

- Ask organization participants to describe their evaluation of the medical management system.
- Ask the organization to describe their antimicrobial stewardship program, including the:
  - Composition of multidisciplinary team (when available, should include: Infectious disease physician, infection preventionist(s), pharmacist(s), practitioner).
  - Protocols – drivers, development process, prescriber use (required or recommended), prescriber accessibility.
- Summarize identified strengths and risk points or vulnerabilities.
- Ask the attendees if they have any questions.
- Ask attendees to consider how they might incorporate a similar tracer to promote continuous readiness.

Additional issues which should be addressed during this or other tracer time include:
- Process for reporting of errors, system breakdowns, near misses.
- Monitoring overrides of automated dispensing systems
- **Process for reporting abuses and losses of controlled substances**
- Data collection, analysis, systems evaluation, and performance improvement initiatives
- Medications brought into the hospital by the patient
- Education of staff about medication safety
- Education of patient about medication safety
- Patient involvement in safe medication management
- Information management systems related to medication management
- **Process for reporting, responding to, and analyzing medication administration errors, adverse drug reactions, and medication incompatibilities**
- **Process for implementing pre-printed order sets and protocols including development, approval, and regular review**

**After**
- Continue interviewing and observing staff in relation to the medication management systems of the organization while conducting individual tracers
- Consider the relationship of your observations to system-level issues
- Alert other team members, if applicable, to potential issues and problems so they can be further explored during other survey activities
## Medication Management – Work Tool

| Patient Identifier: | | | | | | | |
|---------------------|------------------|-------------|------------------|------------------|------------------|------------------|------------------|------------------|
| Medication Ordered  | Date ordered     | Time ordered| Amount Ordered   | Frequency        | Route            | Pharmacy Review   | Amount Administered| Time Administered |
|                     |                  |             |                  |                  |                  |                  |                  |                  |
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Leadership Session

Applies to: All accreditation programs.

<table>
<thead>
<tr>
<th>Duration</th>
<th>60 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>All surveyors on site.</td>
</tr>
</tbody>
</table>

**Organization:**
- Leaders with responsibility and accountability for design, planning, and successful implementation of organization processes

Typically participants include the following:
- **At least one member of the governing body or an organization trustee** (in single-owner organizations, this individual may also be the CEO).
- Senior organization leaders (CEO, COO, CNO, CFO, CIO, Laboratory Medical Director, VP for Clinical Services, Director of Patient Services or Branch Manager, Administrator).
- Senior leaders from all surveyed programs (Ambulatory Care, Behavioral Health, Home Care, Laboratory, and Nursing Care Center).
- Elected and appointed leaders of the medical staff.
- Other organization leaders (Director of Human Resources and Performance Improvement).

The success of this activity is not necessarily walking away with RFIs, but rather facilitating a meeting that will result in:
- Leadership affirming through examples, or discovering right along with you, where they want to be, where they are now, and how they plan to achieve and sustain a wide-spread culture of safety and quality in the organization.
- Exploring with leaders the characteristics of a high reliability organization that they believe their organization demonstrates and why, through the use of examples.

**Objectives**

The purpose of the Leadership Session is to explore where the organization is on the journey to high reliability. This is a facilitated discussion of the characteristics of a high reliability organization, specifically:
- Leadership commitment to improvement of quality and safety
- Creating a culture of safety
- Robust process improvement
- Survey findings that suggest underlying system issues.

**Before**

Thoughtful planning is pivotal to the success of this activity and the utility of on-site survey analysis. All available surveyors from all accredited programs should participate in planning. If surveyors are not available, information they provide should be considered in planning.

- Review survey observations and potential requirements for improvement.
- Review the Leadership Session Tips on the subsequent pages.
- When possible, and in the case of complicated leadership structures, consider outlining the leadership session discussion using the “Organization Culture and Systems Expectations Evaluation Tool.” The tool is located in the Document Library on the Surveyor Portal.
- Plan an approach that will move this discussion beyond theory to an evaluation of performance in the organization.
- The antimicrobial stewardship standard, MM.09.01.01, is an affirmative observation standard, and requires field staff to always survey this standard.
- Review documents that supports leadership making antimicrobial stewardship an organizational priority. **Examples may include:** accountability documents, budget plans, infection prevention plans, strategic plans and performance improvement plans
- **Review documentation that demonstrates leadership making pain assessment, pain management, and safe opioid prescribing an organizational priority. Examples may include:** budget items or plans, strategic plans and performance improvement plans

**During**

To the extent possible, begin the discussion based on a positive observation from the survey. This could include a successful performance improvement initiative, the introduction of a new service, or a well-run department or unit. Explore the reasons for this success related to high reliability concepts: leadership commitment, safety culture, robust process improvement, involvement of physicians and other clinicians, etc.
Applicable System Performance Standards in the Leadership chapter

- Using data LD.03.02.01
- Planning LD.03.03.01
- Communicating LD.03.04.01
- Changing Performance LD.03.05.01
- Staffing LD.03.06.01

Next, engage the leaders in a discussion of something that is less successful, such as:

- A performance improvement project where improvement results were not sustained,
- Problems evident in important functions such as infection control, or
- Lack of compliance with a National Patient Safety Goal.

Explore the same high reliability concepts with the leaders, and facilitate their exploration of what was different and may have contributed to a lack of success.

If there are limited survey observations available to provide context for the discussion, discuss selected components of the high reliability organization characteristics or the system performance standards in the leadership chapter.

- Explore with leaders their efforts to achieve the characteristics of a high reliability organization—flexibility, agility, ability to sustain effective performance.
- Ask for examples of the progress being made and what characteristics they are struggling to achieve and maintain. Suggested Discussion topics are provided on the next page, Tips for Conducting the Leadership Session.
- Ask leaders about internal systems and how they do or do not support their efforts to be a high reliability organization.
- Inquire if leaders have studied the organization’s ability to sustain effective performance. Ask leaders to identify what aspect of performance they chose to study and why. Determine the approach that was taken by the organization in researching performance sustainability.
- Ask leaders to identify how the medical staff is engaged in efforts to achieve and sustain all the characteristics of a high reliability organization.
- Review survey observations and patterns of performance in relation to important components of organization effectiveness, that is, the system performance standards.
- Antimicrobial stewardship: Determine if antimicrobial stewardship is an organizational priority. Examples include additional pharmacy and medical staff time devoted to antimicrobial stewardship, providing resources for antimicrobial stewardship activities, providing funding for consultation if needed.
- Antimicrobial stewardship: Evidence of non-compliance:
  - No evidence of resources provided for antimicrobial stewardship.
  - No assigned team.
  - Leadership unable to identify the prioritization of antimicrobial stewardship in the leadership session.
  - No antimicrobial stewardship protocols or policies or procedures.
• Determine the medical staff’s involvement in evaluating systems performance in the organization.

• By referencing observations made throughout the survey you are pulling the outcome together in a useful way for the organization.

• Discuss leadership’s role in the infection prevention and control performance improvement and training programs. Verify that action plans are successfully implemented.

• Discuss how leadership identifies and reports the number of distinct improvement projects to be conducted annually.

• Discuss senior hospital leadership’s role in fostering organization resilience in emergency management response and recovery.

• Discuss hospital’s relationships with any local, regional, or statewide emergency management groups or coalitions

• Verify that there is a single, organized medical staff.

• Discuss leadership communication with behavioral health providers or authorities in response to boarding of patients who present to the emergency department with psychiatric emergencies - Interview leadership to ascertain that communication at the leadership level had occurred with behavioral health providers or authorities serving the community to help foster coordination of care. Communication could include:
  a) Direct meeting or conference call
  b) Exchange of correspondence or electronic communications
  c) Ad hoc meeting or education event sponsored by 3rd party (e.g., metropolitan hospital council, county mental health department, professional association of emergency physicians or nurses, state hospital association) on topic of emergency services for behavioral health patients
  d) Regular joint participation in work group, board, or forum sponsored by hospital or behavioral health provider or authority.

• Seek clarification from leaders on any open issues.

After

Review additional materials to substantiate any observations or issues questioned by the organization. For example, if the organization is challenging a systemic problem of staffing, take time to review staffing plans or variance reports if you have not yet done so.
Tips for Conducting the Leadership Session

- Begin discussion with positive survey observations. Explore the reasons for success related to noted high reliability concepts.
- Next, engage leaders in discussion of some less successful effort. Explore the same high reliability concepts with leaders, and facilitate their exploration of what was different and that may have contributed to more limited results.

Success of this activity is facilitating a meeting that results in
- Leadership affirming through examples, or discovering right along with you, where they want to be, where they are now, and how they plan to achieve and sustain a wide-spread culture of safety and quality in the organization.
- Exploring with leaders the characteristics of a high reliability organization that they believe their organization demonstrates and why through the use of examples.

The issues below can serve as a framework for discussion with leaders on various topics such as:
- Leaders’ vision for the role and performance of important processes
- Senior leadership’s role/responsibility for design of systems/processes/“infrastructure”
- Role of the Board in safety and quality
- Role of the Medical Staff in performance improvement
- Comprehensiveness of the system/process
- Patient-focused quality and safety criteria and expectations for the system/process
- Agility/adaptability/flexibility, and change as appropriate
- Responsibility for managing and monitoring effectiveness of implemented changes to the five systems

High reliability concepts you might consider exploring include:

Robust Process Improvement
- Evaluating root causes of identified problems
- Systematically developed and implemented solutions
- Evaluation of solutions for effectiveness
- What is in place to make sure that improvement is sustained
- Regular measurement and assessment of the quality and safety of patient care and important organization systems

Leadership Commitment
- Leader focus on quality and safety issues; involvement of Board members, senior management, and medical staff
- Priorities of the organization in terms of improvement and prevention of conditions leading to adverse events
- Making sure that improved performance is sustained
- Leadership participation in role modeling and coaching
- Use of data and information to improve safety and quality
- Evaluation of important organization systems (such as data use, planning, communication, change management and staffing) in terms of how they contribute to quality and safety

Safety Culture
- Process/tool used to conduct a safety culture assessment
- Current and past results of the safety culture assessment; changes made based on results
- Availability of education on safety to those working in the organization
- Evidence of trust and team work, such as in safety survey results, information from staff, management of disruptive behavior
- Proactive efforts to design safety into the work of the organization
- Managing adverse events and close calls
- How the safety culture drives improvement
- Willingness of people at all levels willing to discuss safety issues
- How leaders respond to safety concerns
- How important organization systems support a safety culture

Internal and external reporting
- Leadership expectations on reporting system/process failures and the results of proactive risk assessment
- Types of data reported and to whom
- Reporting performance improvement information internally
- Reporting unsafe conditions
- Sharing external reports with governance
- How reported information is made meaningful

Physician/clinician involvement in performance improvement
- Accountability for quality and safety
- Initiatives that involve changes in clinical practice to improve quality and safety
- Involvement in performance improvement priorities
- Serving as champions for performance improvement goals
- Leading performance improvement initiatives
### Report Preparation

**Applies to:** All accreditation programs

**Duration**
60 – 120 minutes

**Participants**
All surveyors on site.

**Changes in Scoring and Reporting**
Effective January 1, 2017

- Elements of performance no longer categorized as A or C
- All observations of non-compliance are documented
- Direct and indirect EP categories eliminated
- No OFIs in the accreditation report
- All observations of noncompliance require follow-up in the form of a 60-day ESC
- MOS are no longer required
- RFIs will be displayed in the SAFER™ matrix based on the surveyor determination of the likelihood the issue has to harm a patient, visitor, or staff member (low, moderate, high) in addition to the scope of the issue within the organization (limited, pattern, widespread).

#### Before
- Remind the organization of any items they have promised and you are still awaiting.
- Remind the organization that all items that they want you to review or people they want you to interview to clarify surveyor reported observations and findings must be accomplished at this time.
- Allow time for review of items or discussion with staff during the first 15-30 minutes of this session. Increase this time, if necessary.

#### During
- Document any additional observations you made. Follow the Documenting your Observations section of the SAG found in Appendix B. Pay particular attention to the reconciliation process.

- **Confirm that all inpatient and outpatient patient records reviewed are entered into the laptop (using the Records icon).**

- Remove any observations or findings that the organization is able to clarify.

- Revise your documentation of observations that the organization has corrected while you are onsite. Choose “Observed in survey activity but corrected onsite pending acceptable Evidence of Standards Compliance from the “Observed in” drop down list when entering an observation. Survey tech will insert the selected phrase before the observation text. Organizations should still be reminded during the exit conference that the observed and corrected onsite finding(s) will remain in the final report and will require an ESC.

  - Observations that are appropriately documented as “Observed, but Corrected On-Site” have the following characteristics:
    - The deficiencies are easily corrected and do not pose a significant threat to patient safety.
    - The correction should not require any organizational planning or forethought.
    - The practice is correct but the policy needed amending to coincide with the practice, so the policy was amended.
    - Corrections to a form that was missing an element or piece of information and the change would not impact the process.

  - Contact the Standards Interpretation Group if you have any questions about the appropriate use of this provision with a finding.

<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>To allow the organization one final onsite opportunity to clarify and clear observations and findings, particularly from last day activity.</td>
</tr>
<tr>
<td>2.</td>
<td>To complete the entry of observations made throughout the survey.</td>
</tr>
<tr>
<td>3.</td>
<td>To clearly and accurately document requirements for improvement.</td>
</tr>
</tbody>
</table>
How will this affect my survey?

- Accredited organizations will be notified about these changes through various modes of communication prior to implementation.
- Surveyors should mention the changes in observation reporting during the Opening and Orientation to the Program session.

Equivalencies

When preparing the report in WST, a question will be presented:
- Does the organization have previously granted equivalencies?

If the response is NO, then no further action is needed.

If the response is YES, two more questions will be presented:
- Were the conditions associated with the equivalency met?
- Was there evidence corrective actions would create a hardship for the organization?

If both questions are answered YES, then no further action is needed.

If either or both questions are answered NO, the surveyor will need to write an RFI at the appropriate Life Safety Code standard and EP.

If this is a team survey, coordinate report preparation
- Integrate observations and requirements for improvement to the team leader level
- Facilitate team efforts to document observations at the most appropriate EP.
- WST will auto-populate the SAFERTM matrix with standards and EPs based on the surveyors’ designation of likelihood to harm (low, moderate, high) and scope of the issue (limited, pattern, widespread) identified with each observation entry.
  - Auto-population of the standards and EPs within the matrix is based on the worst-case observation in terms of likelihood to harm and scope of issue designation. For example, if there are multiple observations under one EP, by one or more surveyors, the observation with the most likelihood to harm, and the issue with the greatest scope are used independently to determine where the standard and EP will appear in the matrix.
  - Surveyors are able to override the matrix auto-population of a standard and EP if, based on their expertise, observations and judgment, they disagree with the placement.
  - Editing where a standard and EP appear on the matrix is accomplished by accessing the EP (not the individual observations) to adjust the likelihood to harm and scope of issue designations.
  - When an EP has multiple observations entered underneath, and all observations have been designated as having a “limited” scope, a warning will appear in WST for the surveyor finalizing the report (“last surveyor standing”). The warning will list the applicable standards and EPs and ask the surveyor to verify that these are appropriate to keep the “Limited” column of the matrix, or should be moved to either the Pattern or Widespread column.
  - Confirm that observations are complete and fully justified.
  - Update the survey report with any changes prior to the Exit Conference.

Prepare the report
- Read the report to ensure that it is accurate and clearly written.
- Proofread the report for typographical errors, proper placement of observations at EPs, grammar and punctuation.
- Review the SAFERTM matrix to determine that standards and EPs are appearing in the appropriate and intended cell.
- Revise, as needed.
- Publish the report.

Plan the approach for presenting the report during the Exit Briefing and Exit Conference.

When more than one surveyor is present, determine who will facilitate and the presentation approach that will be followed.

After

- Notify the organization’s contact that the report is available on their extranet site for review and printing.
- Make arrangements with the organization to print and copy the report for:
  - The organization (the number requested by the CEO)
  - Each survey team member present.
- Notify the CEO when you are ready for the CEO Exit Briefing and determine the meeting location.
- Submit the report using WST within 24 hours of event completion.
Exit Briefing

Applies to: All accreditation programs.

Duration
15 - 30 minutes

Participants
All surveyors on site

Organization:
Senior leader (for example, CEO, administrator, executive Director, Owner) if available, or their designee

Guidelines
The Summary of Survey Findings Report is organized by standards chapter

- Each survey team member could take a turn reviewing all of the findings grouped under a particular standards chapter
- Alternatively, surveyors could take turns by accreditation program presenting the findings pertinent to their program within a chapter

Objectives
1. Present the organization leader with the Requirements for Improvement (RFIs) reflected in the Summary of Survey Findings Report
2. Identify and discuss any concerns that the organization leader may have with the report
3. Determine if the organization leader wishes the surveyor(s) to participate in an Organization Exit Conference or if the leader(s) prefer to deliver the report privately to the organization
4. Identify any special arrangements required for the Organization Exit Conference

During
- Present and review the Summary of Survey Findings Report
- Remind the CEO that the report contains some additional content which you discussed at the Opening Conference. Note that you are prepared to provide some further explanation of the new material at the Exit Conference.
- Review any patterns or trends that are surfacing in standards, and existing or new risk areas; note any changes in standards or risk areas between this survey event and the organization-specific risk area information available in the ICM Profile.
- Determine if the organization leader would like each Organization Exit Conference attendee to have a copy of the Summary of Findings Report
- Ask the CEO if he or she has any other preferences regarding the sharing of findings with organization leadership and staff
- Indicate to the organization leader that on the organization’s Joint Commission Connect extranet site there is a brochure titled, “What Happens After Your Joint Commission Survey” that describes the post-survey next steps
- Provide time for the organization to print and duplicate the Summary of Survey Findings Report. Arranging for printing and duplicating the report is the responsibility of the organization leader
### Organization Exit Conference

**Applies to:** All accreditation programs

<table>
<thead>
<tr>
<th><strong>Duration</strong></th>
<th>30 minutes</th>
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</thead>
<tbody>
<tr>
<td><strong>Participants</strong></td>
<td>All surveyors on site</td>
</tr>
<tr>
<td><strong>Organization:</strong> Leadership and staff invited to participate</td>
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**Guidelines**
Before you present findings, remind attendees that observations have been communicated throughout the survey.

As you present the requirements for improvement:
- Comment, where appropriate, on areas where the organization is performing well.
- Respond to questions and comments about findings.
- Remember, attendees may or may not have a copy of the Summary of Survey Findings Report as you are reviewing the findings, so, adjust your presentation to fit the situation.

**Equivalencies**
The Joint Commission manages equivalencies, which are based on the LSC (NFPA 101-2012,1.4)
- An equivalency is when alternative methods, systems, or devices offset the risk associated with the LSC non-compliance condition

**Objectives**
- Present the preliminary Summary of Survey Findings Report (only if desired by the organization leader).
- Review identified standards compliance issues. Note that all findings of less than full compliance require resolution through an Evidence of Standards Compliance submission.
- Review required follow-up actions.

**Before**
- Return the organization’s documents directly to the contact/liaison.
- Determine with the surveyor team members who will facilitate the Organization Exit Conference and the presentation approach.

**During**
- Thank the organization for the opportunity to evaluate their performance with respect to the Joint Commission standards.
- Express your appreciation to leaders and staff for their hospitality and assistance.
- Review the Summary of Survey Findings Report; there is a summary page included with the report that explains the contents presented in each section
- Explain that the report is organized into two sections:
  - SAFER™ Matrix display of findings – Standards and EPs that appear in the SAFER™ Matrix are based on likelihood of harm and scope of issue. The organization is not able to contest the placement of findings on the matrix
  - Requirements for Improvement – Observations in this section of the report require official follow-up by the organization with the Joint Commission through the Evidence of Standards Compliance (ESC) process, therefore you will review this section in detail.
- Present the Requirements for Improvement by standards chapter.
- Review any patterns or trends that are surfacing in standards, and existing or new risk areas; note any changes in standards or risk areas between this survey event and the information available in the ICM Profile.
- Explain that the SAFER™ matrix is a tool to illustrate potential risk areas in the organization. While this tool can be referenced during the decision-making process, it will not be used in isolation to drive or determine if certain decision rules will be applied.
- Explain that the accreditation decision is based on the risk level of findings. The higher level of risk associated with the findings, the more immediate the attention required.
- Note that an Evidence of Standards Compliance (ESC) submission is due from the organization to The Joint Commission 60 days from the day the report is posted to the organization’s extranet site.
- Explain the ESC submission process.
  - All Requirements for Improvement (RFIs) due in a 60-day ESC
  - All findings will require an ESC
Current ESC entry fields (who, what, when, and how) required for all RFIs

Findings of higher risk (those appearing in red and dark orange areas on SAFER™ matrix will require completion of two additional ESC entry fields (Leadership Involvement and Preventive Analysis)

- Explain changes to the Clarification Process as follows:
  - Documents not available at the time of Review: Required documents that are not available at the time of review will no longer be eligible for the Clarification Process. These Requirements for Improvement (RFIs) will become action items in the post-review ESC process.
  - Clerical Errors: During the certification review, reviewers and the organization work together to identify and correct any clerical errors in the report. If clerical errors are identified post-review, The Joint Commission will work with the customer to make the corrections. The organization should submit a Clarification Request for the clerical error(s) to be resolved. The correction will be made as part of the Clarification Process. The corrected RFI will remain in the report and become an action item for the ESC process.
  - Audit Option: The audit process will no longer be a part of the Clarification Process. As noted above, with the implementation of the SAFER matrix, the “C” Element of Performance category has been eliminated. The “C” EPs were the subject of Clarification Audits.

- Direct the organization to their extranet site for an informational brochure, “What happens after your Joint Commission Survey”

- Explain that the official survey report will be posted on the Organization’s extranet site post-survey and it will include the potential accreditation decision.

- Indicate that typically, survey reports will be posted within 24 to 48 hours after the survey (weekends excluded), unless the report requires review by Joint Commission central office staff.

- Explain that the final accreditation decision will be made after The Joint Commission receives and approves all required Evidence of Standards Compliance submissions.

- Ask if there are any other questions about the report.

- Once again thank the organization for the opportunity to review the organization’s performance with respect to the Joint Commission standards.

After

Submit the report using WST within 24 hours of event completion
### Primary Care Medical Home (PCMH) Certification

**Applies to:** Hospitals and Critical Access Hospitals that choose this optional certification

<table>
<thead>
<tr>
<th>Participants:</th>
<th>Surveyors trained in primary care medical home requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organization:</strong></td>
<td>Outpatient Clinic staff</td>
</tr>
</tbody>
</table>

**Documents Organization Needs to Have Available:**
- Performance improvement data on the following:
  - Disease management outcomes
  - Patient access to care
  - Patient experience and satisfaction related to access
  - Patient perception on the comprehensiveness, coordination, and continuity of care

### PCMH Certification Reminders
- Certification is optional
- PCMH certification can be conducted at time of triennial survey or as extension survey
- Hospitals can select which eligible sites they want PCMH certified
- Survey 50% of PCMH sites for which certification is requested
- 47 unique PCMH requirements for hospitals
- 57 unique PCMH requirements for critical access hospitals
- Extension survey only includes review of unique PCMH requirements
- Certification at time of triennial survey includes review of both hospital standards and unique PCMH requirements

### Objectives
1. When conducting PCMH certification as part of a triennial survey, evaluate the hospital and primary care medical home-specific standards.
2. When conducting a PCMH extension survey, evaluate the unique PCMH requirements only.
3. No matter which type of survey you are conducting, the emphasis of PCMH is on evaluating the operational characteristics of:
   - Patient-centered care,
   - Comprehensive care,
   - Coordinated care,
   - Superb access to care, and
   - System-based approach to quality (a commitment to quality and quality improvement through ongoing engagement in activities such as using evidence-based medicine and clinical decision support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management).

### Guidance for PCMH Certification at Time of Triennial or as Extension Survey

#### Before
- Review the requirements that are unique to PCMH
- Review PCMH resource documents in surveyor portal
- Review PCMH Example Tracer Questions document to help you prepare for staff and patient discussions during tracers
- Review profile of each site for which the hospital is seeking PCMH certification

#### During
- **Surveyor Arrival and Preliminary Planning Session**
  - Review the primary care medical home Self-Assessment Tool if completed by hospital and provided for review
  - Review PCMH-specific performance improvement data on disease management outcomes; patient access to care; patient experience and satisfaction related to access; and patient perception on the comprehensiveness, coordination, and continuity of care, treatment, or services. This information will be made available by the hospital upon your arrival.

#### Opening Conference
- Explain that the survey of the PCMH selected sites will include an evaluation of compliance of either the PCMH-specific certification requirements together with the hospital standards (triennial survey), or only the unique PCMH requirements (extension surveys)

#### Orientation to the Organization
Determine which primary care sites the organization has selected to be certified as PCMH

Ask about the scope of services provided (i.e., pediatrics, obstetrics/gynecology, behavioral health, oral health)

Determine if electronic health records are used in PCMH sites; if so, are the records integrated with the hospital’s electronic system

Determine if the following are in place and at what PCMH sites:
  o 24/7 patient access to prescription renewal requests, test results, clinical advice for urgent health care needs, and appointment availability
  o Use of an electronic prescribing process
  o The type of providers that serve in the role of primary care clinician (physicians, PAs, APRNs, residents)

Surveyor Planning Session

Use the information learned about the services provided and primary care clinicians at each site in order to select the primary care sites you will visit.

Consider going to sites with unique services such as pediatrics, embedded mental health, on-site dentistry, etc.

Consider going to sites that have more than 1 PCMH clinic

Consider going to sites with different individuals (residents, physicians, APRNs, PAs) serving in the role of primary care clinician

Individual Tracers

Observe site for patient communication and education materials related to PCMH

Begin tracer with some discussion; could be with a patient/family in the waiting room, reception staff, or clinicians.

Interview patients/family about:

  Information provided to them in support of their selecting a primary care clinician (PCC)

  Information provided on how the organization functions (such as how to access the PCC or staff when they have questions, access test results, make appointments, and obtain specialty care) and the available services

  Instructions on how to obtain urgent care after the office is closed if such care is needed

Interview staff about:

  Processes patients use to select and change a PCC

  Tracking of and follow-up on test results and referrals; validate through review of medical records

  How referral recommendations or diagnostic results from referrals are made available to the PCC

  How members of the patient’s interdisciplinary team are determined
• How the interdisciplinary team works to collaborate on patient care (examples may include huddles or team meetings)
• How Incorporation of patient self-management goals into the treatment plan occurs; ask to see examples in the medical record
• How patients are assessed for health literacy; how is this information communicated among the team and incorporated into the care provided
• Use of electronic prescribing (Note: electronic prescribing involves the electronic transmission of a prescription to a pharmacy and does not require the organization to have an electronic medical record in place)
• 24/7 patient access to prescription renewal requests, test results, clinical advice for urgent health care needs, and appointment availability
• PI activities related to PCMH that they are involved in or aware of, and any actions taken or changes made to improve care, treatment, and services for these patients
• Information sharing with other providers involved in patient care
• Ask PCC to discuss composition of his/her patient panel. This might include discussion about chronic disease patients or low-risk healthy patients. This will facilitate discussion in Credentialing and Privileging Session related to PCC having the knowledge-based education to serve in role of PCC as it relates to his/her panel of patients.

Exit Conference
Identify those observations that directly relate to PCMH-specific requirements

Guidance Unique to Triennial Survey PCMH Certification

Individual Tracers
• If possible, trace a patient that is an inpatient and also is a patient at a PCMH that is part of the certification to evaluate coordination of care and follow-up.

Medical Staff Credentialing and Privileging Session
• Provide the surveyor conducting this session with names of individuals serving in the role of primary care clinician. Ask the surveyor conducting this session to determine that the qualifications of clinicians serving in this role include broad-based education and experience in the provision of primary care

System Tracer – Data Management
Ask the surveyor conducting this system tracer to verify that the organization is collecting PCMH data on the following:
  o Patient experience and satisfaction related to access to care, treatment, or services
Remember
Extension Surveys only include the opening sessions, tracer activity, data management, medical staff credentialing and privileging, and closing sessions.

- Patient perception of the comprehensiveness, coordination, and continuity of care, treatment, or services
- Disease management outcomes
- Patient access to care within timeframes established by the organization

Ask leaders how they are using the data collected to improve performance and if they are involving patients in performance improvement activities

**Competence Assessment Session**

- Provide the surveyor conducting this session with the names of some PCMH clinic staff (such as care coordinators, nursing staff, and medical assistants). The surveyor conducting this session should review and discuss the staff’s orientation, qualifications and competence as it relates to PCMH roles and responsibilities.

**Note:** Infection Control, Medication Management, Leadership, Environment of Care, and Emergency Management Sessions should be conducted as usual by the team with discussions taking place related to the inclusion of outpatient locations, including PCMH.

**Guidance Unique to Extension Survey PCMH Certification**

**Medical Staff Credentialing and Privileging Session**

- Review the files of individuals serving in the role of primary care clinician. Determine the qualifications of clinicians serving in the role for evidence of broad-based education and experience in the provision of primary care

**Data Management Session**

Verify that the organization is collecting data on the following:

- Patient experience and satisfaction related to access to care, treatment, or services in the PCMH setting
- Patient perception of the comprehensiveness, coordination, and continuity of care, treatment, or services in the PCMH setting
- Disease management outcomes in the PCMH setting
- Patient access to care within timeframes established by the organization in the PCMH setting

Ask leaders how they are using the data collected to improve performance and if they are involving patients in performance improvement activities
**PCMH Example Tracer Questions**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Primary Care Clinician (PCC)</th>
<th>Ancillary Staff (scheduler, reception, etc.)</th>
<th>Nurse or Medical Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you choose PCC?</td>
<td>Who is part of your care team?</td>
<td>What do you do if a new patient comes to the clinic?</td>
<td>Who is part of the care team?</td>
</tr>
<tr>
<td>Can you change PCC if want to?</td>
<td>How do you handle referrals to specialists?</td>
<td>What information is provided to patients (information on PCCs, rights and responsibilities, access to care, medical home concept)?</td>
<td>What is your role?</td>
</tr>
<tr>
<td>Do you know what a &quot;medical home&quot; is?</td>
<td>What resources are available for consultations?</td>
<td>What do you do if a patient wants to change his/her PCC?</td>
<td>How does the care team communicate with each other?</td>
</tr>
<tr>
<td>Do you feel like you are a partner in your care?</td>
<td>What services are available to patients here (such as telehealth, mental health, dietary)?</td>
<td>Is information available to patients in the waiting area?</td>
<td>How do you communicate with patients (patient portal, email, telephone)?</td>
</tr>
<tr>
<td>Did you work with your care providers to set your goals?</td>
<td>How do you follow-up on referrals?</td>
<td>Can patients be seen when they want to be seen (for example, flexible scheduling and same day appointments)?</td>
<td>How do you track progress toward achievement of goals?</td>
</tr>
<tr>
<td>Do you have 24/7 access to appointment requests, prescription renewals, test results, and clinical advice for urgent health needs?</td>
<td>Do you have a patient panel?</td>
<td>Are you involved in identifying the literacy and language needs of patients?</td>
<td>What is your role in managing chronic disease (diabetes, hypertension, etc.)?</td>
</tr>
<tr>
<td>What do you do if you are ill after hours?</td>
<td>How are patients seen when you are not available?</td>
<td>What do you do if a patient has special language or communication needs?</td>
<td>Do you use standing orders and protocols?</td>
</tr>
<tr>
<td>Do you have access to specialists?</td>
<td>How do you communicate with other providers and your care team?</td>
<td>What PI activities are being conducted and what changes have resulted (success stories)?</td>
<td>Do you assess health risk behavior?</td>
</tr>
<tr>
<td>Are you able to get second opinions?</td>
<td>How do you determine the patient’s goals?</td>
<td></td>
<td>How do you track referrals and need for preventative care?</td>
</tr>
<tr>
<td>Do you know who your care team is and what their roles are?</td>
<td>Are these goals tracked over time?</td>
<td></td>
<td>What services are available to patients (such as mental health)</td>
</tr>
<tr>
<td>Are you satisfied with your care and are you able to provide feedback on your care?</td>
<td>Do patients work with you to set their goals?</td>
<td></td>
<td>How do you follow-up on referrals?</td>
</tr>
<tr>
<td></td>
<td>What population based care do you provide?</td>
<td></td>
<td>What PI activities are being conducted and what changes have resulted?</td>
</tr>
<tr>
<td></td>
<td>What PI activities are being conducted and what changes have resulted (success stories)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Many of these example questions can be asked of more than one group on this table. Also, you may ask any of these example questions of other staff not on this table.
State Survey Addendums (AHC, BHC, HAP, OBS, OME)

The Joint Commission has entered into agreements with various state regulatory agencies to enable the recognition of accreditation surveys in lieu of state licensure surveys. To facilitate state reliance on accreditation the Joint Commission must demonstrate that our standards and survey process meet or exceed that of the state licensure regulations. While the vast majority of times, the Joint Commission standards do meet/exceed state requirements, there are a few instances when a state's requirements contain unique requirements or more prescriptive language. The variation between Joint Commission standards and State regulations have led a small number of state regulatory agencies to require a state specific survey addendum for a subset of state regulations that go beyond the Joint Commission's standards. The Joint Commission has made a commitment to the state agencies listed below to use a survey addendum where we have cross-walked the unique state requirement to an appropriate Joint Commission standard. Whenever a surveyor is conducting a full survey in one of the states/programs listed below, the survey addendum must be incorporated into the on-site survey.

Each of the addendums listed below are available in the Field Representative Portal for access during survey. All addendums can be found under:


Select program, then select applicable state addendum folder.

Hyperlinks to each specific folder containing the addendums are provided with the summaries below

AHC/OBS Program Addendums

California: Applies to OBS, Unlicensed ASCs and non-Medicare certified ASCs

California law requires outpatient settings that perform procedures using anesthesia (beyond local anesthetic) to obtain and maintain accreditation. The Joint Commission is one of four approved accrediting bodies in the state. Provisions of the law contain requirements for organizations that go beyond the Joint Commission’s accreditation requirements and therefore the Medical Board of California requires the Joint Commission to survey for these additional requirements. The requirements can be found in the surveyor portal; in addition the requirements are listed in WST and the surveyor must attest to surveying the additional expectations prior to transmitting the report.


Florida: Applies to OBS

Florida has passed Rules mandating the standard of care for surgical procedures performing in an office setting. The Florida rules, which a under the Boards of Medicine and Osteopathic Medicine, prescribe specific requirements for physicians conducting procedures in OBS practices to adhere to, including a provision for annual inspections, unless the OBS practice is accredited by a nationally recognized and Board-approved accrediting organizations. The rules further state that all nationally recognized and Board-approved accrediting organizations are required to adhere to the same Board-determined standards for surgery and anesthesia use in the office setting. Because of this provision, the Board did make a formal request to the Joint Commission that we survey for compliance with the rules that exceeded the Joint Commission’s requirements.
A survey addendum has been created to guide the onsite survey process to accommodate the request.


BHC Program Addendums (also see NY HAP for addendums that apply to BHC surveyors added to the HAP team)

New York: Applies to Outpatient Psychiatric Programs (Continuing day treatment, day treatment for youth, partial hospital and IPRT) operated by general hospitals surveyed under BHC manual

Hospitals in New York offering Outpatient Psychiatric Programs that are licensed through the New York Office of Mental Health (NYOMH) can elect to use their accreditation in lieu of a state inspection. If an organization elects this option, the surveyor must apply the “Joint Commission Survey Addendum for New York General Hospital – Outpatient Psychiatric Programs”. NYOMH will then renew the organization’s operating certificate in alignment with our 3-year accreditation award. When the hospital elects this option, the surveyor class type assigned will be “NYGM” which will signal the surveyor to apply the addendum during the onsite survey. The addendum provides survey protocols for conducting onsite visits, as well as provisions of New York regulations that are more prescriptive or exceed the Joint Commission’s expectations. In addition to the addendum posted in the surveyor portal, there is also a training module available that provides an overview of all three NYOMH addendums.


HAP/CAH Program Addendums

California: Unlicensed sedation sites that are surveyed under the CAH/HAP manual. Note: should ALWAYS be surveyed by a physician surveyor.

Outpatient settings that provide anesthesia services (beyond a local) that are neither licensed or Medicare certified are required to be accredited under California law. In addition to the accreditation requirement, provisions of the law contain requirements for organizations that go beyond the Joint Commission’s accreditation requirements and therefore the Medical Board of California requires the Joint Commission to survey for these additional requirements. Therefore there is a surveyor addendum to account for these few additional expectations. As noted above, another provision of California law is that these sites must be surveyed by a physician surveyor. If needed, Central Office will staff a physician surveyor as the AMB add-on to travel to these sites, otherwise the physician survey or of record should conduct the onsite visit. While there are several hospitals that have unlicensed sedation sites included in the HAP accreditation process, this is most commonly found with the Kaiser Health System.


New York: Applies to Outpatient Psychiatric Clinics operated by general hospitals surveyed under HAP manual (BHC surveyor added to the team)
Hospitals in New York offering Outpatient Psychiatric Clinics that are licensed through the New York Office of Mental Health (NYOMH) can elect to use their accreditation in lieu of a state inspection. If an organization elects this option, the surveyor must apply the “Joint Commission Survey Addendum for New York General Hospital – Outpatient Psychiatric Clinics”. NYOMH will then renew the organization’s operating certificate in alignment with our 3-year accreditation award. When the hospital elects this option, the surveyor class type assigned will be “NYMHO” which will signal the surveyor to apply the addendum during the onsite survey. The addendum provides survey protocols for conducting onsite visits, as well as provisions of New York regulations that are more prescriptive or exceed the Joint Commission’s expectations. In addition to the addendum posted in the surveyor portal, there is also a training module available that provides an overview of all three NYOMH addendums.


New York: Applies to Inpatient Psychiatric Units in general hospitals surveyed under HAP manual (BHC surveyor added to the team)

Hospitals in New York providing inpatient psychiatric units that are licensed through the New York Office of Mental Health (NYOMH) can elect to use their accreditation in lieu of a state inspection. If an organization elects this option, the surveyor must apply the “Joint Commission Survey Addendum for New York General Hospital – Inpatient Psychiatric Units”. NYOMH will then renew the organization’s operating certificate in alignment with our 3-year accreditation award. When the hospital elects this option, the surveyor class type assigned will be “NYMHI” which will signal the surveyor to apply the addendum during the onsite survey. The addendum provides survey protocols for conducting onsite visits, as well as provisions of New York regulations that are more prescriptive or exceed the Joint Commission’s expectations. In addition to the addendum posted in the surveyor portal, there is also a training module available that provides an overview of all three NYOMH addendums.


New York: Applies to Inpatient Addiction Program in general hospitals surveyed under HAP manual by SRH surveyor.

The New York Office of Alcohol and Substance Abuse Services (OASAS) recognizes the Joint Commission’s survey of inpatient addictions programs in lieu of conducting a state inspection. Any time an SRH is added to a hospital survey in the state of New York, the two addendums below should be applied, as applicable to the services being provided

- Joint Commission Survey Addendum, Chemical Dependence – Part 818 Inpatient Rehabilitation Services
- Joint Commission Survey Addendum, Chemical Dependence – Part 816 Withdrawal and Stabilization Services

Following the survey and ESC submission, OASAS will then renew the organization’s operating certificate in alignment with our 3-year accreditation award.

Pennsylvania: Applies to all general acute care hospitals and critical access hospitals, children’s hospitals, and specialty hospitals, such as rehabilitation and cancer hospitals. Psychiatric hospitals are NOT included.

Effective January 1, 2014, the Pennsylvania Department of Health began accepting accreditation in lieu of conducting routine state inspections for licensure renewal. To facilitate this recognition, the Joint Commission entered into an Agreement with the department. One of the conditions of the agreement stipulates that the Joint Commission must proactively survey for compliance with a subset of Pennsylvania regulations that exceed the Joint Commission’s requirements. A survey addendum has been developed that must be used by the hospital survey team when conducting a full survey in the state of Pennsylvania. In addition to the requirements of the Pennsylvania regulations listed in the addendum, the Department also requires the Joint Commission requires bed count confirmation prior to issuing a new license, as the correct number of beds must be listed on the license. The last page of the addendum contains a bed count form to be completed by the Joint Commission surveyor. We ask that you email or fax this form to central office as directed on the form. The addendum as well as additional resources regarding the state regulations can be found on the survey portal


OME Program Addendums

Maryland: Applies to Home Health Agencies only

The Maryland Department of Health and Mental Hygiene will recognize the Joint Commission’s accreditation survey in lieu of conducted a state survey for routine licensure pending the Joint Commission’s application of a survey addendum. Most of the item contained in the addendum can be linked back to a Joint Commission standard, however the Maryland regulations do contain more prescriptive requirements. The “Joint Commission Home Care Surveyor Addendum to Maryland State Home Health Regulations” can be found on the surveyor portal and should be used whenever conducting a full survey of a Maryland Home Health Agency.

Appendix A – Potential Threat to Health or Safety
Applies to: All Accreditation programs

Joint Commission Participants:
Survey Team, Standards Interpretation Group (SIG), Field Director On-Call, Central Office ITL Team

Organization Participants:
Assigned staff and leaders in areas of evaluation, CEO

Purpose
- To assist surveyors in identifying serious safety or quality concerns, high risk issues, questionable situations or potential threats to health and safety while conducting on-site survey activities
- Provide instructions for surveyors to follow when a potential threat to health and safety is identified during survey

Identification of a Potential Threat to Health or Safety
- Surveyors may identify potential threats to health and safety while conducting survey activities. The following are examples that could be a potential threat to health and safety. This list is not all inclusive. The determination of actual threat to health and safety is situational and requires further discussion with the Central Office.
  - Significant Life Safety Code or failure to implement Interim Life Safety Code measures (failure of fire alarm system or generator)
  - Significant deviations from standards of practice as outlined by the Joint Commission, CDC, APIC, WHO etc.
  - Failures in the high-level disinfection and/or sterilization processes
  - Intimidation or threatening behavior toward patients, residents, clients or individuals served
  - Physical or sexual abuse or assault
  - Inappropriate use of restraints resulting in injury or death
  - Failure to obtain appropriate care or medical intervention, i.e. failure to respond to a significant change in condition
  - Inadequate or inappropriate staffing that negatively impacts safety
  - Ligature and other patient self-harm risks
  - LIPs performing procedures for which they have not been credentialed or privileged—no evidence of competency
  - Equipment malfunction that impacts safety
  - Issues with clinical alarms—functioning, response to, etc., that jeopardize patient safety
  - Lack of competency or licensure
  - Other issues that cause surveyors to question a potential threat to health and safety
- If in doubt, or if you want to discuss a situation, call the SIG or the Field Director On-Call who will engage the ITL team at Central Office.
- In some instances you may be calling into Central Office to ask a question of SIG and based on the situation you are describing you may be advised that it is an immediate threat to health or safety.

IMPORTANT
If you are worried about something you are seeing onsite, call home! The Central Office team will work with you to determine next steps. An Immediate Threat can only be declared when surveyors are onsite.

Definitions
The Joint Commission defines Immediate Threat to Health or Safety as “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.”

Call Central Office Number: 800-965-5888
To reach
- SIG-Clinical Choose 2 three times
- SIG-Engineering Choose 2 twice, then choose 1
- Field Director On-Call Choose 2, then choose 1
When an ITL is called, you will be directed to follow the procedures outlined below.

**Procedure when a Potential Threat to Health or Safety is Identified**

- Surveyors identifying a potential threat:
  - Communicate to the survey team leader the information and your plan to contact SIG or the Field Director On-Call.
  - Include the team leader on the phone call to SIG or the Field Director On-Call.

**Important**
Surveyors need to monitor their email and voicemail frequently in the days after the event as it is highly likely that Central Office will need to confer with them regarding the survey report.

### Additional Guidance Related to Ligature and Self-Harm Risks

- Any identified ligature or self-harm risk will be documented in the survey report at EC.02.06.01, EP 1.
  - All observations and documentation regarding the details of an organization’s short-term mitigation plan must be included in the accreditation survey report.
  - In addition, all findings pertaining to ligature or self-harm risks at EC.02.06.01, EP 1 must be identified as a Condition-level deficiency.

- After review, an ITL will be called for ligature risks unless all the following conditions exist:
  - The organization previously identified the ligature risk point in its comprehensive assessment of potential environmental hazards;
  - The organization had already instituted an acceptable short-term mitigation plan to protect patients until the risk can be removed and is able to show that its mitigation plan is being rigorously implemented;
  - The organization had already developed a corrective action plan with a timeline to permanently remove ligature risk points as quickly as possible when they cannot be immediately removed because of documented constraints e.g., waiting for hardware, contractors to complete the work, or allocation of funds to conduct the repairs.

- The appropriateness of the corrective action plan, the justifications for why it is not possible to immediately remove the ligature risk points, and the timeline for removal and repair will be reviewed by the surveyors and the SIG engineers in the live support telephone call.

- When an ITL is called, you will be directed to follow the procedures outlined below.
Provide an overview of the potential threat and the information gleaned thus far from tracer activity

1. Extent of harm or potential harm to patients, residents, or individuals served
2. Immediacy of situation
3. Organization’s knowledge of situation and responsiveness to issues
4. Any systemic issues identified whether related to the Immediate Threat or not

- SIG and the Field Director On-Call will provide direction about the evaluation of the patient, resident or individual served or situation to the survey team and identify if additional information is needed.

- If a possible Immediate Threat is considered, a discussion with Central Office staff, which includes the Executive Vice President/HI (EVPHI/CMO) or designee needs to take place to discuss the findings and any supporting evidence leading to a recommendation for an Immediate Threat to Health or Safety.

- Only the President of The Joint Commission or his designee can declare an Immediate Threat to Health or Safety.

- Central Office staff will keep the surveyor(s) and team leader informed about any decisions that are made and remain available to answer any surveyor or organization questions or concerns.

- If the decision is made to declare the Immediate Threat, the EVPHI/CMO or designee, in conjunction with the surveyors and the Central Office team, will contact leadership at the organization to explain that The Joint Commission president has determined that there is an Immediate Threat to Health or Safety at their organization and an expedited Preliminary Denial of Accreditation in accordance with the Threat to Health or Safety procedures will be invoked.

- The surveyor will be asked to assist in the coordination of that call. It is best to have a land line available onsite for this call. Central Office can provide a call-in phone line if needed. It is best to NOT use the surveyor’s cell phone, if possible.

- During the call, the procedures will be explained to the organization (as outlined in the Accreditation Process (ACC chapter in the official accreditation manuals.

- The surveyor will be asked to describe the issues that were identified that contributed to the Immediate Threat
  - It is important to be very calm, factual and respectful when describing the issues
  - It is important to send a very clear message that this call is about the Immediate Threat. Therefore, do NOT discuss things the organization is doing well, as this can be confusing to the organization.
  - SIG and the Field Director On-Call are available to surveyors if they would like a dry run in preparation for the call.
The organization will also be informed by Joint Commission staff that:

1. They must determine and implement a risk mitigation strategy while the surveyor(s) is still on site.
2. A letter explaining the process will be posted to its extranet site.
3. Preliminary Denial of Accreditation (which is an accreditation decision category) will be posted on Quality Check by the next business day.
4. CMS and state authorities will be notified (if applicable).

Surveyors proceed with the remainder of the survey, as scheduled, incorporating information about the situation in subsequent tracer activities.

- Do not conduct a root cause analysis of the specific event.
- During the remaining planned survey activity, explore systems and processes related to the situation that may have contributed to the Immediate Threat event.

When an Immediate Threat is declared, the surveyor must write a Requirement for Improvement (RFI) at APR.09.04.01 to explain that an Immediate Threat was declared, the reasons for it, and document the risk mitigation strategy implemented by the organization until the deficiency can be resolved.

- The PDA 01 decision rule will be triggered with the scoring of the APR.
- Any other observations at other standards and NPSGs that are related to or support the Immediate Threat should have “This is related to the Immediate Threat” added to the start of the observations. Observations must be labeled this way as the organization will NOT be allowed to submit clarifying information for those RFIs.
- The survey report must also include documentation of the risk mitigation strategy implemented by the organization until the deficiency can be resolved.
- Enter surveyor comments regarding anything else not in the RFIs that would be helpful, like the organization’s reaction, response, etc.
- The organization is very likely to appeal the PDA so the more precise the survey report is, the better.

During the Exit Conference, it is important to reference the Immediate Threat and the need to make corrections as soon as possible. The organization is at risk of losing their accreditation so try not to downplay the situation.
Appendix B – Surveyor Documentation Guidelines

Documenting Observations
Well written observations are essential for both the surveyed organization and the Joint Commission. The organization uses the documented observations in their post survey planning while the Joint Commission depends upon the documentation to substantiate the observations that lead to confirmed findings post survey. Documentation is also used in review hearing panels and Central Office analysis. Additionally, documentation supports the Joint Commission's credibility with key stakeholders, such as the Centers for Medicare/Medicaid services (CMS). Well written observations that are congruent with CMS requirements may decrease disparity rates.

The following pages offer guidance for surveyors across programs to document clear, solid findings in the survey report to facilitate a thorough and fair accreditation process. Though some of these documentation guidelines are requirements many are truly guidelines giving the surveyor/reviewer the flexibility to make a judgment based on the particular situation.

Create Measurable/Observable Observations
Each observation of non-compliance needs to be documented. The surveyor must identify and select all applicable Elements of Performance within the particular standard. Some Elements of Performance (EP) require process, some require documentation, and some require both. The written observation must be consistent with the EP requirement.

The following always apply. The written observation should:
1. be grammatically correct, check for clarity, spelling and punctuation,
2. Be written in full sentences ,
3. use the past tense (e.g. was, did, had),
4. write out numbers less than 10 and use the numeral for numbers 10 or greater (unless you opt to use the quantification lead-in statement, in which case only numeric values are allowed to be entered) ,
5. whenever possible written in measurable and/or observable language.

The observation should be two or three sentences written in such a way that allows someone unfamiliar with the topic to understand what was observed. A lead-in statement that includes the standard and EP language that relates to the deficiency observed may be necessary to clearly identify the issue. However, rewriting the entire EP is likely unnecessary and the focus should be on the related issue. The observation is proofread by the author to address clarity, spelling, and punctuation errors. The written observation should not include abbreviations, jargon, or acronyms that are HCO specific or uncommon.

Example:
HAP EM.02.02.01 The Emergency Operations Plan describes the following:
EP 1 How staff will be notified that emergency response procedures have been initiated.
Weak: “The organization's EOP lacked critical elements.”
Solid: “The organization's Emergency Operations Plan lacked the process by which staff would be notified if an emergency occurred and response procedures were to be enacted. When asked about the plan’s missing element, the Chief Operating Officer concurred that the process of contacting staff when emergency response procedures were initiated was missing from the plan.”

Document Staff Title
Document the title of the person with whom the Surveyor(s) spoke. This ensures the staff who witnessed, or observed, the finding along with the surveyor can corroborate the finding to the organization. Also, identifying the staff title acknowledges the organization’s confirmation of the surveyor observation and strengthens the finding thereby discouraging post-survey clarification. Identifying the person by title is not intended to highlight a staff who has made a mistake or is at the root cause of a deficiency. This is particularly important if there are safety culture issues at the organization.

While documenting the title of the staff who observed the deficiency during tracer activity strengthens the finding and makes the citation difficult to refute, referencing staff names in an observation is not
appropriate and should be avoided. Generic words like “leadership” or “leaders” should not be used, rather use the specific staff position title.

Example:
AHC IC.02.01.01 EP 2 The organization uses standard precautions, including the use of personal protective equipment, to reduce the risk of infection.
Weak: "Staff interviews revealed that protective eye shielding was not used when performing cleaning and brushing of contaminated dental instruments prior to steam sterilization."
Solid: "Interview with the infection control nurse revealed that protective eye shielding was not used when performing cleaning and brushing of contaminated dental instruments prior to steam sterilization."

Use a Statement to Identify the Evidence
Observations should contain the phrase “….as evidenced by…” or something similar. The specific fact, and not just a negative Element of Performance, is written into the observation to support the finding. To highlight how the facts were discovered, the use of a statement of evidence is required.
Example:
HAP MM.01.02.01 EP 1 The hospital develops a list of look-alike/sound-alike medications it stores, dispenses, or administers.
Weak: "The hospital did not develop a list of look-alike/sound-alike medications."
Solid: "The hospital did not develop a list of look-alike/sound-alike medications as evidenced by the Chief Nursing Officer’s inability to produce a list when requested. This was also confirmed by the Pharmacy Director."

OME PC.01.03.01 EP 30 For home health agencies that elect to use The Joint Commission deemed status option: The registered nurse, or other professional who is responsible for supervision of the home health aide, prepares written patient care instructions that specify the duties of the home health aide or homemaker.
Weak: "During review of record for home visit #2 it was noted that on the aide care plans dated 4/20/15, start of care and 6/18/15, recertification, the bath assignment was not specified."
Solid: "During review of the record for home visit #2 it was noted that on three of three aide care plans the bath assignment was not specified. For example, only "bath" was checked however the type of bath, i.e. bed, shower, chair, tub, partial/sponge was not indicated. This was confirmed by the home care aide."

If the deficiency identified is inherent in the observation statement, then a statement of evidence is not necessary because the observation contains the evidence.
For example:
Solid: "In the record reviewed in the Intensive Outpatient Program, the plan of care did not identify how the family participated in the care, treatment, or services of the client. Additionally, no refusal from the client or clinical contraindication for family involvement was noted within the record as confirmed by the primary clinician."
NOTE: In many cases there is an opportunity to use pre-populated lead-in statements in WST. The statements are recommended and may make the documentation process easier, but they are not required.

Managing Protected Health Information (PHI)
The Joint Commission’s goal is to use the minimum necessary PHI wherever possible, and to eliminate it if possible, to prevent inappropriate disclosure of protected health information. Due to the possibility that dates could make individual patient information identifiable, they must not be used in documentation when related to a patient, patient care, or clinical procedure. Rather, note the number of days or hours that identify the deficiency referenced in the standard or EP. Dates are permissible if there is no other way to specify the standard deficiency and is related to non-patient related information (examples given later in this section).
We are taking a strict look at all documentation in which there is a reasonable basis to believe the information could be used to identify the individual, or where the identifiers used meet the technical definition of PHI.

**Protected Health Information** (45 CFR Parts 160 and 164) and the HIPAA Security Rule (45 CFR Part 160 and Part 164, subparts A and C) identifies the following:

Individually identifiable health information is information, including demographic data, that relates to:

- the individual’s past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.\(^\text{13}\) Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

The following information about an individual should NEVER be used in observation documentation:

All elements of dates (except year) for dates directly related to an individual, including:

- birth date,
- admission date,
- discharge date,
- date of death; and
- all ages over 89 and all elements of dates (including year) indicative of such age

**Rule of Thumb:** If the date is related to the patient, patient care, or clinical procedure for the patient then it is prohibited.

The following examples demonstrate the use of dates:

**HAP RC.01.02.01 EP 4** The hospital records the patient’s medical history and physical examination, including updates, in the medical record within 24 hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services.

**Weak:** “The history and physical in one record of five reviewed on the cardiac unit was completed and dated 7/31/2015, however, the date of admission was 7/29/2015.

**Solid:** “The history and physical in one record of five reviewed on the cardiac unit was completed 48 hours after date of admission.”

**NOTE:** The number of hours/days was easily substituted for the actual date of admission.

In another example a generally well written note could be slightly altered to meet PHI requirements:

**Weak:** “Medical Staff Rules and Regulations/Bylaws and Residency Policy and Procedure No 18; Medical Records requires that the attending staff physician will make "daily chart entries indicating review of resident assessment and care.” A pediatric patient was admitted on 5/17/15 at 1740. At the time of survey 1130 5/19 there was no attending note on the chart or an attending attestation linked to a resident evaluation. Staff oversight of residents was not demonstrated.”

**Solid:** “Medical Staff Rules and Regulations/Bylaws and Residency Policy and Procedure No 18; Medical Records required that the attending staff physician will make ‘daily chart entries indicating review of resident assessment and care.’ There was no attending note in the chart or an attending attestation linked to a resident evaluation, despite the pediatric patient having been on the unit for greater than two days. Staff oversight of residents was not demonstrated. This was confirmed by the unit manager.”

**NOTE:** The timeframe (e.g. days, hours) demonstrating the deficiency was easily identified without using PHI.

There are certain standards where a *timeframe* is necessary because of the TJC standard requirement or because the standard suggests it is required based on organization policy, the law, or regulation. This does not mean a date is necessary to document the finding.

Examples are:
BHC CTS.02.01.03 EP 2 The organization conducts each individual’s assessment within the time frame specified by the needs of the individual served, organization policy, and law and regulation.

**Weak:** “Review of a record indicated the date of admission was April 2, 2015 and the assessment was completed April 16, 2015. Organization policy indicated assessments are to be completed within 10 days of admission.”

**Solid:** “In one of five records reviewed, the assessment completion date was fourteen (14) days after date of admission as confirmed by the clinical services director. Organization policy ‘Intake and Assessment’ indicated assessments are to be completed within 10 days of admission.”

BHC CTS.02.01.06 EP3 For organizations providing residential care: Individuals for whom a physical examination conducted by a practitioner qualified by the scope of his or her license is indicated are either examined by the organization or referred to an outside source within 30 calendar days after admission, or sooner if warranted by the individual’s physical health needs, and in accordance with law and regulation.

**Solid:** “In two of five records reviewed, clients with comorbid medical conditions did not have a physical examination completed within 30 days of admission to the adult residential unit. A referral was not completed or documented in the record as confirmed by the nursing supervisor during tracer activity.”

HAP RC.02.03.07 EP4 Verbal orders are authenticated within the time frame specified by law and regulation.

**Solid:** “During the second closed record review of four, it was noted that the medical record included a verbal order written on December 17, 2014 to insert a PICC line. At the time of survey March 17, 2015 the order had not been authenticated. This was not consistent with the organization’s policy (#123 Authentication of Orders, pg. 2) that verbal orders be authenticated within seven days.”

Dates and times related to non-patient information are permissible. Most notably this occurs with Life Safety Code, Environment of Care, and Emergency Management, but is evident in other chapters as well. Examples are:

**LS.01.02.01 EP 1** The hospital notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm or sprinkler system is out of service more than 4 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented.

**Solid:** “As noted in the organization emergency response documentation, the sprinkler alarm system stopped working at 11:45 a.m. 5/11/2015, but the fire department was not notified until 6:15 p.m. that evening that the system was non-functional.”

Ome HR.01.02.07 EP 2 Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration and as required by law and regulation.

**Solid:** “During the Competency Session, it was identified that the Interim Senior Manager of the Physical Therapy Department did not have a current California License. She is licensed in the States of Arizona, Colorado, and Utah and has received information that the California license is pending her taking the boards. The California statute states that she can be supervised by a licensed physical therapist during the interim of being boarded and licensed. She began on December 15, 2014 and there is no documentation that she was in a pending license situation or receiving supervision until May 19, 2015. This was confirmed by the Human Resources Director.”

**LAB QSA.01.05.01 EP 2** The laboratory performs verification testing at least every six months. The verification is documented.

**Solid:** “The laboratory did not perform calibration verification every six months for the Cobas analyzer in 2014. During the tracer activity in the current survey of September 9, 2015, the calibration verification documentation was reviewed for 2015 and 2014. However, the most recent date of the Cobas calibration verification was January 6, 2014. Interviews with the laboratory manager and the testing personnel confirmed that the laboratory did not perform calibration verification for the Cobas every six months in 2014 or in 2015.”

Always use the **Rule of Thumb** (If the date is related to the patient, patient care, or clinical procedure for the patient then it is prohibited) to determine what to include in the observation. Inclusion of more personal identifiers in the observation increases the chances of identifying the patient.
Examples are:

**AHC WT.04.01.01 EP 4** For instrument-based waived testing, quality control checks are performed on each instrument used for patient testing per manufacturers’ instructions.

**Solid:** “The organization did not follow manufacturer’s recommendations for quality control for the Quidel QuickView - Dipstick Strep A Test. Daily quality controls were not documented between 5/11-5/15/15. This was confirmed by the nursing supervisor.”

**AHC WT.05.01.01 EP 2** Test results for waived testing are documented in the patient’s medical record.

**Weak:** “During record review it was noted that a geriatric diabetic patient who had a glucose test performed 7/30/2015 did not contain the reference range for glucose.”

**Documenting PHI in WST**

Instead of adding details to the observation, note any identifying information in the Record within the Record Comments section and ensure that you connect the record to the observation in WST. It is secure and will ensure the information is available for central office review.

1. **In the WST Itinerary Home Page, select the Records section:**

![Image of WST Itinerary Home Page with Records section highlighted]

   - **View Only:** BHC
   - **Search By:** Standard
   - **Search Terms:**

   ![Image of Record Details Window]

2. **Then select Add New Record and the following window will open:**

   ![Image of Add New Record Window]

3. **Back on the Itinerary Home Page, select the Standard section:**

   ![Image of Itinerary Home Page with Standard section highlighted]
4. After entering the information regarding the observation, click on the corresponding Record Number to link the observation to the record:

Remember to attach the record, or records, reviewed during tracer activity when completing the Tracer entry:
Validated Conversations
Validate conversations with one member of the staff by speaking to additional staff.
To solidify the finding through agreement from the org, another direct care staff (the survey coordinator, a staff supervisor, etc.) is queried to confirm what was discussed in the initial conversation. This is completed as part of the tracer process.
Examples are:

HAP MM.03.01.01 EP  6 The organization prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation.
Weak: "The staff nurse said medications were kept at the patient's bedside."
Solid: "The staff nurse on the 4th floor medical/surgical unit stated that the organization's practice was to leave medications at the patient's bedside; making it possible to misuse, mishandle or divert the medications. This was confirmed with the unit manager who made the same statement."

Document the Policy Title
If a policy is necessitated by the standard or if a policy is referenced, the detail must be included. The formal policy name must be capitalized to distinguish it from a generic description of the policy content. If a written policy is required and not produced, include that information in the observation.
Examples are:

AHC HR.01.02.05 EP 5 Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented.
Weak: "It was noted during review of staff health records that a RN did not have a documented PPD since November 2011 although the organization's policy is to have a TB test every two years."
Solid: "It was noted during review of staff health records that a RN did not have a documented PPD since November 2011. The survey coordinator confirmed the organization's policy is to have a TB test every two years (Policy: Vaccination and Testing version May 5, 2015)."

BHC RI.01.03.01 EP 13 Informed consent is obtained in accordance with the organization’s policy and processes.
Weak: "The medication informed consent form to administer Xanax was signed by the nurse on 3/13/15 but not signed by the patient until 3/17/15."
Solid: "In one of five medical records reviewed, the medication informed consent form to administer Xanax was signed by the nurse on 3/13/2015 but not signed by the patient until 3/17/2015. There is no evidence that the hospital's informed consent process requiring signature at the time of administration as
articulated in policy "6.5 Informed Consent" (last revised in March 2013 and most recently reviewed in February 2015) was followed. This was confirmed by the quality director."

**NOTE:** Do not state that the HCO “…did not have a policy on xyz…” unless the standard/EP specifically requires a policy. Also, when an EP calls for ‘documentation’, it does not prescriptively refer to a policy. When an EP states something is documented, such as education, the HCO determines what/where and how such information is documented (e.g. a checklist, a power-point presentation, a data field on a form, etc).

**Use Counts for Detail**
Counts of supplies/equipment are documented when related to observed deficiencies. The actual number of deficient items is documented. This makes the finding more objective and reduces questions from the organization regarding the extent of the deficiency.

Examples are:

HAP IC.02.02.01 EP 4 The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

**Weak:** "Multiple products were expired in the Radiology CT room.

**Solid:** "Observation of the Radiology CT room revealed the following expired products: five (5) Quick Core disposable biopsy needles, one (1) spinal needle, and one (1) BD Vacutainer which leaves patients exposed to possible infection due to out-of-date medical supplies."

**Quantification**
Utilize numerator and denominator information to more specifically detail the amount of review or census of items reviewed. An observation that indicates that the finding was noted in “many other records” is an example of weak documentation. Such phrases add little to no quantitative value. Words with vague qualifiers such as “numerous”, "many", "some", and “several” make it impossible to determine the manner and degree of deficiencies and, therefore, the appropriate level of citation.

Changes were made to Web-based Survey Technology to prompt surveyors to capture quantification in a more thorough and consistent manner. A lead-in statement that captures the numerator and denominator can be completed in situations where a numerator/denominator exists and is pertinent to the scoring of the standard or EP. A category drop-down is also available to identify the activity or item that is being quantified.

Examples are:

HAP MS.06.01.09 EP 1 The decision to grant, limit, or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within the time frame specified in the medical staff bylaws. Requesting practitioners are notified regarding the granting decision.

**Weak:** “It was observed that three of three newly appointed practitioners did not receive notification of the granting decision for the privileges that they had requested. For example an emergency room physician did not receive notification that all of the privileges that they had requested were granted. A Gastroenterologist did not receive notification that all of the privileges that they had requested were granted. A surgeon did not receive notification that all of the privileges they had requested were granted.”

**Solid:** "In 3 of 3 medical staff/credentialing files reviewed, it was observed that newly appointed practitioners did not receive notification of the granting decision for the privileges they had requested. Specifically, an Emergency Room physician, a Gastroenterologist and a Surgeon did not receive notification that all of the privileges that they had requested were granted."

**Be Specific to the Standard/EP**
The observation must not contain multiple deficiencies that should be cited under other standards and/or elements of performance. Deficiencies related to different EPs must have their own cited observation. For instance:
Weak: “No biohazard label was placed on the container that was used to transport the dirty endoscope from the procedure room to the cleaning room. Emergency access to the eyewash station blocked. The cabinet in which the endoscopes were stored after reprocessing was not ventilated.”

In the example above, all findings were cited under the same element of performance. Cite under three separate standards and/or EPs.

Examples are:

Solid: "No biohazard label was placed on the container that was used to transport the dirty endoscope from the procedure room to the cleaning room as confirmed by the director of nursing." (HAP EC.02.02.01 EP 12)

AND "Emergency access to the eyewash station outside the procedure room was blocked by a chair and a rolling cart." (HAP EC.02.02.01 EP 5)

AND "The cabinet in which the endoscopes were stored after reprocessing was not ventilated which could pose infection risk for the endoscopy patients receiving treatment." (HAP IC.02.02.01 EP 4)

Document the Facts

Only use facts to communicate the reasons for the standard deficiency (no embellishment, inference, opinion, or peer review should be added to the citation).

Do not infer that certain facts exist if those facts were not actually observed. Similarly, do not draw conclusions about outcomes that were not actually observed. Do not include personal clinical opinion (peer review). Do not include positive comments to "soften" the impact of the observation.

Do not use statements such as:

"The documentation suggests…”

“The organization should have…”

“The organization could have…”

“The organization would have…”

“It would be better if the hospital…”

“The organization needs a policy on…”

“The organization should consider…”

HAP MM.01.02.01 EP2. The hospital takes action to prevent errors involving the interchange of the medications on its list of look-alike/sound-alike medications.

Weak: “The medication management policies were in good order. However, the look-alike/sound-alike policy did not address labeling on medications. The label in the container should have used TALLman letters to indicate that the medication was on the look-alike/sound-alike medications list”

Solid: "The Look-Alike/Sound-Alike policy (04-1119) did not address labeling on medication. Lack of direction regarding medication labeling increases the risk of confusion.”

Ultimately the foundation of documentation rests on the clarity and detail of what is written. Once surveyors have completed their report documentation they can review their work to assess if the following factual components have been addressed:

- Who
- What
- When
- Where
- How

Generally speaking, documenting who was involved with the review of the finding; what was the deficiency observed; when and where did it occur and how; describing the event as related to a standard or element of performance, will ensure a solid observation. During survey, feel free to review your documentation with the Team Lead, contact the Standards Interpretation Group (SIG), or contact your Field Director to ensure a comprehensive, clear survey report.
## Tracer Patient Selection Criteria

<table>
<thead>
<tr>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Services</td>
</tr>
<tr>
<td>Patient taking a high risk medication</td>
</tr>
<tr>
<td>Patient with complex pain management needs</td>
</tr>
<tr>
<td>Patient identified as high risk for an adverse event that is receiving opioids</td>
</tr>
<tr>
<td>Patient with an infection</td>
</tr>
<tr>
<td>Patient being discharged</td>
</tr>
<tr>
<td>Rehab patient</td>
</tr>
<tr>
<td>Surgical patient receiving anesthesia</td>
</tr>
<tr>
<td>Outpatient Services</td>
</tr>
<tr>
<td>Patient undergoing waived testing</td>
</tr>
<tr>
<td>Patient receiving Radiology Services</td>
</tr>
<tr>
<td>Patient receiving Nuclear Medicine Services</td>
</tr>
<tr>
<td>Patient receiving Emergency Services</td>
</tr>
<tr>
<td>Patient receiving Respiratory Care</td>
</tr>
</tbody>
</table>

**Did you see the following data during the survey?**

1. Behavior Management
2. Blood and blood product use
3. Complaint
4. Data for measuring the performance of processes and outcomes to care
5. High Risk Populations
6. Infection prevention and control
7. Medication management
8. NPSG Data (hand hygiene monitoring, critical values, UP, etc.) **Reminder: All applicable NPSGs must be evaluated during the course of the survey**
9. Operative and other invasive procedures
10. Organ Procurement Conversion Rate Data
11. Organ transplant related data, if transplants are performed
12. ORYX Core Measure
13. Patient Flow (Efficiency of patient care, treatment, and service areas; Safety of patient care, treatment, and service areas; support service processes that impact patient flow)
14. Patient perceptions of care, treatment and services (specific needs and expectations, how the hospital will meet these needs and expectations, how the hospital can improve patient safety, effectiveness of pain management, when applicable)
15. Patient Safety
16. Practitioner specific data
   - individual and aggregate
   - morbidity and mortality
17. Quality Control
18. Research, when applicable
19. Restraint
20. Risk Management
21. Seclusion
22. Sentinel Events
23. Staff opinions and needs*
24. Staff perceptions of risks to individuals and suggestions for improving patient safety*
25. Staff willingness to report unanticipated adverse outcomes*
26. Throughput data
27. Utilization Management
28. Environment of care issues
29. Other PI Activities

* Recommended, not required.

### HAP Survey Process Rules for Surveyor Planning

**Did you…….**

<table>
<thead>
<tr>
<th>Visit 100% of all moderate or deep sedation and anesthetizing locations – inpatient and outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit 100% of the following inpatient care units:</td>
</tr>
<tr>
<td>- Psychiatric</td>
</tr>
<tr>
<td>- Dialysis (inpatient &amp; outpatient)</td>
</tr>
<tr>
<td>- Labor and Delivery/Post Partum/Newborn Nursery</td>
</tr>
<tr>
<td>- Pediatrics</td>
</tr>
<tr>
<td>Visit a representative sample of special care units (i.e., ICU, CCU)</td>
</tr>
<tr>
<td>Visit a representative sample of all remaining inpatient care units</td>
</tr>
<tr>
<td>Visit the main pharmacy to include observing sterile medication compounding (if compounding occurs at the organization). In addition visit:</td>
</tr>
<tr>
<td>- All locations which conduct High Risk (Non-Sterile to Sterile Medication Compounding)</td>
</tr>
<tr>
<td>- All locations which conduct Hazardous Sterile Medication Compounding</td>
</tr>
<tr>
<td>Visit at least 50% of outpatient services with the following sampling guide</td>
</tr>
<tr>
<td>- Sample a mix of large, medium, and small volume clinics</td>
</tr>
<tr>
<td>- Sample both onsite and offsite clinics</td>
</tr>
<tr>
<td>- Prioritize clinics based on service</td>
</tr>
<tr>
<td>- Five (5) single specialty physician clinics are weighted as one ambulatory site (i.e., 20 single specialty clinics would require that two clinics be visited to meet the 50% requirement)</td>
</tr>
<tr>
<td>- If Behavioral Health service are provided, all services should be sampled (100% sampling if residential; additional time is not allowed for outpatient sampling, surveyor may visit one site and perform record review to cover others.)</td>
</tr>
</tbody>
</table>

All inpatient buildings must be surveyed. If there is more than one inpatient building, plan to:

- Conduct a Life Safety Code™ building assessment of each building
- Distribute tracer activities based on types of care and services provided and approximate volume of patients receiving care and services at the different building sites
- Example: Approximately 25% of inpatient services are handled at a hospital five miles away from the main site. Therefore, approximately 25% of tracer activity should occur at this hospital.

**“Psychiatric Hospitals” Hospital Accreditation Program – Deemed Status Business Summary**

**Did you…….**

<table>
<thead>
<tr>
<th>Visit 100% of child/adolescent sites that are under inpatient, residential, or supervised living categories (including outpatient MRDD and ACT programs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit 100% of ECT sites</td>
</tr>
<tr>
<td>Schedule to have lunch with patients/clients</td>
</tr>
</tbody>
</table>

**Team Leaders:** Please ensure that all program surveyors are following the worksheets from their program specific SAGs.
Appendix D – Team Leader Responsibilities

Applies to: All Accreditation programs

Primary Team Leader Expectations

Field representatives are assigned the team leader skill based upon individual field representative performance and program need. The team leader skill set can be assigned or removed from an individual field representative’s job duties at any time. The team leader assignment is reviewed, at a minimum, during the annual performance.

The Primary Team Leader role is a survey-specific assignment.

Surveyors and reviewers assigned as Team Leaders fulfill the expectations outlined in this document.

In addition to duties outlined in the Surveyor and/or Reviewer Job Description, the Team Leader is expected to demonstrate leadership and provide guidance by:

- coordinating pre-survey and/or pre-review activities for the on-site team
- managing the on-site survey/review in order to achieve a thorough, credible and fair evaluation of the organization
- promoting positive communication and interpersonal interactions between team members and the organization to achieve a professional and valued on-site experience
- maintaining appropriate contact with central office to manage the quality of the on-site survey/review and the quality of the report of survey/review findings left on-site
- leading and coaching team members, as needed
- resolving interpersonal issues among the team that arise on-site

Primary Team Leader Responsibilities

Pre-Survey Responsibilities

Two weeks prior to the survey:

1. Review pre-survey information.
   a. If needed, place pre-survey phone call to TJC Account Exec. to gather information for the entire survey, not just for your primary program.

2. Share pre-survey information with the entire survey team via e-mail.
   a. Provide additional pre-survey information provided by the Account Rep to other team members, as needed.
   b. Assure that all team members have shared phone numbers, to assure effective communication.
   c. Choose the most appropriate agenda from Survey tech and modify as needed.
   d. Each program creates their own agenda, but assure that activities are coordinated across all programs as needed (System tracers, Interim exits, etc.)
   e. Communicate plan with the team and publish agenda in survey technology

3. Inform survey team of your travel arrangements.
   a. Encourage the team to stay at the same hotel.
   b. Encourage the team to share rental cars, when possible
   c. Check in with the survey team members the night before; and let them know you have arrived, and where they should meet the next morning.
   d. Confirm team members’ travel plans post survey, to assure that the last day of survey is not shortened.

On-Site Responsibilities

1. Assure a thorough and professional survey is conducted.
   a. Manage the survey process as outlined in the Surveyor Activity Guide
b. Manage the agenda in collaboration with the customer so survey activities are implemented effectively and professionally. Publish, modify and coordinate agendas, as needed.

c. Provide leadership and facilitate conflict resolution when needed to manage the survey; including facilitating a conference call with the customer and central office.

d. Utilize customer relationship management skills

2. Manage survey team member assignments

a. Review agenda assignments with team members

b. Assign responsibilities for system tracers with input from other team members

c. Coordinate Survey Team Meetings

i. Set up telephone conference calls for other program surveyors if required.

ii. Facilitate the sharing of information and issues found during tracers with team members from all programs

iii. Review the progress being made on observing and evaluating compliance with all applicable National Patient Safety Goals. Plan an approach for accomplishing the evaluation of any remaining NPSGs

d. Facilitate discussions with team members to ensure EPs are scored accurately; that the language in the RFI is clear; and that documentation from all surveyors is included.

e. Coordinate Report Preparation

i. Assure all team members lock their findings

ii. Facilitate team efforts to document observations at the most appropriate EP

iii. Review to insure that similar observations from different surveyors are scored at same standard and/or element of performance

iv. Confirm that observations are complete and fully justified.

v. Update survey report with any changes prior to exit conference.

vi. Submit survey findings within 24 hours.

f. Oversee professionalism of survey team

3. Manage relationship with the organization

a. Coordinate communication between organization staff and survey team;

b. Lead problem-solving activities, when needed, to resolve issues of compliance

c. Attend interim exit conferences

d. Confirm that all organization documents have been returned at the close of each day and at the end of the survey/review.

e. Share accreditation report with CEO prior to the exit conference

4. Coordinate communication with central office

a. If sites or services not identified on E-app are discovered, call Field Director On-Call.

b. If the team identifies a serious situation, (immediate threat to life; scope of practice issues; falsification issues) contact the Field Director On-Call.

c. Coordinate a conference call with surveyors and SIG, to resolve compliance and documentation issues.

Responsibilities for Corporate and System Surveys

1. Educates team members about the organizations centralized and de-centralized functions

2. Keep notes across sites and programs

a. Record positive attributes within the organization, observed by the survey team through the course of the survey route

b. Record leading practices within the organization, observed by the survey team through the course of the survey route

c. Record trends that could be considered as leadership insights that did not translate into official survey report observations, (e.g. issues related to supervision, education, quality improvement, customer/patient satisfaction) that the leaders within the organization should be aware of relative to the overall performance of the corporation

3. Deliver summation conferences at the end of the corporate route.

Secondary Team Leader Role
The Secondary Team Leader role is utilized on a tailored survey when a secondary program has more than one surveyor assigned. The Primary Team Leader will be assigned from the primary program and is the main lead for the survey. The Secondary Team Leader is responsible for coordinating the activities of all surveyors for their specific program and serving as the point person to coordinate and communicate with the Primary Team Leader.

For example:

**Hospital (HAP) tailored survey with Home Health Care (OME) and Behavioral Health Care (BHC)**
- 3 - Hospital surveyors (HAP surveyor would be assigned as the Primary Team Leader)
- 1 - Behavioral Health Care surveyor
- 2 - Home Health Care surveyors (OME would have a Secondary Team Leader assigned)

**Ambulatory Health Care (AHC) tailored survey with Behavioral Health Care and Home Health Care**
- 2 - Ambulatory Health Care surveyors (AHC would be assigned as the Primary Team Leader)
- 2 - Behavioral Health Care surveyors (BHC would have a Secondary Team Leader assigned)
- 1 - Home Health Care surveyor

**Secondary Team Leader Expectations**

Field representatives are assigned the secondary team leader skill based upon individual field representative performance and program need. The secondary team leader skill set can be assigned or removed from an individual field representative’s job duties at any time. The secondary team leader assignment is reviewed, at a minimum, during the annual performance.

The Secondary Team Leader role is a survey-specific assignment. Surveyors assigned as Secondary Team Leaders fulfill the expectations outlined in this document. In addition to duties outlined in the Surveyor and/or Reviewer Job Description, the Secondary Team Leader is expected to demonstrate leadership and provide guidance by:

- coordinating pre-survey and/or pre-review activities for the on-site program team members
- managing the on-site survey/review in order to achieve a thorough, credible and fair evaluation of the organization
- promoting positive communication and interpersonal interactions between program team members, Primary Team Leader and the organization to achieve a professional and valued on-site experience
- maintaining appropriate contact with central office to manage the quality of the on-site survey/review and the quality of the report of survey/review findings left on-site
- leading and coaching program team members, as needed
- in collaboration with the Primary Team Leader resolving interpersonal issues among the program team that arise on-site

**Secondary Team Leader Responsibilities**

**Pre-Survey Responsibilities**

Two weeks prior to the survey:
1. Review pre-survey information.
   a. If needed, place pre-survey phone call to TJC Account Exec to gather information for your program.
2. Share pre-survey information with the program survey team via e-mail.
a. Provide additional pre-survey information provided by the Account Executive to other program team members and Primary Team Leader, as needed.
b. Assure that all program team members have shared phone numbers, to assure effective communication.
c. Choose the most appropriate program agenda from Survey tech and modify as needed.
d. Collaborate with the Primary Team Leader to assure activities are coordinated across all programs as needed (System tracers, Interim exits, etc.)
e. Communicate plan with the program team members and publish agenda in survey technology.

3. Inform the Primary Team Leader and program team members of your travel arrangements.
   a. Check in with the Primary Team Leader and your program survey team members the night before; and let them know you have arrived
   b. Confirm program team members’ travel plans post survey, to assure that the last day of survey is not shortened.

On-Site Responsibilities for Program and Collaboration with the Primary Team Leader

1. Assure a thorough and professional survey is conducted.
   a. Manage the survey process as outlined in the Surveyor Activity Guide
   b. Manage the agenda in collaboration with the Primary Team Leader and customer so survey activities are implemented effectively and professionally. Publish, modify and coordinate agendas, as needed.
   c. Collaborating with the Primary Team Leader, provide leadership and facilitate conflict resolution when needed to manage the survey; including facilitating a conference call with the customer and central office.
   d. Utilize customer relationship management skills

2. Manage program team member assignments
   a. Review agenda assignments with program team members and Primary Team Leader, as needed
   b. Assign responsibilities for system tracers with input from other program team members and in collaboration with the Primary Team Leader
   c. Coordinate Survey Team Meetings and participation of the program team members with the Primary Team Leader
      i. Facilitate the sharing of information and issues found during tracers with program team members and the Primary Team Leader as needed
      ii. Review the progress being made on observing and evaluating program compliance with all applicable National Patient Safety Goals. Plan an approach for accomplishing the evaluation of any remaining NPSGs
   d. Facilitate discussions with program team members to ensure EPs are scored accurately; that the language in the RFI is clear; and that documentation from all surveyors is included.
   e. Coordinate program Report Preparation
      i. Assure all program team members lock their findings
      ii. Facilitate program team efforts to document observations at the most appropriate EP
      iii. Review to insure that similar observations from different surveyors within your program are scored at same standard and/or element of performance
      iv. Confirm that observations are complete and fully justified.
      v. Update survey report with any changes prior to exit conference.
   f. Oversee professionalism of program survey team

3. In collaboration with the Primary Team Leader, manage relationship with the organization
   a. Coordinate communication between organization staff, program survey team and Primary Team Leader;
   b. Lead problem-solving activities, when needed, to resolve issues of compliance for your program
   c. Attend interim exit conferences for your program
d. Confirm that all organization documents have been returned at the close of each day and at the end of the survey/review.

4. In collaboration with the Primary Team Leader, coordinate communication with central office
   a. If sites or services not identified on E-app are discovered, call Field Director On-Call.
   b. If the team identifies a serious situation, (immediate threat to life; scope of practice issues; falsification issues) notify the Primary Team Leader and determine who will contact the Field Director On-Call.
   c. Coordinate a conference call with program surveyors and SIG, to resolve compliance and documentation issues, collaborate or notify the Primary Team Leader of the situation.

Responsibilities for Corporate and System Surveys – *(Central Office will determine if a corporate Secondary Team Leader will be assigned)*

1. Educates program team members about the organization’s centralized and de-centralized functions for your specific program
2. Enter notes in WST corporate comments sections across sites for the program
   a. Record positive attributes within the organization’s program, observed by the program survey team through the course of the survey route
   b. Record leading practices within the organization’s program, observed by the program survey team through the course of the survey route
   c. Record trends that could be considered as leadership insights that did not translate into official survey report observations, (e.g. issues related to supervision, education, quality improvement, customer/patient satisfaction) that the leaders within the organization should be aware of relative to the overall performance of the corporation
3. Participate with the corporate summation as requested by central office
Appendix E – HAP Applicability Grid for Program-Specific & System Tracers

<table>
<thead>
<tr>
<th>Type of Tracer</th>
<th>One Surveyor for Two Days</th>
<th>One Surveyor for Three Days &amp; Two Surveyors for Two Days</th>
<th>All Other Survey Configurations</th>
<th>Complex Organization Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Tracer for Data Management</td>
<td>Include</td>
<td>Include</td>
<td>Include</td>
<td>Include</td>
</tr>
<tr>
<td>Program Specific Tracer for Lab Integration</td>
<td>Evaluate this subject matter as part of your individual tracers</td>
<td>Include Use Individual Tracer Activity time</td>
<td>Include Use Individual Tracer Activity time to conduct</td>
<td>If agenda contains only the system tracer for data management follow the column titled “One Surveyor for Three Days &amp; Two Surveyors for Two Days”</td>
</tr>
<tr>
<td>System Tracer - Infection Control</td>
<td>Evaluate this subject matter as part of your individual tracers</td>
<td>Include</td>
<td>Include</td>
<td>If the agenda allots time for three system tracer sessions (data management and two others) follow the column for All Other Survey Configurations</td>
</tr>
<tr>
<td>System Tracer - Medication Management</td>
<td></td>
<td></td>
<td>Include</td>
<td></td>
</tr>
<tr>
<td>Program Specific Tracer for Suicide Prevention</td>
<td></td>
<td></td>
<td>Include</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Include, when applicable, using Individual Tracer Activity Time</td>
<td></td>
</tr>
</tbody>
</table>
Appendix F – Handout for the Hospital

To access information about your survey, proceed to your Joint Commission extranet site by accessing www.jointcommission.org

- Click on ‘Log-in-Joint Commission Connect’ under the Action Center section
- Enter your login and password
- You will find the following information
  a. Notification of scheduled Joint Commission event authorizing the presence of the surveyors for the unannounced survey
  b. Surveyor(s) name, picture and biographical sketch
  c. Scheduled survey dates

As a Hospital, you will need the following information and documents available for the surveyor to review during the Preliminary Planning Session and Surveyor Planning Session, which occurs on the first day of survey.

In addition to the documents noted below, please be prepared to provide the Life Safety Surveyor, upon arrival, the documents found on the Life Safety and Environment of Care Document List and Review Tool, which is located later in this Guide.

Note: The 12-month reference in the following items is not applicable to initial surveys.

1. Hospital license
2. CLIA Certificates
3. An organization chart
4. Name of key contact person who can assist surveyors in planning tracer selection
5. A map of the organization, if available
6. List of all sites that are eligible for survey
7. List of sites where deep or moderate sedation is in use
8. List of sites where high-level disinfection and sterilization is in use
9. List of departments/units/areas/programs/services within the organization, if applicable
10. List of patients that includes: name, location, age, diagnosis and length of stay, admit date, source of admission (ED, direct admit, transfer)
11. Lists of scheduled surgeries and special procedures, e.g. cardiac catheterization, endoscopy lab, Electroconvulsive Therapy, Caesarian Sections, including location of procedure and time
12. List of unapproved abbreviations
13. List of all contracted services
14. Agreement with outside blood supplier (Not applicable to Critical Access Hospitals unless they operate Rehab and Psych Distinct Part Units)
15. Organ Procurement Organization agreement
16. Tissue and Eye Procurement Organization agreement
17. Organ, tissue and eye procurement policies
18. Performance improvement data from the past 12 months
19. Documentation of performance improvement projects being conducted, including the reasons for conducting the projects and the measurable progress achieved (this can be documentation in governing body minutes or other minutes)
20. Patient flow documentation: Dashboards and other reports reviewed by hospital leadership; documentation of any patient flow projects being conducted (including reasons for conducting the projects); internal throughput data collected by emergency department, inpatient units, diagnostic services, and support services such as patient transport and housekeeping

21. Analysis from a high risk process

22. Organ donation and procurement conversion rates *(Hospital)*

23. Environment of Care data

24. Environment of Care Management Plans and annual evaluations

25. Environment of Care multidisciplinary team meeting minutes for the 12 months prior to survey

26. Hazard Vulnerability Analysis

27. Emergency Operations Plan (EOP) and documented annual review and update, including communications plans

28. Continuity of Operations Plan*

29. Documentation of completed/attempted contacts with local, state, tribal, regional, federal EM officials in organization’s service area*

30. Annual training*

31. Tracking system for sheltered and relocated patients*

32. Emergency Management Policy*

33. Emergency management protocols for Transplant Services*

34. Integrated EM system risk assessments, plan, and annual review*

35. Emergency management drill records and after action reports

36. Written fire response plan

37. Interim Life Safety Measure policy

38. Fire drill evaluations

39. Infection Control Plan
   - Annual risk assessment and annual review of the program
   - Assessment-based, prioritized goals

40. Infection Control surveillance data from the past 12 months

41. Medical Staff Bylaws and Rules and Regulations

42. Medical Executive Committee meeting minutes

43. The organization’s signed and dated agreement with the QIO; in the absence of an agreement with a QIO, the organization’s Utilization Review plan *(Not applicable to Critical Access Hospitals unless they operate Rehab and Psych Distinct Part Units)*

44. Governing Body minutes for the last 12 months

45. Autopsy policy

46. Blood transfusion policy

47. Complaint/grievance policy

48. Restraint and seclusion policy

49. Waived testing policy and quality control plan

50. ORYX data – *(required only for very small hospitals exempt from submitting this data through vendors)*

51. Available regulatory reports (CMS, State)
52. Medication management policy *(which defines what is a complete medication order and therapeutic duplication)*
53. Abuse and neglect policy for inpatient, and ambulatory sites, if applicable
54. Fall risk assessment and policy
55. Document describing how the organization is using the CDC’s Core Elements of Hospital Antibiotic Stewardship Programs
56. Organization approved antimicrobial stewardship protocols (e.g. policies, procedures, or order sets)
57. Antimicrobial stewardship data
58. Antimicrobial stewardship reports documenting improvement  *(Note: If the data supports that antimicrobial stewardship improvements are not necessary make sure the surveyor is informed of this.)*
59. Final Reports of Certification/Testing for all Primary Engineering Controls and Secondary Engineering Controls associated with Sterile Medication Compounding *(including any documentation of remediation/retesting conducted based on reported results)*

*These documents are related to the CMS Emergency Management Final Rule and will need to be available for surveyor review on all Deemed Status Hospital surveys.  Note: Document formats may vary, and many of the documents may be included in the Emergency Operations Plan.

Please note that this is not intended to be a comprehensive list of documentation that may be requested during the survey.  Surveyors may ask, on an as needed basis, to see additional documents throughout the survey to further explore or validate observations or discussions with staff.
## Appendix G – Hospital Accreditation Survey Activity List

<table>
<thead>
<tr>
<th>Survey Activity Name</th>
<th>Suggested Duration of Activity</th>
<th>Suggested Scheduling of Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveyor Arrival and Preliminary Planning</td>
<td>30-60 minutes</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; day, upon arrival</td>
</tr>
<tr>
<td>Opening Conference and Orientation to the Organization</td>
<td>30-60 minutes</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; day, as early as possible</td>
</tr>
<tr>
<td>Surveyor Planning Initial</td>
<td>30-60 minutes</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; day, as early as possible</td>
</tr>
<tr>
<td>Individual Tracer</td>
<td>60-120 minutes</td>
<td>Individual Tracer activity occurs each day throughout the survey; the number of individuals that surveyors trace varies by organization. If travel is required to perform tracer activity (e.g., to an outpatient setting), it will be planned into this time.</td>
</tr>
<tr>
<td>Lunch</td>
<td>30 minutes</td>
<td>At a time negotiated with the organization</td>
</tr>
<tr>
<td>Issue Resolution</td>
<td>30 minutes</td>
<td>End of each day except last; can be scheduled at other times as necessary</td>
</tr>
<tr>
<td>Team Meeting/Surveyor Planning</td>
<td>30 minutes</td>
<td>Mid-day and/or end of each day except first and last</td>
</tr>
<tr>
<td>Daily Briefing</td>
<td>30-45 minutes</td>
<td>Start of each survey day except the first day; can be scheduled at other times as necessary</td>
</tr>
<tr>
<td>Competence Assessment</td>
<td>30-60 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization</td>
</tr>
<tr>
<td>Medical Staff Credentialing &amp; Privileging</td>
<td>60 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization</td>
</tr>
<tr>
<td>Environment of Care</td>
<td>60-90 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization</td>
</tr>
<tr>
<td>Emergency Management</td>
<td>60-90 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization</td>
</tr>
<tr>
<td>System Tracer – Data Management</td>
<td>60-90 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization. If this is the only system tracer taking place during survey, the topics of Infection Control and Medication Management will be covered in this discussion.</td>
</tr>
<tr>
<td>Leadership</td>
<td>60 minutes</td>
<td>Towards the middle or end of survey at a time negotiated with the organization</td>
</tr>
<tr>
<td>Report Preparation</td>
<td>60-120 minutes</td>
<td>Last day of survey</td>
</tr>
<tr>
<td>CEO Exit Briefing</td>
<td>15-30 minutes</td>
<td>Last day of survey</td>
</tr>
<tr>
<td>Organization Exit Conference</td>
<td>30-45 minutes</td>
<td>Last day, final activity of survey</td>
</tr>
</tbody>
</table>

**Note:** The following activities may be incorporated into the survey agenda as noted under the Suggested Scheduling of Activity column.

<table>
<thead>
<tr>
<th>Survey Activity Name</th>
<th>Suggested Duration of Activity</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Tracer – Infection Control</td>
<td>60 minutes</td>
<td>Occurs on surveys greater than three days in duration. After some individual tracer activity has occurred; at a time negotiated with the organization.</td>
</tr>
<tr>
<td>System Tracer – Medication Management</td>
<td>60 minutes</td>
<td>Occurs on surveys greater than three days in duration. After some individual tracer activity</td>
</tr>
<tr>
<td>Survey Activity Name</td>
<td>Suggested Duration of Activity</td>
<td>Suggested Scheduling of Activity</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Interim Exit – w/ early departing surveyors &amp; Org.</td>
<td>30 minutes</td>
<td>At the end of any day another program surveyor or Life Safety Code Specialist is departing from the survey in advance of the team.</td>
</tr>
</tbody>
</table>

**Life Safety Code® Survey Activity**

<table>
<thead>
<tr>
<th>Activity Name</th>
<th>Suggested Duration of Activity</th>
<th>Suggested Scheduling of Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Safety Code Specialist Arrival and Preliminary Planning Session</td>
<td>30 minutes</td>
<td>LSCS survey 1st day, early</td>
</tr>
<tr>
<td>Facility Orientation/ Maintenance Document Review</td>
<td>60-90 minutes</td>
<td>At a time negotiated with the organization</td>
</tr>
<tr>
<td>Life Safety Code® Building Assessment</td>
<td>2-5 hours per day</td>
<td>At a time negotiated with the organization</td>
</tr>
<tr>
<td>Lunch</td>
<td>30 minutes</td>
<td>At a time negotiated with the organization</td>
</tr>
<tr>
<td>Facility Maintenance / Document Review (Critical Access Hospital ONLY)</td>
<td>60-90 minutes</td>
<td>At a time negotiated with the organization</td>
</tr>
<tr>
<td>Environment of Care &amp; Emergency Management (Critical Access Hospital ONLY)</td>
<td>60-90 minutes</td>
<td>At a time negotiated with the organization</td>
</tr>
<tr>
<td>Facility Tracer / Issue resolution (Critical Access Hospital ONLY)</td>
<td>30 minutes</td>
<td>At a time negotiated with the organization</td>
</tr>
<tr>
<td>Report Preparation</td>
<td>60 minutes</td>
<td>Towards the end of last day of survey</td>
</tr>
<tr>
<td>Interim Exit</td>
<td>30 minutes</td>
<td>Last activity on last day of survey</td>
</tr>
</tbody>
</table>
# Appendix H – Accreditation with Follow-up Survey

**Applies to:** All accreditation programs

<table>
<thead>
<tr>
<th><strong>Duration</strong></th>
<th>Per itinerary; one day in most cases.</th>
</tr>
</thead>
</table>
| **Participants** | Joint Commission: Surveyors  
Organization: Survey coordinator, senior leadership, others |

## What’s a Surveyor To Do If…

| **Q:** What should a surveyor do if assigned to conduct an Accreditation with Follow-up Survey (AFS) and an ESC is not available?  
**A:** The ESC is submitted 60 days after the final report is posted to the organization’s extranet site and is usually available to the surveyor prior to conducting the AFS survey. However, issues may have occurred that delayed the submission of the ESC or circumstances may warrant the AFS survey to be scheduled prior to the receipt of the ESC. An AFS survey can occur without an ESC; use the following guidelines in this situation: |
|---|---|
| Review the organization’s previous survey report to verify the cited RFIs  
Pre-survey – plan what type of activity will be required to verify compliance, such as individual patient tracer activity, record review, personnel file review, PI data review, etc.  
On-Site – ask the organization how they are monitoring their corrective actions for sustained compliance with the standards. |

## Objectives

1. To determine the organization’s compliance with standards that generated a Requirement for Improvement (RFI) through the evaluation of follow-up actions when an organization has received a decision of Accreditation with Follow-up Survey (AFS).  
2. To verify that the organization has implemented plans of correction as reported in their Evidence of Standards Compliance and that compliance with the standards is being sustained.

## Before

1. Through your itinerary, locate the organization and click on the event ID. When the event is displayed, click on Quick Links to view:  
a. Previous Recommendations  
b. Available ESC submissions, Basic Building Information (BBI) data  
c. Organization’s application |

2. Through survey technology, select the appropriate survey agenda template for the length of survey, this will most often be one surveyor for one day. Based on the RFIs being followed-up, plan the activities you want to conduct and prepare a draft agenda.  
3. Identify the reason for the organization’s Accreditation with Follow-up Survey by the code on your itinerary. There may be more than one reason for the AFS decision.  
4. Review the application for information about the organization (e.g. days and hours of operation), travel directions, hotel accommodations, and other logistics. Document the organization’s survey coordinator name and phone number for easy reference.  
5. Review the ESC, if it is available.  
6. **Do not contact the organization.** This is an unannounced event. Call the Joint Commission Account Executive if you have any questions.  
7. Review the SAFER™ matrix and RFIs from the past survey report.  
8. Identify survey activities that would evaluate each element of performance (EP) previously found out of compliance. Remember, the focus of survey activity for this on-site event is on the EP’s that generated an RFI. For example, if the organization did not collect data about the perceptions of care, treatment and services, you would need to evaluate the effectiveness of the process they implemented in their ESC. You would not review all of their data collection.

## Conducting the Survey – Know the Event Type

1. Arrive at the organization no earlier than 10-minutes before the designated start time for an unannounced survey. If the survey includes multiple surveyors, all surveyors should enter the organization together.  
2. Report to the reception area, security officer, information desk or administrative office upon arrival and:  
a. Provide your name and the purpose for your visit.  
b. Display your Joint Commission identification badge.
the Accreditation with Follow-Up Survey?
A: The surveyor records all observations and findings related to any standard or EP found non-compliant.

**Q:** What should you do if the organization is still non-compliant with originally scored standards?
A: Record all findings related to standards non-compliance. Trip the manual decision rule for AFS05.

3. Direct the survey coordinator or administrative contact to access the Joint Commission’s web page at www.jointcommission.org. Once there, select the link to access The Joint Commission Connect. They will need the user ID and password to sign-on. They should find the following information:
   a. Notification of scheduled Joint Commission event authorizing your presence
   b. Surveyor picture and biographical sketch

4. After the organization validates the authenticity of your visit, ask if they have a space where you can begin the survey.

5. Review the agenda for the survey and with the guidance of the organization, make adjustments as needed.

6. Begin the opening conference. If the organization requires additional time to gather or obtain coverage for those attending opening conference:
   a. Postpone the opening conference to mid-morning;
   b. Review documents or begin an individual tracer.

7. Select tracers based on the standards and elements of performance that were non-compliant. For example, proceed to a unit that was identified in a high-risk finding or other RFI, select individuals currently receiving care and services in the area, and trace a patient there focusing on the subject of the RFI.

8. Focus interviews and group discussion on the standards and EPs being evaluated. For example, if you choose to conduct a Data Management System Tracer because the organization did not collect PI data about restraint and seclusion, focus the discussion on the collection of restraint and seclusion data. As you trace a patient requiring restraints, interview staff about data collection.

9. Prepare your report using survey technology. Note: If you document findings that lead to a RFI at the same standard:
   a. Hover on the Standard tab to see the drop-down menu. Select “Manual Rules”
   b. Click on “AFS05” if the organization was Accredited with Follow-up Survey and has continued non-compliance at the same standards requiring a second Accreditation with Follow-up Survey. Document
the location of unresolved RFI's. At the conclusion of the survey, prepare a report using WST.

10. Lock and publish a report for the organization. Ask the organization contact to access their Joint Commission Connect extranet site to locate and print the report.

11. At the conclusion of the survey, review the report as part of the exit conference. Explain that follow-up questions should be directed to the organization’s Account Executive.

12. Transmit the report to the Central Office within 24 hours of the exit following existing survey technology procedures.
Appendix I – Random Unannounced Validation (RUV) Survey

Applies to: All accreditation programs (except LAB)

Duration
Per itinerary; one day in most cases.

Participants
Joint Commission: Surveyor
Organization: Survey Coordinator, senior leadership, staff throughout the organization, licensed independent practitioners if part of the organization.

Pre-Survey Planning
1. Through your itinerary, locate the organization and click on the event ID. When the event is displayed, click on Quick Links to view:
   a. Previous Recommendations
   b. Available ESC submissions, Basic Building Information (BBI) data
   c. Organization’s application
2. The RUV template agenda is available to surveyors through WST for editing.
3. Review the ESC and the SAFER™ matrix.
4. Do not contact the organization. This is an unannounced event. Call the Joint Commission Account Executive if you have any questions.
5. Review the ESC. Note: this includes surveyor findings for non-compliant standards found during the last survey.
6. Identify survey activities that would evaluate each element of performance identified in the ESC. The focus of survey activity for this survey is only the EPs being evaluated. For example, if the organization did not collect data about the perceptions of care, treatment and services, you would need to evaluate the effectiveness of the process it implemented in its ESC. You would not review all of the data collection.
7. Modify the template agenda for review with the organization at the Opening Conference.

Conducting the survey
1. Arrive at the organization approximately 10 minutes prior to the designated start time. Note: hospital surveys begin at 8 AM. Other program surveys start when the organization opens as identified in the organization's demographic data.
2. Report to the reception area, security officer, information desk or administrative office upon arrival and introduce yourself and the purpose of your visit.
3. Display and show the organization’s representative your Joint Commission identification badge.
4. Ask the staff person, first encountered, to contact the administrative office or an organization leader to let them know
of your arrival. You may be asked to wait in the lobby or in a different location, e.g. the administration office, a conference room, desk or table located in the organization.

5. Direct the survey coordinator or administrative contact to access the Joint Commission’s web page at www.jointcommission.org. Once there, select the link to access The Joint Commission Connect. They will need the user ID and password to sign-on. They should find the following information:
   a. Notification of scheduled Joint Commission event authorizing your presence
   b. Your picture and biographical sketch

6. Ask to meet with the CEO and others, as requested by the CEO, for a brief opening conference.

7. Provide the organization with the list of requested documents, prepared during pre-survey planning.

8. Provide the organization with the revised agenda template, prepared during pre-survey planning.

9. Evaluate the elements of performance identified in the ESC.

10. When time permits, conduct the following additional survey activity following the processes outlined in the Survey Activity Guide.
   a. BHC – assessment process for a high risk patient (reference program specific tracers in BHC SAG)
   b. HAP/CAH – hand hygiene or discharge planning (reference process in Individual Tracer Components, HAP SAG)
   c. NCC – dietary tracer for a patient with weight loss or treatment observation (reference process in Individual Tracer Components, NCC SAG)
   d. OME – contract oversight process, equipment management tracer or medication reconciliation process for patient referred from hospital (reference process in OME SAG)

11. The primary focus of this survey is to determine the organization has implemented the corrective action, documented in their ESC. However, if other non-compliant performance is identified, an observation should be entered at the appropriate standard and EP.

12. At the conclusion of the survey, prepare a report using WST.

13. Lock and publish a report for the organization. Ask the organization contact to access their Joint Commission Connect extranet site to locate and print the report.

14. At the conclusion of the survey, review the report as part of the exit conference. Explain that follow-up questions should be directed to the organization’s Account Executive.

15. Transmit the report to the Central Office within 24 hours of the exit following existing survey technology procedures.
Appendix J – Medicare Condition-Level Deficiency Follow-up Survey

Applies to: Organizations that use Joint Commission accreditation for deemed status purposes
(Existing Medicare Certified Organizations)

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>When condition-level deficiencies are found, The Joint Commission conducts a follow-up survey within 45 days.</td>
<td>1. To evaluate the organization’s follow-up actions in response to Medicare Condition-Level Deficiencies.</td>
</tr>
<tr>
<td>Duration</td>
<td>2. To evaluate current compliance with requirements that generated Condition-Level Deficiencies.</td>
</tr>
<tr>
<td>Per itinerary; one day in most cases. The length will be dependent on the volume of condition-level deficiencies.</td>
<td>3. To document that an evaluation of the Condition-Level Deficiencies (CLD) occurred (see survey technology instructions on next page).</td>
</tr>
</tbody>
</table>

Pre-Survey Planning

1. Through your itinerary, locate the organization and click on the event ID. When the event is displayed, click on Quick Links to view:
   a. Previous Recommendations
   b. Available ESC submissions, Basic Building Information (BBI) data
   c. Organization’s application

2. Review the application for accreditation for information about the organization, travel directions, hotel accommodations, and other logistical information. Make note of the survey coordinator name and phone number.

3. Do not contact the organization. This is an unannounced event. Call the Joint Commission Account Executive with any questions.

4. Review the last survey report (Previous Recommendations under Quick Links) and, if available, any Evidence of Standards Compliance submitted by the organization. Note: MEDDEF surveys are typically scheduled to occur prior to the organization’s submission of all ESC responses due to the time frames specified by CMS. Therefore, it is likely that an ESC will NOT be available for review prior to the MEDDEF survey. Surveyors are still encouraged to check.

5. Identify survey activities that would evaluate the element(s) of performance and the associated condition-level deficiencies previously found out of compliance. The primary focus of this follow-up survey is on the area(s) identified as condition-level deficiencies. However, if additional areas of non-compliance are discovered during the follow-up survey, document the additional observations in survey technology.

6. Plan for the on-site visit. While not required, consider selecting an agenda template from those available in WST that closely matches the survey length and complement for the assigned event. Revise the template to reflect activities that will allow for evaluation of the standards and the associated condition-level deficiencies you are reviewing. The agenda can include individual tracers, system tracers, building tours and review of documents.

7. One to two days before the scheduled MEDDEF survey date, access the organization’s extranet site and check the last survey report (Previous Recommendations) for any Central Office updates. If an ESC was not available at the time of assignment, also check to see if the organization has since submitted one.

Please note:
This survey differs from an Accreditation with Follow-Up Survey, which is described in Appendix H.

Standard Level Deficiency: An issue(s) that demonstrates non-compliance with a CMS standard but does not rise to a level that impacts patient safety or quality of care based on manner or degree.
**Condition Level Deficiency:**

An issue(s) that demonstrates non-compliance that has a strong potential or does impact patient safety and quality of care based on manner or degree.

**Manner – Frequency**
- Pertains to the frequency that an issue of non-compliance occurs at a particular CMS standard (8 of 10 charts)
- If the occurrence/frequency is significant then the issue should be raised to a Condition Level

**Degree – Severity**
- Pertains to the seriousness of an issue (e.g., patient was re-hospitalized, wound status has worsened)
- Multiple standards under a CoP are non-compliant (e.g., Aide did not have 12 hours of training and competencies were not evaluated)
- Only one patient may be affected; but if serious, the issue should be raised to a Condition Level

**Conducting the Survey**

1. Arrive at the organization no earlier than 10 minutes before the designated start time for the unannounced survey. If the survey includes multiple surveyors, all surveyors should enter the organization together.

2. Report to the reception area, security officer, information desk or administrative office upon arrival and:
   - Provide your name and the purpose for your visit.
   - Display your Joint Commission identification badge.
   - Ask to speak with the survey coordinator, by name. If the coordinator is unavailable, ask to speak with an administrator or the most senior leader available.
   - Clearly explain the purpose of the survey to the organization.

3. Direct the survey coordinator or administrative contact to access the Joint Commission’s web page at [www.jointcommission.org](http://www.jointcommission.org). Once there, select the “Click here to access The Joint Commission Connect”. They will need the user ID and password to sign-on. They should find the following information:
   - Notification of scheduled Joint Commission event authorizing your presence
   - Your picture and biographical sketch

4. After the organization validates the authenticity of your visit, ask if they have a space where you can get settled.

5. Begin the opening conference. At a minimum, discuss the schedule for the visit (the activities you want to conduct and an approximate time for each) and work with the organization to make any necessary adjustments. The organization needs to know your plan to effectively facilitate the visit. If you have prepared an agenda, provide the organization with a copy. NOTE: If the organization requires additional time to gather staff or obtain coverage for staff attending the opening conference:
   - Suggest postponing the opening conference to mid-morning;
   - Proceed with an individual tracer, conduct a building tour, or request and review documents.

6. Select tracers based on the reason for the Medicare Condition-Level Deficiency Follow-up survey. For example, proceed to the care setting(s) that was identified in a Requirement for Improvement (RFI) and the associated condition, select individuals currently receiving care and services in the area, and trace a patient there, focusing on the subject of the RFI/condition level deficiencies.

7. Focus interviews and group discussion on the requirements/condition level deficiencies being evaluated.

8. If the Medicare requirement(s) that generated condition-level deficiencies continues to be non-compliant or if there are new condition-level deficiencies identified, document and flag the observations as required. Call SIG to discuss the situation and to receive further instruction if needed.

9. If the organization has only one or a small number of condition-level deficiencies to evaluate, offer the organization the option of using the remainder of the time to discuss other RFIs or to review and discuss aspects of their planned ESC submission. If the organization declines further discussion proceed with concluding the survey. See Early Departure Procedures below.
10. At the conclusion of the survey:

a. Prepare your report using Survey Technology.

   1. Access each standard reviewed related to a Condition-Level Deficiency (CLD), including existing CLD(s), and any additional CLD(s).

      If there is only one EP under the standard that is related to the CLD:

      2. Flag the standard (not the EP) using one of the following reason codes: Condition Level Deficiency cleared; Recurring Condition Level Deficiency; New Condition Level Deficiency.

      3. Enter a flag note (not required when selecting “Condition-Level Deficiency cleared”).

      If there are multiple EPs under the standard that roll-up to generate the CLD:

      4. Review each EP that is tied to the CLD and determine current compliance.

      5. If all EPs are compliant, flag the standard with the cleared code and enter a comment, such as, “EPs 1, 2 and 3 are compliant. No observations will be entered into survey technology. In this instance, the report will show no findings.”

      6. If all EPs are non-compliant, flag the standard with the Recurring code and enter a comment, such as, “EPs 1, 2 and 3 remain non-compliant.” Enter your observations into survey tech under the appropriate EP.

      If there are multiple EPs under the standard that roll-up to generate the CLD, but only some of the EPs are compliant and one or more remain non-compliant:

      7. Determine if the remaining non-compliant EP is a Condition Level deficiency, or can this be reduced to a Standard Level deficiency. Manner and Degree should be the basis of your decision as to whether or not the issue is Condition or Standard Level. Contact SIG to verify as needed.

      8. If you determine that the Condition Level deficiency still remains, flag the standard and choose the Recurring code, enter a comment, such as, “EP 1 is compliant, but EPs 2 and 3 remain non-compliant.” Enter your observations into survey technology under the non-compliant EPs as appropriate.

      9. If you determine the Condition Level deficiency is cleared, but there still remains a Standard Level deficiency, flag the standard and choose the Cleared code. Enter a note, such as, “EP 1 and 2 are compliant, but EP 3 remains non-compliant, but based on manner/degree it is now a Standard level deficiency.” Enter your observations into survey technology under the appropriate EP.

      If several EPs at multiple standards roll up to generate the CLD:

      10. Each EP must be reviewed to determine compliance.

      11. If EPs remain non-compliant, determine if the issue is a Condition or Standard Level deficiency using Manner and Degree as your guide.

      12. Use the same steps described above to indicate if the various EPs are Cleared or Recurring.
Your survey activity should be focused on the previously identified CLD. However, if during the course of the MED DEF survey you identify a new CLD,

13. You are required to enter the observation at the appropriate Standard/EP.

14. Flag the Standard, choose the New CLD code and enter your observation at the appropriate EP(s).

11. Lock and publish a report for the organization. Ask the organization contact to access their Joint Commission Connect extranet site to locate and print the report.

12. At the conclusion of the survey, review the report as part of the exit conference. Explain that follow-up questions should be directed to the organization’s Account Executive.

13. **EARLY DEPARTURE PROCEDURES:** Once the survey is complete and the customer has been given the opportunity for additional education or consultation and they have declined; please email the Field Director On-Call indicating the reason for the early departure. Please place the following content in the “Subject” line – “Early Departure Med Def HCO #_____”. Additionally, enter a note in the CO Comments tab in WST to document the reason for the early departure and approximate time of departure.

**Post Survey Process**

Transmit the report to the Central Office within 24 hours of the exit following existing survey technology procedures.
## Appendix K – Medicare Survey Mid-Cycle – Survey Event Guide

### Applies to: All CMS deemed accreditation programs

| Duration | Per itinerary | Varies by program |

| Participants | One or more Joint Commission surveyors |

| This is an unannounced survey event |

### Reasons Organizations Assigned this Event Type (MEDSRVMC)

- An organization requests to add deemed status to their existing accreditation somewhere between full accreditation surveys
- An organization acquired another hospital that was not Joint Commission accredited AND the organization decided to reject the existing Medicare provider agreement for this facility, and has elected to add the hospital as an additional (provider-based) inpatient location to the existing provider agreement

### Overview of Event

- Serves as the initial deemed status survey for the organization
- CMS expects that a new initial Medicare survey take place at the acquired facility, and that the organization demonstrate compliance with all of the CoPs prior to being considered eligible for inclusion under the acquiring organization’s provider agreement and eligible for Medicare reimbursement.
- **The approach to the survey is the same as conducting a full initial accreditation survey at the acquired location according to the Survey Activity Guide.**
- If there are any Medicare Condition-level deficiencies identified, The Joint Commission will not be able to issue a recommendation for Medicare certification for the new location, and the organization will have to undergo another full, initial Medicare survey.
- Contact the Field Director or Account Executive for further information or guidance regarding this event type.
Appendix L through O – Not Applicable to Hospital
Appendix P -- Onsite Evidence of Standards Compliance (ESC), and Preliminary Denial of Accreditation-Evidence of Standards Compliance (PDA–ESC) Survey

**Applies to:** All accreditation programs

<table>
<thead>
<tr>
<th><strong>Duration</strong></th>
<th><strong>Purpose</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Per itinerary; usually one day, but is dependent on the number and severity of RFIs</td>
<td>The Onsite Evidence of Standards Compliance (ESC), and Onsite Preliminary Denial of AccreditationEvidence of Standards Compliance (PDA–ESC) are conducted to validate that an organization</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
<td></td>
</tr>
<tr>
<td>Usually one surveyor</td>
<td>• Has implemented the corrective action documented in its ESC submission, and</td>
</tr>
<tr>
<td>Organization:</td>
<td>• Is demonstrating current compliance with the elements of performance addressed in the ESC.</td>
</tr>
<tr>
<td>• Survey coordinator</td>
<td></td>
</tr>
<tr>
<td>• Senior leadership</td>
<td></td>
</tr>
<tr>
<td>• Staff throughout the organization</td>
<td><strong>Objectives</strong></td>
</tr>
<tr>
<td>• Licensed independent practitioners</td>
<td>1. Review all ESC submissions for the assigned program to verify that the organization has implemented reported plans and corrected previously cited standards non-compliance.</td>
</tr>
<tr>
<td><strong>What triggers this type of survey?</strong></td>
<td>2. Determine if the organization has sustained compliance since implementing corrective action plans.</td>
</tr>
<tr>
<td>A surveyor, staff person in the Standards Interpretation Group (SIG) or an ACO Field Director can recommend that an onsite survey be conducted to validate ESC implementation when they believe that there may be</td>
<td>3. The PDA-ESC survey will occur approximately 60 days after the last survey event. Due to the serious nature of the issues previously identified, a quick return is required to assure corrections have been successfully implemented.</td>
</tr>
<tr>
<td>1. Questions about the integrity/accuracy of an organization’s ESC submission, or</td>
<td>4. Provide coaching and mentoring to the organization on sustaining and improving performance in those areas addressed in its ESC.</td>
</tr>
<tr>
<td>2. A concern about the significant nature of the findings from a survey.</td>
<td><strong>Pre-Survey Planning</strong></td>
</tr>
<tr>
<td><strong>Who approves the conduct of an Onsite ESC?</strong></td>
<td>1. Access the HCO information in the usual manner through your itinerary on the Surveyor Portal.</td>
</tr>
<tr>
<td>All Onsite ESC surveys require authorization from the ACO Chief Operating Officer.</td>
<td>• Scroll through your assignments to find the Onsite ESC or PDA–ESC event. Select the event by clicking on the Event ID.</td>
</tr>
<tr>
<td>PDA-ESC Events will occur for all organizations who have received a PDA02 decision, which means, The organization’s patients have been placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings.</td>
<td>• You will use survey technology to access all available TJC information related to the organization through the Quick Links option. Click on the Quick Links button in the lower right corner of the screen to view the menu of available information.</td>
</tr>
<tr>
<td><strong>If there are ESCs for multiple programs, is the assigned surveyor expected to review ESCs for all programs?</strong></td>
<td>• Click on the ESC selection to display a list of submissions from the organization. This list is cumulative over time, so you may need to scroll down to find the organization submission that is related to your current assignment. Click on the applicable date to display the ESC. <strong>Note:</strong> Call the Account Executive if you are uncertain which of the previous survey events is related to the Onsite ESC that you are performing.</td>
</tr>
</tbody>
</table>

No. Surveyor assignment to an Onsite ESC or PDA-ESC survey event is based on the program that needs the onsite validation. Surveyors will not evaluate ESCs for other programs.

Is there a minimum number of records that must be reviewed during any Onsite ESC survey?
There is no defined number of records to review during the Onsite ESC or PDA-ESC survey.

What if there are no patients available to trace at the time of the Onsite ESC or PDA-ESC survey?
Contact the Field Director on call for further guidance.

How far back should the surveyor look to confirm current compliance?
Refer to the ESC report to determine the implementation date of the organization’s corrections and use this as your guide.

3. Plan your strategy to evaluate the organization's current compliance with the EPs addressed in the ESC. **You are surveying standards compliance first.** The quality and effectiveness of the ESC corrective action plan should be revealed through evaluating standards compliance.

4. **Do not contact the organization.** This is an unannounced event.

5. Determine if ESC implementation can be verified by performing the survey at the organization’s main site. If the Requirement for Improvement (RFI) resulted from observations and performance at other organization sites, plan out several approaches for how you can verify ESC implementation using distance evaluation methods such as remote tracer activities. Call your Field Director for additional guidance and planning assistance as needed.
   - If sites are only a short distance from the main site, plan to travel to one or two sites. **Exception: The Laboratory surveyor must visit all sites relevant to the RFI.**
   - If sites are a significant distance from the main site, consider using other evaluation options that the organization may be able to facilitate, such as: Accessing records of care for all sites via computer from the main site, remote sites use of email or fax to send a patient schedule for the day, reviewing universal policies and procedures and interviewing staff about implementation at remote sites, remote sites faxing or emailing documentation to the main site, site staff availability for phone interviews, sites arranging for patient phone interviews).
   - Prepare to review these approaches with the organization upon your arrival and reach agreement on the best options.

6. Identify survey activities that will provide you with access to organization staff and documentation that will allow you to evaluate current compliance with each EP identified as being corrected in the ESC report. For example,
   - Issues with orders, patient care or medical record content should be addressed through tracer activity. Conduct a number of tracers to evaluate current compliance.
   - Issues related to medication management should prompt the selection of a patient to trace that allows the best view possible of medication processes addressed in the ESC.
   - Issues related to collecting data would prompt evaluating the implementation of the process described in its ESC to facilitate this data collection (e.g., view the collection instrument, plans to administer the instrument, results desired, follow-up plan when results are not achieved, etc.). Reviewing the collected data is not required. Perhaps a 30-minute Data Management System Tracer with a targeted group of organization staff would reveal current compliance.
   - Environment of care issues could require touring various building areas, so scheduling time for a Building Tour with appropriate staff is recommended.
   - If the organization underwent a focused Medicare Deficiency survey to validate resolution of a Condition Level Deficiency (CLD) you will review the EP’s associated with the CLD again to assure sustained compliance

7. The following guidance is offered regarding template agendas for Onsite ESC and PDA-ESC surveys
Accreditation surveyors will select a one-day template agenda through survey technology and edit to reflect the activities you believe will help reveal the organization's ESC implementation.

Surveyors should be prepared to discuss the agenda with the organization at the Opening Conference and make adjustments to activities and timing as needed.

**Conducting the survey**

1. Arrive at the organization approximately 10 minutes prior to the designated start time. **Note:** Most surveys begin at 8 AM unless the organization opens at a later time as identified in the organization’s e-application data.

2. Report to the reception area, security officer, information desk or administrative office upon arrival and introduce yourself and the purpose of your visit.

3. Display and show the organization’s representative your Joint Commission identification badge.

4. Ask the staff person, first encountered, to contact the administrative office or an organization leader to let them know of your arrival. You may be asked to wait in the lobby or in a different location.

5. Direct the survey coordinator or administrative contact to access the Joint Commission’s web page at [www.jointcommission.org](http://www.jointcommission.org). Once there, select the “Click here to access The Joint Commission Connect.” They will need the user ID and password to sign-on. Ask them to view the following information
   a. Notification of scheduled Joint Commission event
   b. Surveyor picture and biographical sketch

6. Ask to meet with the CEO or senior leader, and other staff at their discretion, for a brief opening conference.

7. Provide the organization with a list of any documents that you want to review during the survey so that representatives have time, as necessary, to gather them. Remind the organization that you prefer to review the materials that are in everyday use.

8. Provide the organization with the draft agenda template and determine if any adjustments are needed to the activity timing.

9. Review with the organization the distance evaluation method/remote tracer activity you are planning to use to verify ESC implementation and current standards compliance for those instances where the RFI was based on observations and performance at other organization sites. If none of these approaches will work, call the Field Director on Call for direction.

10. Evaluate the organization's current compliance with the elements of performance addressed in the ESC. Discuss with the organization what the data revealed about their performance. **Evaluating compliance with other standards and EPs beyond those addressed by the ESC identified as the focus for the follow-up event is out of scope for this survey type.** If other standards non-compliance is identified, call the Field Director on call for further guidance.

- If the organization still has not achieved compliance or is struggling to sustain compliance, you should consider the corrective action details (who, what, when, how) and/or the measure selected to monitor performance. You may be able to help the organization identify where the actions were ineffective or help them understand why selected measures are not accurately reflecting performance.
11. If the review of current compliance on the identified ESC is completed any time before the noted departure time on the agenda, surveyors should provide coaching and mentoring to the organization on sustaining and improving performance in those areas addressed in the ESCs. Surveyors should offer assistance to the organization relative to compliance with other standards where performance is a concern. If the organization does not need or want to take advantage of this assistance, proceed to concluding the visit. **If the departure time is adjusted greater than one hour before or after the noted agenda departure time, the surveyor should contact the program Field Director or the Field Director On-Call.**

12. At the conclusion of the survey, prepare a report using survey technology. Note: If you document observations during the On Site ESC survey that lead to an RFI at the same standard: you are required to:

   a. Hover on the Standard tab to see the drop-down menu. Select “Manual Rules”

   b. Click on “ESC02.” Document the location of unresolved RFIs.  

   Note: The PDA–ESC survey, with or without findings, does not require the selection of a manual rule. All PDA–ESC reports will stop in Central Office for SIG review and SIG will recommend follow up survey activity as required.

13. Enter a note in CO Comments in WST that provides a brief overview of what was looked at and any information that would be helpful to paint a picture of this organization. The note needs to reflect an affirmative observation of each Standard/EP related to the PDA-ESC survey.

14. Lock and publish a report for the organization. Ask the organization contact to access the Joint Commission Connect extranet site to locate and print the report.

15. At the conclusion of the survey, review the report as part of the exit conference. Explain that if the organization has any follow-up questions they should contact their Account Executive.

**Post-Survey**

Submit the report to Central Office following existing survey technology procedures.
Appendix Q – Extension Surveys

Applies to: All accreditation programs.

Duration
Per itinerary; one day in most cases.

Unannounced Format

Participants
All surveyors on site.

Organization: Survey Coordinator, Senior leadership

Reasons for Extension Surveys
An extension survey is conducted at an accredited organization or at a site that is owned and operated by the organization if the accredited organization’s current accreditation is not due to expire for at least nine months and when at least one of the following conditions is met:
- Changed ownership and has a significant number of changes in the management and clinical staff or operating policies and procedures
- Offered services at a new location or in a significantly altered physical plant
- Expanded its capacity to provide services by 50% or more, as measured by patient volume, pieces of equipment, or other relevant measures
- Provided a more intensive level of service

Extension Survey Agenda
The day begins with 30 minutes for Arrival and Preliminary Planning followed by 30 minutes for an Opening and Orientation. The remainder of the day is spent on individual tracer activity. During individual tracer activity consider the following as applicable to the reason for the extension survey:
- Life Safety Code,
- Environment of Care,
- Emergency Management,
- Staff Competency,
- Infection Control,
- Medication Management, and
- National Patient Safety Goals.

Pre-Survey Activity
1. Review Central Office correspondence on the surveyor portal through the itinerary to identify the reason for an extension survey. Check notes to identify the site name and address for arrival as this may be different from the main site.
2. Review the e-app for information about the HCO, travel directions, hotel accommodations and other logistical information.
3. Speak with the Accreditation and Certification Operations account executive for additional details about the extension survey.
4. If this is an extension survey for expanded capacity of existing services, review the previous accreditation report.
5. If this is an extension survey due to change in ownership, check the internet for information about the previous and new owner to identify any transition challenges.

Onsite Process and Survey Conclusion
1. It is recommended that surveyors arrive no earlier than 10-minutes before the intended start time for an unannounced survey.
2. If the survey includes multiple surveyors, surveyors should enter the organization together.
3. All surveyors will report to the reception area, security officer, information desk or administrative office upon arrival and indicate your name and purpose for your visit.
4. Display your Joint Commission identification badges.
5. Have the organization’s survey coordinator name and phone number from the e-app available to give to the staff person greeting you.
6. If the organization’s survey coordinator is unavailable, ask the staff person to contact the administrative office or an organization leader to let them know of your arrival.
7. Direct the survey coordinator or administrative contact to access their Joint Commission Connect extranet site. They will need the user ID and password to sign-on. The morning of your arrival, the HCO’s extranet site will have the following information available:
   a. Notification of scheduled Joint Commission event authorizing your presence
   b. Surveyor picture and biographical sketch
   c. Extension survey agenda template, and
8. Allow the organization an opportunity to access the information on their extranet site.
9. Ask the organization to print the extension survey agenda from their extranet site.
10. Once the organization verifies the authorization ask if they have a space where you can get settled while they begin to gather needed information as well as people to participate in the first activities of the day.
The day ends with time for issue resolution, report preparation and an Exit Conference.

Surveyors can change individual tracer time to other available survey activities. For example: A Life Safety Code building tour might be appropriate if the organization has added a new building and still has outstanding citations with local inspectors; or if the surveyor notices potential environment issues while conducting individual tracer activity.

What's a Surveyor To Do If...

Q: The extension survey cannot be completed in the scheduled time?
A: Discuss with the HCO at the outset that the day may go beyond the agenda end time. Provide the HCO with updates as the day progresses and you begin to determine if you will need additional time.

Q: The extension survey cannot be completed in a day?
A: Call the Field Director On-Call for instructions.

Q: The reason for the extension survey does not exist when the surveyor arrives on site?
A: Call the Account Executive and your Field Director or the Field Director On-Call for instructions.

11. If the organization is requiring extra time to gather some of the initial planning information and people for the first activities, ask to begin with an individual tracer and reschedule the Planning and Opening for later in the morning.

12. Select tracers based on the reason for the extension survey. For example, select individuals accessing the new program or service, or trace an individual receiving care and services in the area with expanded capacity, trace two individuals—one receiving care and services under previous owner and another experiencing care and services under the new owner.

13. If this extension survey is due to new owner (merger, acquisition), ask to speak with members of the transition team if one was established.

14. If the extension survey is due to a new program or service or expanded volume or new location, inquire about the data that drove the decisions and ask to speak with the planning team if one was established.

15. Determine if there are any issues that require follow-up or closure and use the issue resolution time for this purpose.

16. At the conclusion of the survey prepare a report using WST.

17. Lock and publish a report for the organization. Ask the organization contact to access the Joint Commission Connect extranet site to locate and print the report.

18. At the conclusion of the survey, review the report as part of the exit conference. Explain that follow-up questions should be directed to the organization's Account Executive.

Post-Survey

Transmit the report to Central Office following existing survey technology procedures.
Appendix R – Early Survey Policy – Survey Event Guide
Applies to: All accreditation programs

Duration
Per itinerary
Varies by program

Participants
One or more Joint Commission surveyors

Organization: Survey coordinator, senior leadership, staff throughout the organization, licensed independent practitioners

This is an unannounced survey event.

Why would an organization request this type of survey?
The two most common reasons organizations seek this type of survey include:

- The state requires evaluation by an approved accrediting body in order to issue a license to the organization.
- The organization holds no accreditation or had accreditation through a Joint Commission competitor or state certification, and prefers an incremental survey approach to ease the transition to compliance with new standards.

Note: A Limited, Temporary Accreditation decision is not recognized by CMS for Medicare certification purposes.

Early Survey Policy Eligibility
The Early Survey Policy is available to any organization currently NOT accredited, with the exception of an organization that has been denied accreditation.

Account Executives have checked that organizations meet the following eligibility criteria.

- The organization is licensed, provisionally licensed, or is engaged in the licensing process as required by law and regulation.
- The building in which the organization will offer services or from which services will be coordinated is identified, constructed, and equipped to support services.
- The organization has identified a CEO or administrator, a director of clinical or medical services and a nurse executive, if applicable.
- The organization has identified the date it will begin operations.

The surveyor will confirm aspects of the criteria throughout the course of the survey.

Overview of Event

- This survey uses a designated limited set of standards (See appendix in the accreditation manual.)
- Web-based Survey Technology will only present surveyors with the subset of standards that applies to this type of survey.
- During this survey event, surveyors assess the organization’s:
  - Physical facilities, as required for care provision or care coordination
  - Policies and procedures (for example, assessment and reassessment, staff orientation and education), plans (for example, infection control, emergency management, environment of care, performance improvement
  - Organizations are not required to collect or analyze data at the time of the Early survey
  - Organizational structures (for example, leadership team, mission, budget, human resources, information management)
- Limited, Temporary Accreditation is granted to organizations that demonstrate satisfactory compliance with the limited set of standards as determined by the onsite survey and submission of timely and acceptable Evidence of Standards Compliance (ESC) post survey for any Requirement for Improvement (RFI).
An initial, full accreditation survey must occur within six months of the successful achievement of Limited, Temporary Accreditation.

Procedures

Before

• Access the HCO information in the usual manner through the surveyor itinerary on the Surveyor Portal.

• Scroll through the surveyor assignments to find the Early Survey Policy (ESP) event. Select the event by clicking on the Event ID.

• Surveyors use Web-based Survey Technology (WST) to access all available TJC information related to the organization through the Quick Links option. Click on the Quick Links button in the lower right corner of the screen to view the menu of available information.

• Surveyors should review the subset of standards that applies to this type of survey to prepare for the event. This will assist surveyors in planning the agenda for the onsite visit.

• Surveyors will select a template agenda that is appropriate for the event through WST and edit accordingly.

• The survey agenda will include:
  ▪ Opening Conference and Orientation to Organization
  ▪ Surveyor Planning Session
  ▪ Life Safety Code Building Tour (HAP and CAH only)
  ▪ System Tracer – Data Management that includes review of Infection Control and Medication Management structures and processes – data collection and analysis is not required
  ▪ Competence Assessment processes
  ▪ Credentialing and Privileging structure and processes, as applicable
  ▪ Environment of Care and Emergency Management
  ▪ Report Preparation
  ▪ Exit Conference

• NOTE: No individual tracer activity takes place on this survey, even if the organization is already engaged in patient care.

During

1. Arrive at the organization approximately 10 minutes prior to the designated start time. Note: Most surveys begin at 8 AM unless the organization opens later as identified in the organization’s e-application data.

2. Report to the reception area, security officer, information desk or administrative office upon arrival. Surveyors should provide their name(s), and explain the purpose of the visit.
3. Each surveyor should display and show the organization’s representative their Joint Commission identification badge.

4. Ask the staff person first encountered to contact the administrative office or an organization leader to indicate that Joint Commission surveyors are onsite, unless someone is already waiting.

5. Direct the survey coordinator or administrative contact to access the Joint Commission’s web page at www.jointcommission.org. Once there, select the “Click here to access The Joint Commission Connect”. They will need the user ID and password to sign-on. Ask them to view the following information
   a. Notification of scheduled Joint Commission event
   b. Surveyor picture and biography

6. Ask to meet with the CEO or senior leader for a brief opening conference.

7. Begin the survey with the Opening Conference
   - Provide the organization with the list of documents that need to be available for review during the survey so that representatives have time, as necessary, to gather them. Remind the organization that you will review documentation wherever it is most convenient.
   - Provide the organization with the draft agenda and determine if any adjustments are needed to activity timing; make revisions as necessary.
   - Verify the date the organization plans to begin provision of care, treatment and services, or will be ready for a full, initial accreditation survey.
   - Explain that on-site activity focuses on evaluating the structures and processes that the organization has put in place to support the provision of care, treatment and services. **Note: Data collection and analysis is not required for this survey.**
   - **Activities are conducted similar to how they would be on a full survey, however, with no individual tracers.**
   - Learning about organization structures, plans, policies and procedures will be accomplished through interview and document review. This will be as interactive as possible, with organization representatives guiding surveyors to content and providing explanation for the planned implementation.
   - Surveyors will interact with staff and focus on the design and knowledge of policies and procedures expected to support day-to-day operations.
   - Evaluating readiness of the physical facilities to support operations is a critical component of this survey. The Life Safety Code building tour and the Environment of Care activities will focus on organization preparations to provide safe and secure facilities for staff to deliver care, treatment and services.
   - Indicate that any discovery of non-compliance with standards outside the sub-set will serve as an educational opportunity.
8. Continue to implement the agenda as planned with the organization. Surveyors should refer to and follow the detailed guidance for each activity found in the SAG.

Note: Report any potential immediate threat to health or safety as early as possible to the Field Director on call.

9. Surveyors prepare a report using WST. Reminder: Only a subset of standards is applicable on this survey and WST will only present these standards for scoring and observation entry.

10. Surveyors will lock and publish a report for the organization and ask the organization contact to access the Joint Commission Connect extranet site to locate and print the report.

11. Surveyors review the report with the organization at the exit conference and note that RFIs will require a 60-day ESC submission.

12. Remind the organization that they need to be ready for the full, initial survey within six (6) months.

13. Instruct the organization to direct any follow-up questions to the Account Executive.

After
Surveyors transmit the report to Central Office following existing WST procedures.
## Early Survey Policy Survey
### Sample Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:30 a.m.</td>
<td>Surveyor Arrival and Preliminary Planning Session</td>
</tr>
<tr>
<td>8:30 – 9:00 a.m.</td>
<td>Opening Conference and Orientation to Organization</td>
</tr>
<tr>
<td>9:00 – 9:30 a.m.</td>
<td>Life Safety Code® Building Assessment</td>
</tr>
<tr>
<td>9:30 – 10:00 a.m.</td>
<td>Individual Based System Tracer – Data Use</td>
</tr>
<tr>
<td>10:00 – 10:30 a.m.</td>
<td>Individual Based System Tracer – Infection Control</td>
</tr>
<tr>
<td>10:30 – 11:00 a.m.</td>
<td>Individual Based System Tracer – Infection Control</td>
</tr>
<tr>
<td>11:00 – 11:15 a.m.</td>
<td>Surveyor Lunch</td>
</tr>
<tr>
<td>11:15 – 11:45 a.m.</td>
<td>Individual Based System Tracer – Infection Control</td>
</tr>
<tr>
<td>11:45 – 12:00 p.m.</td>
<td>Individual Based System Tracer – Medication Management</td>
</tr>
<tr>
<td>12:00 – 12:30 p.m.</td>
<td>Surveyor Lunch</td>
</tr>
<tr>
<td>12:30 – 1:00 p.m.</td>
<td>Individual Based System Tracer - Medication Management</td>
</tr>
<tr>
<td>1:00 – 1:30 p.m.</td>
<td>Credentialing and Privileging and/or Competence Assessment Process</td>
</tr>
<tr>
<td>1:30 – 2:00 p.m.</td>
<td>Surveyor Report Preparation</td>
</tr>
<tr>
<td>2:00 – 2:30 p.m.</td>
<td>CEO Exit Briefing and Organization Exit Conference</td>
</tr>
<tr>
<td>2:30 – 3:00 p.m.</td>
<td></td>
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<tr>
<td>3:00 – 3:30 p.m.</td>
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<tr>
<td>3:30 – 4:00 p.m.</td>
<td></td>
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<tr>
<td>4:00 – 4:30 p.m.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix S – Intracycle Monitoring (ICM) Option 2 & 3 Surveys & Focused Standards Assessment (FSA) Tool

Applies to: All accreditation programs that are subject to the Focused Standards Assessment, except Office-Based Surgery.

<table>
<thead>
<tr>
<th>Duration</th>
<th>Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>Joint Commission: All surveyors on-site Organization: Per activity guides</td>
</tr>
</tbody>
</table>

**ICM Option 2 Description**
- Organization undergoes an on-site ICM survey. Survey length is determined by the organization and there is a fee to cover survey costs. Surveyors review and respond to HCO-identified risk areas and General topics for Discussion identified in the ICM Profile submission. **Organization receives a written report of survey activities.**
- Organization develops Plan of Action and measures of success, as applicable, to address areas of non-compliance found during on-site survey. Joint Commission works with organization to refine its Plan of Action and measures of success via an optional scheduled phone conference with Standards Interpretation Group.

**ICM Option 3 Description**
- The organization undergoes an on-site ICM survey. The survey length is determined by the organization and there is a fee to cover survey costs. Surveyors review and respond to HCO-identified risk areas and General topics for Discussion identified in the ICM Profile submission. **No written documentation or written report of the survey is provided to the organization.**
- Findings are verbally conveyed. This eliminates the availability of a survey report for possible discovery from the organization, and permits the organization, as in Option 1, to control the language and documentation of the assessment activity.

**Other information**
As organizations complete their Intracycle Monitoring (ICM) Profile, they tailor their ICM Option 2 or Option 3 visit to meet their needs by determining:

**Pre-Onsite Activity**
1. Access your itinerary and then HCO information
2. Click on the Quick Links button
3. View ICM Profile data in advance of the survey
4. Use the e-app and Survey Process Rules for Surveyor Planning as well as ICM Profile data to organize the on-site visit (Note: An ICM Profile Review Form is available on the Surveyor Portal Document Library, in the ICM folder)
5. If conducting the survey with a team, communicate with other surveyors

**Reminder:** For multiple surveyor events, the ICM Profile/FSA Tool is accomplished at an organization level; the last surveyor on-site submits the acknowledgement of completion of the ICM event. Surveyors departing before the last scheduled date of the event should enter their findings and comments into the ICM Profile/FSA Tool, but should not submit.

**Onsite Survey Process**

**Opening Conference and Orientation**
1. Remind the organization that you will evaluate compliance with as many standards as possible (with an emphasis on the risk-focused standards), but it is not likely that you will touch on 100% due to the reduced onsite time.
2. Remind the organization that they are responsible for compliance with all the standards.
3. Advise the organization that they need to continue to explore their own compliance with standards.
4. Remind the organization you will be following the Survey Activity Guides in conducting all onsite activities. IMPORTANT REMINDER—the organization only sees a template for a single day of survey which indicates that this agenda will be repeated each day of the on-site visit. You must review with the organization the plans for all additional survey days once these are established.
5. Depending on the option the organization has selected, advise them of what they can expect at the conclusion of the survey, and when that is expected to occur.

**ICM Template Agenda**
ICM Option 2 & 3 surveys are educational in nature. The agenda is intentionally generic so that you may focus attention on the needs of the organization based on the ICM Profile, rather than on all activities. Remind the organization you will be following the Survey Activity Guides in conducting all onsite activities. The agenda template, which can be found under the FSA tab of the ICM Profile, includes the core activities of the first and last days of survey:
1. 1-hour Opening Conference and Orientation session, including a review of the ICM Profile
2. 1-hour Surveyor planning session
3. 4.5-hours of Individual Tracer Activity
4. 30-minute lunch
5. 1-hour Surveyor Report Preparation
6. 1-hour CEO Exit Briefing and Organization Exit Conference
- Which accreditation programs will participate?
- How many surveyors will participate?
- How long the surveyors will be on-site?

Surveyors should not expect to do the same scope and depth of evaluation on an ICM Option 2 or Option 3 survey that they would on a full survey.

Only cross-trained surveyors are scheduled to conduct ICM touch point surveys in organizations with multiple programs. If more than one surveyor is scheduled, the team will cover all the programs that need to be addressed in the ICM on-site event.

The template agenda is used for any length of survey or with any number of surveyors. When multiple surveyors are on-site, activities must be coordinated and should address all programs being covered by the ICM.

**Web-based Survey Tech FSA Instructions**

1. Access your itinerary and then select appropriate event ID
2. Click on Quick Links button
3. Select ICM Option 2 or 3 Survey from the list of links
4. Enter your login/password
5. On the HCO’s Intracycle Monitoring Profile Dashboard page, in the center column, click the orange ‘Go to History’ button.
6. The ICM History page displays; select the appropriate historical ICM submission (GEN or LAB). The ICM Accreditation Status page displays. From the horizontal menu bar at the top click the **Focused Standards Assessment (FSA)** tab.
7. The ICM Focused Standards Assessment page displays. Click on **Access the focused Standards Assessment Tool** option.
8. The FSA History Page displays. Under the Historical Submissions section, Option Submitted column, click on the View button next to the appropriate FSA Event.
9. The FSA tool opens and displays the Standards/EPs tab.

On multi-day surveys, activities 5 and 6 occur on the last day of survey.

On multi-day surveys, each day between the first and last includes:
1. 30-minute Daily Briefing
2. 7-hours of Individual Tracer Activity
3. 30-minute lunch
4. 30-minute Surveyor Team/Planning Meeting

**You have the option to convert individual tracer activity time into any of the other sessions that are available in the survey activity guide.** Duration of onsite activities should not exceed the time typically allotted on a regular survey agenda.

For example, you note that two of the risk areas for the organization are assessment and infection control. You can take a block of individual tracer activity time and convert it to a 60-minute Infection Control System Tracer and a 60-minute assessments focused tracer in order to explore these topics in more depth. Thus, your agenda for a 3-day survey may look something like the following:

**Day 1**
1. 1-hour Opening Conference and Orientation session, including a review of the ICM Profile
2. 1-hour Surveyor planning session
3. 5.5-hours of Individual Tracer Activity
4. 30-minute lunch
5. 30-minute Surveyor Team/Planning Meeting

**Day 2**
1. 30-minute Daily Briefing
2. 3.5-hours Individual Tracer Activity
3. 30-minute lunch
4. 1-hour Infection Control System Tracer
5. 1.5-hour Individual Tracer Activity
6. 1-hour Assessment Focused Tracer Activity
7. 30-minute Surveyor Team/Planning Meeting

**Day 3**
1. 1-hour Leadership Session
2. 2-hours Individual Tracer Activity
3. 1-hour Data Use System Tracer
4. 30-minute lunch
5. 1.5-hour Environment of Care Session
6. 1.5-hour Surveyor Report Preparation
7. 1-hour CEO Exit Briefing and Organization Exit Conference

You must coordinate the agenda changes with the organization to identify the day and time for the sessions so that appropriate staff can be available for these discussions.

**The last day of an ICM Option 2 survey, you will:**
1. Designate 1-1.5 hours to enter findings into the extranet-based FSA Tool, as well as to confirm your response to any noted ICM Profile risk area or Topics for Discussion. **NOTE:** You must be connected to the internet in order to access the ICM Profile and FSA Tool, enter data, print reports and submit findings.
2. Designate 1-hour for the CEO and Organization Exit Conference.
10. In the left navigation column, select the desired Program, View and Chapter.

11. Click Show Standard Detail to expand the view for a standard for which you have a finding.

12. Change the score of the desired EP from Sufficient to either Partial or Insufficient.

13. Enter your finding statement

14. Click Save button to save entered data

15. When finished scoring standards, click on Scoring Summary tab and review. Select the Program name in the left navigation column to display the summary detail.

16. For ICM Option 2 Surveys ONLY: To print a report of your findings for use during the exit conference,
   
   A. Exit the completed FSA tool—the screen will return to the historical ICM Profile.

   B. Select the ICM Profile’s Submission tab—click the SUBMIT button. This will lock the FSA tool and change your access to read-only. In real-time, the historical ICM Profile becomes active again on the organization’s extranet site.

   C. Exit the ICM Profile.

   D. Ask the organization contact to access the appropriate historical FSA tool; on the Reports tab of the tool they should print copies of the Organization-level Not Compliant Standards report for use during the exit conference. (You may also refer the contact to the lower center tile of the ICM Dashboard for these instructions—“After an ICM Option 2 Survey.”

The last day of an ICM Option 3 survey, you will:
1. Designate 1-1.5 hours to organize a summary of survey findings. If you have used the FSA Tool to document findings for your own review, any entries made in the FSA Tool will be deleted when you submit the acknowledgement of exit conference completion.

2. Present a verbal report of findings; no report is left with the organization. The organization will NOT be able to see your findings on their Joint Commission Connect extranet site.
Appendix T – Focused Evaluation Screening Tool & Activities

Topic Area: Cleaning, Disinfection, and Sterilization    Program: HAP

Part I: Focused Evaluation Screening Checklist

Verify the organization performs cleaning, disinfection, and sterilization of medical equipment, devices, and supplies.

Observations should be noted in the record review or tracer screen as appropriate and scored at the appropriate standard/EP as needed.

Locations where cleaning, disinfection, and sterilization are performed
    Centralized location
    Decentralized locations (________________________________________________________________________)

If decentralized, verify:
    _____ Oversight of cleaning, disinfection, and sterilization
    _____ A process is in place to ensure the cleaning, disinfection, and sterilization are performed in a consistent manner throughout the organization
    _____ A process is in place for oversight of purchasing equipment and supplies for cleaning, disinfection, and sterilization
    _____ Confirm staff orientation and ongoing education related to work processes and task associated with cleaning, disinfection, and sterilization
    _____ During the patient tracer to the operating rooms or where procedures such as endoscopies or bronchoscopies are performed, review and observe how clean and dirty items are transported to and from cleaning areas
    _____ Observe how clean and dirty items are stored
    _____ Observe appropriate use of personal protective equipment by staff during work tasks
    _____ Interview staff about availability and accessibility of manufacturer guidelines
    _____ Interview staff about routine quality checks being performed
    _____ Interview staff about processes to handle equipment failures

PART II: If the severity and or frequency of issues identified through the Focused Evaluation Screening Checklist drives the need for further exploration, continue with the evaluation activities which may include:

- Additional patient tracer activity to all locations where cleaning, disinfection, and sterilization are performed
- Additional HR file review
- Interview additional staff that perform cleaning, disinfection, and sterilization
- Verify education, orientation and competency process for staff who perform cleaning, disinfection, and sterilization
WST - Check off Focused Evaluation for Cleaning, Disinfection, and Sterilization if screening drives the need for further exploration. Observations should be noted in the record review or tracer screen as appropriate and scored at the appropriate standard/EP as needed.

NOTES: (optional)
Appendix U – Evaluating Cleaning, Disinfection, High-level Disinfection and Sterilization Processes

Applies to: Ambulatory Health Care, Critical Access Hospitals, Laboratories, Nursing Care Centers, and Office-Based Surgery Accreditation Programs, and any sites or services where these tasks are performed.

Surveyor Tips & Tools

**The CDC’s Definition of High-Level Disinfection:** High-level disinfection traditionally is defined as complete elimination of all microorganisms in or on an instrument, except for small numbers of bacterial spores. The FDA definition of high-level disinfection is a sterilant used for a shorter contact time to achieve a 6-log10 kill of an appropriate *Mycobacterium* species. Cleaning followed by high-level disinfection should eliminate enough pathogens to prevent transmission of infection.

**Objectives**
1. Assess and determine the degree of compliance with established guidelines and standards and elements of performance relating to infection control, and cleaning, disinfection, high-level disinfection and sterilization of medical equipment, devices, and supplies.
2. Increase organization’s awareness of any identified risks relating to cleaning, disinfection, high-level disinfection and sterilization of medical equipment, devices, and supplies.

The evaluation of these processes is to be incorporated into the following existing survey activity sessions:

- Orientation to the Organization
- Individual Patient Tracer
- Environment of Care
- Infection Control System Tracer
- HR/ Competence Assessment

**Process**
It is important initially to gather information about the organization’s processes related to cleaning, disinfection, high-level disinfection and sterilization of medical equipment, devices, and supplies. This initial screening will help with the selection of tracers and decisions about which areas or departments to go to during patient tracer activity.

**Initial Screening:**
During Orientation to the Organization explore:

- Whether the organization implements its infection prevention and control plan, including surveillance, to minimize, reduce or eliminate the risk of infection as per IC.02.01.01, EP 1?
- Where cleaning, disinfection, and sterilization activities are performed in the organization.
- Are they performed in a centralized location, or is the process de-centralized, and performed in more than one location throughout the organization?
- Do they perform endoscopy and/or duodenoscopy?
- In what settings are endoscopy and/or duodenoscopy performed? Does the organization adhere to manufacturer’s recommendations for use of endoscopy and/or duodenoscopy?
- Do they conduct procedures that utilize probes (vaginal probes, TEE probes)?
2. Review applicable equipment maintenance and QC logs
3. Review HR files for staff qualifications, content addressed in staff orientation and evidence of on-going training

Resources:
- AAMI - Association for the Advancement of Medical Instrumentation
- CDC - Centers for Disease Control and Prevention: Healthcare Infection Control Practices Advisory Committee (HICPAC).
- Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 [link]
- CDC Interim Duodenoscope Surveillance Protocol [link]
- FDA - Duodenoscopy [link]
- Multisociety Guideline: [link]
- AORN - The Association of periOperative Registered Nurses [link]
- SGNA - The Society of Gastroenterology Nurses and Associates [link]

- Is there competent, trained oversight of cleaning, disinfection, high-level disinfection and sterilization processes, particularly if they are de-centralized?
- How does the organization ensure that cleaning, disinfection, high-level disinfection and sterilization are performed throughout their organization in a consistent and effective manner?
- What oversight is there over purchasing of equipment and supplies related to these processes?
- Does the cleaning process for endoscopy and/or duodenoscopy meet CMS' specifications and other evidence based guidelines (see sidebar)?

Topics to be routinely evaluated during patient tracer activity:
- Staff orientation and on-going education relative to cleaning, disinfection, high-level disinfection and sterilization work tasks
- How clean or dirty items are transported to and from procedural and processing areas
- How are clean and/or dirty items stored?
- Use of personal protective equipment during work tasks
- Are manufacturer guidelines readily available to staff?
- What routine quality monitoring checks are performed (to include chemicals used and associated test strips)?
- How are quality monitoring failures handled?
- How are equipment failures handled?
- During patient tracer(s) conduct direct observation of cleaning, disinfection, high-level disinfection and sterilization processes
- Observe staff and engage them in discussion on cleaning, disinfection, high-level disinfection and sterilization processes observed
- The surveyor(s) will go to additional locations in the organization where cleaning, disinfection, high-level disinfection and sterilization is performed, as needed to trace issues related to these processes.

Observations and responses to these questions can help to inform the surveyor(s) as to additional areas to explore and can identify issues that may warrant a more in-depth evaluation of processes.

Issues that may indicate the need to conduct a more in-depth evaluation of cleaning, disinfection, and sterilization processes include:
- Lack of standardized processes for cleaning the same types of equipment
- Lack of oversight of cleaning, disinfection, high-level disinfection and sterilization processes.
- Lack of a process to document or follow-up on equipment failures
- Lack of a process to identify and document quality monitoring failures
- Missing or incomplete documentation quality monitoring failures
- Lack or inconsistent staff orientation or on-going training on cleaning, disinfection, high-level disinfection and sterilization processes including training related to endoscopy and/or duodenoscopy
- No oversight of purchasing of equipment and/or supplies used to perform cleaning, disinfection, high-level disinfection and sterilization.
- Inconsistent quality checking procedures
Applicable Standards/EPs include:

- IC .02.02.01 EP 1, 2, & 4
- IC .01.05.01 EP 1
- EC .02.04.01 EPs 1-6
- EC .02.04.03 EPs 1 & 4
- HR .01.02.01 EP 1
- HR .01.04.01 EP 1-4
- HR .01.05.03 EPs 1 & 4
- LD .04.01.07 EP 1 & 2
- EC .02.05.01 EP 15
- LD .04.01.05 EPs 3, 4
- LD .04.01.11 EP 5

Related Systems
- Infection Control
- Environment of Care
- Leadership
- Human Resources

- Use of contracted staff to perform cleaning, disinfection, high-level disinfection and sterilization tasks
- New and/or infrequently utilized cleaning, disinfection, high-level disinfection and sterilization equipment
- Manufacturers instructions for use not available to staff
- Evidence-based guidelines not available to staff
- Policies not based on national recognized guidelines, such as AAMI, CDC, SGNA, ASGE, or AORN

To perform a more in-depth evaluation of cleaning, disinfection, and sterilization processes:

- Conduct additional patient tracers to areas in the organization where cleaning, disinfection, high-level disinfection and sterilization processes are performed
- During patient tracer(s) follow dirty / used equipment after procedure(s) to evaluate the processes from point-of-use that includes pre-cleaning, transport to decontamination through high-level disinfection or sterilization and storage
- Conduct additional staff interviews, inquire about their orientation and training - is there consistency?
- Conduct additional staff interviews, inquire about their workflow and quality monitoring processes - are they standardized?
- HR File review - for evidence of staff training
- Interview those responsible for staff education - discuss the content of staff orientation and on-going training
- Policy and procedure review
- Review quality monitoring logs
- Review equipment maintenance logs
Appendix V – Evaluating Aspects of Health Information Management
Requirements

Applies to: Any of the sites or services where these systems are used in patient care, treatment or services.

The activities described in this optional tool are to be incorporated into patient tracer activity, orientation, leadership session, and system tracers. Use this guide to enhance your evaluation of an organization’s clinical information systems and the impact these systems have on health care practitioner ability to provide safe, quality, highly reliable patient care and treatment. This tool will provide guidance on how to incorporate a review of these complex and crucial systems within the context of a tracer-based survey approach.

Surveyor Tips & Tools

Organization
Suggested individuals to speak with during patient tracer activity include:

- Care, treatment, and services staff, health care professionals, administrative staff (schedulers, registration, billing) that collect, supply and use health information
- Organization leadership responsible for health information technology systems design, day-to-day computer support operations, and establishing and enforcing related policies and procedures
- Staff responsible for directing and overseeing security of and accessibility to patient health data and information
- Staff supporting those throughout the organization who work with computer applications that support care, treatment and services: Information management support staff, help desk technicians, network administrators, etc.
- Staff who program reports and fulfill requests for data from the organization’s databases: Information systems managers, business analysts, etc.
- Staff responsible for health records—monitoring accuracy, content quality, integrity, privacy, and use

Objectives

1. Assess and determine the degree of compliance with established guidelines and standards and elements of performance relating to health information management.
2. Increase organization’s awareness of any identified risks relating to the management of health information throughout the organization.
3. Identify activities the organization implements to help detect and address potential cyber emergencies that could impact care, treatment, or services.

Evaluation of information management processes is to be incorporated into the following existing survey activity sessions:

- Orientation to the Organization
- Individual Patient Tracers
- Data Management System Tracer
- Leadership
- Emergency Management
- Special Issue Resolution

Initial Screening:
During Orientation to the Organization explore:

- The format of health information systems – all electronic; all paper; or a combination of electronic and paper
- How well computer systems are integrated throughout the organization
- Medical equipment and devices that connect to the internet for installation, set-up, use, or maintenance
- How mobile devices and equipment are used remotely by staff or patients to access or transmit information on patient care, treatment, or services
- How long the existing state of systems has been in place
- Anticipated future state of systems and timeline for implementation

Topics for routine evaluation during patient tracer activity
Documentation
Review, as necessary, the following documentation required by the standards
- Plans for managing interruptions to the information process
- Policy addressing privacy of health information
- Policy on security of health information, including access, use, and disclosure
- Policy addressing protection of health information integrity (protection against loss, damage, unauthorized alteration, unintentional change, accidental destruction)
- Policy addressing intentional destruction of health information
- Policies addressing data capture, display, transmission, and retention

Applicable Standards include:
- EC.01.01.01, EP 1
- EM.01.01.01, EP 6
- EM.02.01.01, EP 4
- EM.02.02.01, EP 14
- EM.02.02.11, EP 2, 8
- IC.01.02.01, EP 1
- IM.01.01.01
- IM.01.01.03
- IM.02.01.01
- IM.02.01.03
- IM.02.02.01
- IM.02.02.03
- RC.01.02.01, EP 1, 5
- RC.01.01.01
- RC.01.03.01
- RC.01.04.01
- RI.01.01.01, EP 7

Related Systems
- Leadership
- Emergency Management
- Rights and Responsibilities of the Patient
- Record of Care, Treatment and Services
- Performance Improvement

- Staff and practitioners knowledge and ability to access data they need to provide patient care
- Orientation and training that staff and practitioners received on accessing data needed to provide patient care
- Availability of data to staff and practitioners—timeliness of entries, accuracy of entries, access to and timeliness of data from other systems (e.g., laboratory, radiology, pharmacy)
- Troublesome features of computer systems; "work-arounds" that staff and practitioners may employ to accomplish their tasks in a more efficient manner
- Features of computer systems that allow efficiency, but that can compromise data accuracy and integrity – clinical information systems not synchronized, posing risk that current version of clinical information cannot be viewed from all systems; "cutting and pasting" of data from one part of an electronic health record to another without determining it is the latest information or if it needs editing to reflect the current patient condition
- Procedures followed by staff and practitioners when help with automated systems is needed; responsiveness of the support system
- Procedures followed by staff and practitioners when automated systems are interrupted and patient health information is not available via routine sources and means
- Security and access permissions processes that staff and practitioners must follow, including password procedures
- Staff and practitioner processes for suggesting changes and improvements to current health information technology systems
- Staff and practitioner processes for requesting aggregate data for purposes of ongoing performance improvement

Observations and responses to these questions can help inform the surveyor(s) about additional areas to explore and can identify issues that may warrant a more in-depth evaluation of processes.

Issues that may indicate the need to conduct a more in-depth evaluation of information management include:
- Patient data and health information is not easily and readily accessible to staff and practitioners
- There is a pattern of staff and practitioner difficulty locating patient data and information
- Staff and practitioners report that patient health data and information is not available in time to influence patient care, treatment and services
- Staff and practitioner reports of discontent with the existing systems for contributing to and accessing patient health data and information
- Staff and practitioner reports of difficulty viewing the patient's episode of care in its entirety
- Health information technology and medical record policies not based on available, nationally recognized guidelines
- Observations and reports of health information privacy breaches
- Staff and practitioners do not have an awareness of hospital standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.
• Observations reveal concerns for the security and integrity of patient health information – such as inaccurate data resulting from access to health records from multiple systems that are not updated or refreshed simultaneously; or from “cutting and pasting” data from one area of a record into another without regard for selecting accurate content (such as the latest laboratory results)

• Staff and practitioners are unable to obtain data and information for performance improvement initiatives

To perform a more in-depth evaluation of information management systems and processes:

• Interview staff responsible for health information management or health records about the records maintenance systems and processes

• Visit the information systems department and interview staff that support the clinical end-users; ask if calls for assistance are being tracked and trended to identify problematic systems for end-users

• Interview those individuals responsible for staff orientation, training and ongoing education on use of the data and information systems in day-to-day patient care

• Ask to see results of patient health data and information audits for completeness and accuracy; ask if audits include reviewing and comparing contents of documentation that is available through multiple systems or for cutting and pasting from one area of a record (e.g., lab results) into another (e.g., progress notes); ask about actions taken to address undesirable audit results

• Ask to see logs or reports that track information systems (computer) down-time, scheduled and unscheduled

• Review policies and procedures for checking the integrity of data and information

• Review procedures related to protections from risks due to spam, phishing, weak passwords, viruses or malware in USBs, and potential points of intrusion such as the following:
  o Email
  o Phone calls
  o Internet/web sites
  o Wi-fi
  o Public access spaces (meeting rooms, waiting rooms, cafeteria)

• Review organization emergency management plans to determine if and how health information management is addressed in terms of:
  o Potential risks to care, treatment, or services from catastrophic cyber failures or threats
  o The organization’s capability to detect, respond to and recover from cyber emergencies that could impact care, treatment, or services.

• Review with leaders the organization’s approach to risk awareness, detection and response as it relates to cyber emergencies
Appendix W – Evaluating Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) Processes

Applies to: Critical Access Hospitals and Hospitals

The activities described are to be incorporated into existing survey tracer activities. Use this guide to enhance your evaluation of an organization’s processes related to developing and conducting OPPE and FPPE processes. This tool will provide guidance on how to conduct a thorough review of an organization’s OPPE and FPPE processes and to evaluate the topics addressed in the standards.

Surveyor Tips & Tools

Patient Tracer Selection
When selecting patients to trace consider including those who have undergone high risk/low volume procedures, high risk/high volume procedures, and procedures performed by contracted practitioners. Also consider including those who have undergone procedures performed by practitioners with new privileges.

Organization
Suggested individuals to speak with during patient tracer activity include:
- Organization leadership
- Individual(s) responsible for directing OPPE and FPPE processes
- Chief of Medical Staff
- Medical Director
- Medical Staff Coordinator

Documentation
1. Review written OPPE and FPPE processes
2. Specifically review the triggers and criteria/indicators included in these processes that would set the processes in motion
3. Review selected number of practitioners’ files

Resources
Joint Commission BoosterPak on OPPE and FPPE

Applicable Standards/EPs include:
MS.08.01.01
MS.08.01.03

Related Systems
- Human Resources
- Performance Improvement

Objectives
- Assess the organization’s OPPE and FPPE processes (this includes answering questions such as are the processes in place; are they written; are they correctly implemented; what is the medical staff’s involvement; what is the organization’s data collection process).
- Determine whether the OPPE process has criteria/indicators that are sensitive enough to detect those practitioners who have performance issues.
- Determine whether the organization uses department or specialty specific criteria/indicators as part of the OPPE process.
- Determine whether the FPPE process can actually identify performance issues once a practitioner has been identified by the OPPE criteria/indicators.
- Help the organization refine its OPPE and FPPE processes if it is determined that they are not sufficient to detect practitioners who have performance issues and to monitor practitioner performance on an ongoing basis.
- Determine whether practitioners with new privileges are consistently undergoing the FPPE process (this applies to both those practitioners who are new to the organization and those who are not new to the organization but who have new privileges).

The evaluation of these processes is to be incorporated into the following existing survey activities:
- Orientation to the Organization
- Surveyor Planning Session
- Individual Patient Tracers
- Special Issue Resolution
- Medical Staff Credentialing and Privileging

Orientation to the Organization
- It is important to let the organization know early in the survey that you will hold a discussion about OPPE and FPPE in the credentialing and privileging session.
- Tell the organization that you will expect to receive an overview of its OPPE and FPPE processes and that you will be examining these processes and how it is implemented.
Leadership

Surveyor Planning Session
- Request the organization’s written OPPE and FPPE processes for review during Special Issue Resolution prior to conducting the Medical Staff Credentialing and Privileging Session.
- Request files for five or six practitioners with differing specialties along with the most recent OPPE information on these individuals to be available during the Medical Staff Credentialing and Privileging Session.
- Request files of two or three practitioners new to the organization within the past year and then focus on how the organization’s FPPE process was or wasn’t applied to these individuals during the Medical Staff Credentialing and Privileging Session.
- Request files of two or three practitioners identified by the OPPE criteria/indicators and examine how the organization’s FPPE process was or wasn’t applied to these individuals during the Medical Staff Credentialing and Privileging Session.
- Request data the organization collects for OPPE and FPPE to be available during the Medical Staff Credentialing and Privileging Session.

Individual Tracer
- Note the names of practitioners you want added to the credentials file review (for example, practitioners who perform procedures and practitioners who provide medical treatments).
- Reports from practitioners that they do not receive any performance-related data from the organization.

Medical Staff Credentialing and Privileging Session
- Confirm the hospital has provided information requested from the Surveyor Planning Session.

Topics to be Discussed and Explored
- Does the organization have written OPPE and FPPE processes?
- Was the medical staff involved in the development of the criteria used for evaluating practitioners’ performance (for both OPPE and FPPE)?
- Is the organization following its processes?
- Are the processes consistently implemented?
- Is the medical staff involved in conducting these processes?
- Are the measures used to resolve performance issues clearly defined and consistently applied?
- Is the organization collecting data for OPPE? Are the data relevant and useful? Are the data at least in part department or specialty specific? Is the organization analyzing the data and using its analysis in the OPPE process?
- How often do practitioners undergo FPPE?
- What are the triggers or indicators for FPPE?
- Is the organization putting all practitioners who are new to the organization through the FPPE process?
- Is the FPPE process for new privileges clearly defined in terms of the method(s) for conducting, and the length of, the performance monitoring period?
- Is the organization putting all practitioners who are seeking new privileges (whether the practitioner is new to the organization or not) through the FPPE process?
- How many practitioners underwent FPPE in the past year? What was the reason? What was the process? What was the result?
Review of Credentials Files

- Trace the OPPE process when examining credentials files. These reviews allow for assessment of the organization’s criteria/indicators and determination of how much data is collected, how often reviews are conducted, and who is doing the reviews.
- Check to see that the organization’s OPPE and FPPE processes are related through the criteria/indicators and triggers that are being used (in other words, the OPPE’s criteria/indicators should be identifying practitioners who may need to undergo FPPE). Allow for sufficient time to thoroughly discuss and understand the organization’s processes. Incorporate time to discuss any issues with leadership.
- Determine the age of the data being used for OPPE; sometimes organizations use data that are too old to make recredentialing decisions. Ask the organization what it has done to assess practitioners in the past year and a half.
- Ask the organization how many practitioners have undergone FPPE for cause in the past year. If no one has, the surveyor should discuss this situation with the organization. Review the organization’s criteria and process for triggering FPPE for cause to see if they are being implemented properly. Some triggers are very poor or too broad. Sometimes practitioners undergo FPPE but no performance problems are found. Such cases can serve as a springboard to a good discussion with the organization about the quality of its process.
- Ask the organization how many and what type of performance issues that were identified through its OPPE process resulted in a practitioner undergoing the “for cause” FPPE process.
- Ask the organization how many practitioners have undergone FPPE in the past year because they have requested new privileges. All practitioners, whether they are new to the organization or not, need to undergo FPPE when requesting new privileges.
- It is appropriate to schedule time at a Special Issue Resolution Session to speak with key individuals within the organization who are involved with the OPPE and FPPE processes if they were not present to participate during the Medical Staff Credentialing and Privileging Session.

Additional Issues Unique to Surveys in the State of California

- Remind organizations that proctoring should occur when a practitioner begins to practice a specific privilege(s). The organization should perform ongoing review of proctoring reports, rather than grouping them and reviewing them all at one time. Proctoring can consist of direct observation, timely chart review for cognitive privileges, and any other characteristics as defined by the organization. Proctoring is usually completed within one year, with a one year extension for specific low volume procedures.

OPPE and FPPE Observations

- Absence of written OPPE and FPPE processes. (Score noncompliance at MS.08.01.01 EPs 2, 7, and 8 and MS.08.01.03 EP 1)
- Little or no medical staff support of the OPPE and FPPE processes. (Score noncompliance at MS.08.01.01 EP 2 and MS.08.01.03 EPs 1 & 2)
- Little or no medical staff participation in the OPPE and FPPE processes. (Score noncompliance at MS.08.01.01 EP 2 and MS.08.01.03 EP 1)
• Little or no data collection related to OPPE and FPPE processes. (Score noncompliance at MS.08.01.01 EP 1 and MS.08.01.03 EPs 2 & 3)
• Infrequent or irregular data collection related to OPPE and FPPE processes. (Score noncompliance at MS.08.01.01 EP 1 and MS.08.01.03 EPs 2 & 3)

Tips
• Help the organization to understand that the purpose of these processes is not to get rid of practitioners. OPPE will generally show that 98% of practitioners are doing a fine job and that the issues related to the other 2% are very correctable and should be treated as learning experiences. OPPE is similar to a performance improvement process.
• If no or very few physicians are undergoing FPPE, discuss with the organization to determine whether this is due to a poor process or the organization simply does not have many opportunities to implement its process (for example, a small organization may not often have requests for new privileges or new practitioners joining its staff, and FPPE may be rarely implemented “for cause”).
• Explain to the organization that the data collected for OPPE should be department or specialty specific because the individual departments are in the best position to determine which data reflect quality of care.
• Help the organization to understand how the OPPE and FPPE processes are related to each other, particularly how OPPE criteria/indicators should be selected so that they will identify practitioners who may need to undergo the FPPE process.
• Explain to organizations that they must be careful and thoughtful when selecting triggers. Triggers for FPPE that are too sensitive result in too many practitioners undergoing FPPE, while triggers for FPPE that are not sensitive enough result in no or too few practitioners undergoing FPPE.
• Many organizations have difficulty with data collection. Explain to organizations that they do not have to create everything from scratch. For instance, the medical staff can meet with the information technology and performance improvement departments to find out what data is currently being collected, decide if it is useful to the medical staff, and determine a presentation format for the data. The Information Technology (IT) department can then provide these reports to the medical staff on a regular basis.
• Remind organizations that data collection methodologies can include direct observation, chart review (both concurrent and retrospective), monitoring of diagnostic and treatment techniques, discussions with other practitioners and staff, and proctoring, in addition to review of available management information reports.
• Remind organizations that data required by other Medical Staff chapter standards can also be used in OPPE. These include MS.03.01.01, MS.05.01.01, and MS.05.01.03.
• Remind organizations struggling with data collection that they are required by law and regulation to collect certain data; these data can be used as a starting point.
• Help organizations to understand that collecting inadequate or irrelevant data on OPPE and FPPE processes can contribute to poor outcomes for these processes.
• Note that organizations can share with practitioners the data collected and used for the OPPE process. This allows the practitioners to see how they’re doing. Recommend that the
organization engage the practitioners in designing a data-sharing tool; the tool can be in any format.

- Tell organizations that they should be looking for and investigating patterns and trends in data. Variation from the accepted norm reveals an opportunity for improvement. Variation needs to be reduced when found. The "why" connected to the variation needs to be investigated; why does this particular practitioner vary from the others? Discovering the "why" can help the practitioner to improve.

- Point out to organizations that problems that arise are not always the practitioner’s fault. It could be a systems issue, and using these processes can help to identify and resolve such issues. It is important to report any systems issues to the organization’s leaders.

- Mention to organizations that they do not have to use The Joint Commission’s terms ("OPPE" and "FPPE"). They will probably find that they are already conducting most or all of these activities but calling them by other names.

- Explain to organizations that while practitioners privileged through the human resources process (as opposed to the medical staff process) are not required to be subject to OPPE and FPPE, it could be helpful to have them go through these processes. It might be that a performance issue is related to a physician assistant (for example) and not a physician; OPPE and FPPE can help to correctly identify the practitioner and resolve the issue.

- Suggest to organizations that they may want to investigate ways to make data collection simple and routine. An example of this is assigning codes to every privilege on the privilege list so that data can be pulled by code when it is needed. This process allows the organization to determine how many times each practitioner has performed each procedure. It can also reveal practitioners who are privileged for a procedure but who are not performing the procedure. And it can serve as a double check to make sure practitioners are indeed privileged for the procedures they are performing.

- Explain to organizations that multi-discipline review groups are much more effective at detecting practitioner performance issues than traditional peer review. Such review groups allow for a wide variety and valuable mix of disciplines to provide feedback to the organization on a practitioner’s performance which supplies the organization with a much more complete and well-rounded profile of each practitioner.

- Share with organizations that the peer review process will rarely find fault with a practitioner’s performance unless the problem is truly egregious.
Appendix X – Annual Performance Evaluations of Diagnostic Imaging Equipment

A diagnostic medical physicist (or magnetic resonance imaging (MRI) scientist, as applicable) must conduct an annual performance evaluation of the following diagnostic imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, must be documented. While conducting the individual tracer:

- Ask when and by whom the performance evaluations were done
- Ask to review the reports – this can be held for the issue resolution session
- When reviewing the reports, look to see if all required tests were done
- Did the report indicate any follow-up was needed? If so, was it done?
- Review of the actual report (if needed) can be done during issues resolution sessions

The evaluation includes the use of phantoms to assess the following imaging metrics (these are also listed in EC.02.04.03 EPs).

Computed Tomography (CT) Equipment

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Image Uniformity</td>
<td>a phantom is used to quantify the degree to which the image is equally bright from one side to another or from top to bottom. Non-uniform brightness makes diagnosis more difficult for the radiologist.</td>
</tr>
<tr>
<td>Slice Thickness Accuracy</td>
<td>a phantom is used to verify that scanned image “slices” are actually of the designated thickness. Proper slice thickness is important for many types of imaging.</td>
</tr>
<tr>
<td>Slice position accuracy</td>
<td>A test to verify that the correct scan position.</td>
</tr>
<tr>
<td>Alignment Light Accuracy</td>
<td>measures the deviation between the laser alignment (positioning) beam with the actual x-ray beam.</td>
</tr>
<tr>
<td>Table travel accuracy</td>
<td>Tests CT table motion</td>
</tr>
<tr>
<td>Radiation beam width</td>
<td>Measures the radiation beam width to assess its relationship to the selected scan beam width. This can help determine if more radiation than needed is being used to create the image.</td>
</tr>
<tr>
<td>High Contrast Resolution</td>
<td>a phantom is used to quantify the degree which small objects of very high density can be resolved. The test object may take the form of closely spaced lines or bars of varying sizes and spacing. The test assesses the ability of the scanner to image these very small features.</td>
</tr>
<tr>
<td>Low Contrast Resolution</td>
<td>a phantom is used to verify that objects with similar densities can be distinguished from each other. The test object may take the form of circular objects, lines or other configurations of varying sizes and spacing. The test measures the ability of the scanner to resolve low-density objects (i.e., tumors).</td>
</tr>
<tr>
<td>Geometric or Distance Accuracy</td>
<td>a measurement of known size or between two markers of known distance. This is important when sequential comparisons are made of a lesion or organ over time.</td>
</tr>
<tr>
<td>CT Number Accuracy and Uniformity</td>
<td>a phantom is used to verify the scanner’s ability to show different materials.</td>
</tr>
<tr>
<td>Artifact Evaluation</td>
<td>a phantom is used to assess whether any abnormal streaks, rings, pinpoints, or other non-real image artifacts compromise the overall image quality.</td>
</tr>
<tr>
<td>Image acquisition display monitor testing</td>
<td>this monitor is used by the technologist to monitor and review the CT examination. It is not the monitor used by the physician for image interpretation. The measurements made on this monitor include maximum and minimum luminance, luminance uniformity, resolution, and spatial accuracy.</td>
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Magnetic Resonance Imaging (MRI) Equipment

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Image Uniformity</td>
<td>a phantom is used to quantify the degree to which the image is equally bright from one side to another or from top to bottom. Non-uniform brightness makes diagnosis more difficult for the radiologist. This parameter should be measured for EVERY volume RF coil.</td>
</tr>
</tbody>
</table>
### Signal to Noise Ratio (SNR)
- This parameter should be measured for EVERY RF coil.

### Slice Thickness Accuracy
- A phantom is used to verify that the scanned image “slices” are actually of the designated thickness. Proper slice thickness is important for many types of imaging.

### Slice Position Accuracy
- A phantom is used to verify the scanned image “slices” are actually positioned in the position indicated on graphic slice prescriptions. Improper slice positioning can result in missed anatomy in scans.

### Alignment Light Accuracy
- Measures the deviation between the laser alignment (positioning) beam with the actual MRI scanner position.

### High Contrast Resolution
- A phantom is used to quantify the degree which small objects can be resolved. The test object may take the form of closely spaced lines, holes, or lines of varying sizes and spacing. The test assesses the ability of the scanner to image these very small features.

### Low Contrast Resolution
- A phantom is used to verify objects with similar densities can be distinguished from one another. This test measures the ability of the scanner to identify low-density objects (i.e. tumors). OR
- **Contrast to Noise Ratio (CNR)** – this test measures the graininess of the image. Changes in this value indicate a problem that could compromise image quality.

### Geometric or Distance Accuracy
- A phantom is used and measurements are made to determine the accuracy of on-screen distance measurements relative to actual distances in the three spatial directions (x, y, and z).

### Magnetic Field Homogeneity
- A phantom is used to measure the amount of variation in the magnetic field strength within the useful scanning volume inside the machine. This test is critically important because the calculations and calibrations used in MR scanning and image reconstruction assumes that the field is uniform.

### Artifact Evaluation
- Using a phantom, a subjective assessment is made on of whether any abnormal streaks, bright or dark areas appear in the image. Image artifacts compromise the overall image quality.

### Image Acquisition Display Monitor Testing
- This monitor is used by the technologist to monitor and review the MRI examination. It is not the monitor used by the physician for image interpretation. The measurements made on this monitor include maximum and minimum luminance, luminance uniformity, resolution and spatial accuracy.

### Nuclear Medicine (NM) Equipment

| **Image Uniformity/System Uniformity** | – exposing the gamma detector to uniform source of radiation and subjectively and/or quantitatively assessing whether the image produced matches a control image established during monthly tests or calibrations performed as part of preventive maintenance. |
| **High contrast resolution/system spatial resolution** | – involves exposing the gamma detector to a uniform source of radiation while covered with a lead mask with slits of various sizes (“bar pattern phantom”) to assess the ability of the device to image small objects. |
| **Sensitivity** | – tests the NM camera’s ability to detect amounts of radiation |
| **Energy resolution** | – tests the ability of the NM camera to detect areas of radionuclide uptake |
| **Count rate performance** | – measures the effectiveness of the NM camera to detect radiation |
| **Artifact evaluation** | – using a uniform source of radioactivity (“flood” source), a subjective assessment is made of whether any abnormal streaks, bright or dark areas appear in the image. Image artifacts compromise the overall image quality. |
| **Image acquisition display monitor testing** | – this monitor is used by the technologist to monitor and review the MRI examination. It is not the monitor used by the physician for image interpretation. The measurements made on this monitor include maximum and minimum luminance, luminance uniformity, resolution and spatial accuracy. |

### Positron Emission Tomography (PET) Equipment

<p>| <strong>Image uniformity/system uniformity</strong> | – a phantom or source is imaged and assessed visually or quantitatively for areas of non-uniformity (too bright or too dark). Uniformity of response is necessary to tell true areas of radioactivity concentration. |</p>
<table>
<thead>
<tr>
<th><strong>High contrast resolution/ system spatial resolution</strong> – measures the ability of the PET scanner to distinguish between two areas of radionuclide uptake.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low-contrast resolution or detectability</strong> – a phantom is used to verify that objects with similar concentrations of radioactivity can be distinguished from each other. (i.e., tumors vs normal tissue uptake). This test is not applicable for planar acquisitions.</td>
</tr>
<tr>
<td><strong>Artifact evaluation</strong> - evaluation of a uniform distribution of radioactivity (phantom or source of radioactivity) for streaks, rings, areas of non-uniformity in the collected data and/or reconstructed image; may use other phantoms with evaluation of a reconstructed image of the phantom one another in the images.</td>
</tr>
<tr>
<td><strong>Image acquisition display monitor</strong> testing – this monitor is used by the technologist to monitor and review the MRI examination. It is not the monitor used by the physician for image interpretation. The measurements made on this monitor include maximum and minimum luminance, luminance uniformity, resolution and spatial accuracy.</td>
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Appendix Y – Evaluating Organizations that Provide Mobile Delivery of Healthcare Services (MDHCS)

The purpose of this guide is to enhance the evaluation of organizations that provide mobile healthcare services (MDHCS). Note: These organizations do not use The Joint Commission’s deemed status option.

Objectives:

1. Assess and determine the degree of compliance with established guidelines and standards and elements of performance relating to the provision of MDHCS.
2. Increase the organization’s awareness of identified risks related to the provision of MDHCS.

Definition:

The Joint Commission defines Mobile Delivery of Healthcare Services (MDHCS) as “The provision of healthcare services (that includes staff and equipment) in the presence of the patient through a transportable or relocatable platform.” This definition excludes organizations that exclusively provide telehealth, telemedicine, healthcare staffing, or mobile health technology services.

Background on Mobile Health Clinics:

Mobile clinics provide a wide range of services tailored to community needs. Some function as comprehensive patient-centered medical homes, while others focus on specific diseases, such as pediatric asthma. Overall, 44% of mobile clinics provide primary care, 42% provide prevention services, and 31% provide dental care. Many also provide mammography, mental health, and a variety of specialty services. Mobile clinics represent an integral component of the healthcare system that serves vulnerable populations and promotes high-quality care at low cost. There are an estimated 1500 mobile clinics receiving 5 million visits nationwide per year. Mobile clinics improve access for vulnerable populations, bolster prevention and chronic disease management, and reduce costs. Mobile clinics are particularly successful in reaching vulnerable populations that have poorer health and less-than-optimal access to healthcare. By traveling to these communities and offering affordable, or, oftentimes, free services, mobile clinics remove logistical constraints such as transportation issues, difficulties making appointments, long wait times, complex administrative processes, and financial barriers such as health insurance requirements and copayments. More information on this mode of care delivery can be found at: http://www.ajmc.com/journals/issue/2014/2014-vol20-n3/mobile-health-clinics-in-the-era-of-reform

Types of MDHCS organizations include (please note: the list below is not intended to be exhaustive):
- **Primacy Care and Dental clinics**
  These clinics provide primary care or dental services to rural, migrant, or other underserved areas. Examples include school-based clinics operating out of mobile trailers to directly provide healthcare services at schools. Many of these clinics have achieved Joint Commission’s Primary Care Medical Home certification.

- **Mobile Imaging**
  The Joint Commission currently accredits several imaging organizations that provide mobile imaging services. These organizations typically use mobile trailers to provide onsite imaging services to hospital or clinic patients on a part-time scheduled or full-time basis, through a contractual agreement. Types of imaging equipment transported include MRI, PET, CT, x-ray and ultrasound units.

- **Mobile Anesthesia Services**
  Mobile anesthesia organizations contract with ambulatory surgery centers and office-based surgery practices, to support a wide variety of specialty services such as: dermatology, endodontics, ENT, gynecology, neurology, neurosurgery, ophthalmology, oral surgery, orthopedic surgery, plastic surgery, GI, and urology. These organizations often use board-certified anesthesia practitioners (MDs) as well as Certified Nurse Anesthetists (CRNAs), and the mobile anesthesia service will often provide the needed staff, equipment, monitors, medications and supplies.

- **Vascular Access Services**
  These organizations provide mobile, on-demand vascular access service. They are typically staffed by RNs utilizing ultrasound or imaging equipment to assist with the placement and insertion of PICCS, central lines & midlines. (Certified Registered Nurse Infusionist)

- **Mobile Sleep Medicine**
  These organizations use mobile units to bring sleep study equipment and specialized staff to contracted organizations (such as hospitals that do not have their own sleep labs). They utilize credentialed respiratory therapists and sleep technologists to provide services. Sleep studies are initially scored by the technologists and then handed-off to (contracted) board-certified sleep physicians for interpretation.

- **Intraoperative Neuro-monitoring (IONM)**
  These organizations provide intraoperative monitoring technicians/technologists (or depending on the procedure, surgical neurophysiologists, evoked potential (EP) technicians, or electroneurodiagnostic technologists), who work under directly alongside and the supervision of a surgeon or neurologist. The technician performs testing and monitoring of the nervous system during surgery to localize anatomical structures and identify changes in brain, spinal cord, and peripheral nerve function to reduce the risk of neurological deficits following surgeries that involve the nervous system. These
organizations often bring their own monitoring equipment (e.g. leads and electrodes) for use in the OR room. The types of surgeries that would involve IONM include:

- Spine surgery
- Neurosurgery
- Interventional neuroradiology
- Cardiothoracic surgery
- Vascular surgery
- General orthopedic surgery
- Otolaryngology

Survey Process Guidance:
The following survey activities can be used to explore standards compliance when surveying MDHCS. Some suggestions for areas to explore and questions to ask are provided below, along with related standards/EPs, as applicable.

Commonly used MDHCS terminology:

- Host – commonly used in the mobile industry to refer to the organization that has the patient.
- Types of mobile units:
  - Mobile or Fixed mobile - a unit that is fixed and doesn’t move. (These units may be outside the organization or within a wall built around the mobile unit)
  - Independent diagnostic testing facility (IDTF) – some companies who have mobile units also operate IDTF’s, in these instances additional standards may apply
- Logistics department - responsible for moving the trailer/coach and tractors
  - Identify the Logistics Manager
  - Ask about ownership of the tractor/trailer. Is there a warehouse for its storage/ maintenance?
  - Explore Department of Transportation (DOT) inspections
  - Explore role and responsibilities associated with packing up the mobile unit prior to it being moved
  - Explore processes for coach Set-up: including patient lift and stair safety, and leveling of the mobile unit/coach, (a critical safety factor).
  - Disaster planning – for example, where are the mobile units moved to when a hurricane is anticipated, to minimize damage?
  - Explore the organization’s plan for routing and on-time delivery of mobile units
  - For anesthesia and sleep study services, ask about equipment maintenance activities and storage
  - Discuss medication storage
Preliminary Planning Session / Orientation to the Organization

- During these activities, explore the types and locations of mobile services provided.
- Site selection - ask about the number of sites, the distances between, and time needed to reach each site.
- Consider current sampling guidelines for diagnostic services and % of sites to visit
- What levels of sedation are administered? Who administers and where?
- Sterilization or high-level disinfection, if applicable; who performs and where does it take place?
- Explore oversight of MDHCS services and how it relates to the following:
  - Organization’s mission, vision, goals, and strategic initiatives
  - Operational management structure
  - Information management, (e.g., format of medical records, paper or electronic)
  - Contracted services – are contracts detailed and/or specific enough

<table>
<thead>
<tr>
<th>Areas to explore</th>
<th>Related Standards</th>
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<tbody>
<tr>
<td>1  Environment of care- visit the mobile site. Depending on the physical location of the mobile unit, environmental/safety hazards will vary. Is there a designated space for storage of supplies and equipment? Equipment maintenance procedures? Are there safety and security risks/hazards in the environment?</td>
<td>EC.02.01.01 EC.02.04.01 EC.02.04.03</td>
</tr>
<tr>
<td>2  Does the mobile service have access to the ASC/ OBS/hospital’s EHR system? What is the process for documentation of assessments and care provided? Is advance directive info available to mobile providers?</td>
<td>RC.01.01.01 RC.02.01.01</td>
</tr>
<tr>
<td>3  How is PHI handled? What about patient personal privacy?</td>
<td>IM.02.01.03 RI.01.01.01</td>
</tr>
<tr>
<td>4  Interview staff about the orientation process for MDHCS staff. What about ongoing education? Is the orientation site-specific? What included, (e.g. IC, equipment operation, security)? Interview the mobile unit driver.</td>
<td>HR.01.04.01 HR.01.05.03</td>
</tr>
<tr>
<td>5  Describe staffing or equipment contracts that are in place. What specific expectations for services to be provided are detailed in the contract?</td>
<td>LD.04.03.09</td>
</tr>
<tr>
<td>6  Describe patient/staff ratio. How is it adjusted based on patient acuity?</td>
<td>LD.04.01.11</td>
</tr>
<tr>
<td>7  How is security addressed, such as access to the mobile unit during and after hours?</td>
<td>EC.02.01.01</td>
</tr>
</tbody>
</table>
|   | 8 | Emergency equipment and devices available and ready for use? Discuss inventory and maintenance activities and frequencies for inspection. | EC.02.04.03  
EC.02.04.01  
PC.02.01.09 |
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<tbody>
<tr>
<td></td>
<td>9</td>
<td>Hand hygiene is performed utilizing hand sanitizer/soap and water between patient contact and after glove removal</td>
<td>NPSG.07.01.01</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Appropriate use of personal protective equipment</td>
<td>IC.02.01.01</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Medications are stored in accordance with manufacturers' guidelines.</td>
<td>MM.03.01.01</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>Medications are administered per organization’s policies and procedures.</td>
<td>MM.06.01.01</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>Safe needle practices are followed.</td>
<td>IC.02.02.01</td>
</tr>
</tbody>
</table>
|   | 14 | Consent(s) for care, treatment and services are completed and in the medical record. Who’s responsible for obtaining consent? | RC.02.01.01  
RI.01.03.01 |
|   | 15 | Pre and post-procedural assessments are performed and documented. | RC.02.01.01  
PC.01.02.01  
PC.01.02.03 |
|   | 16 | Pre and post-procedural vital signs are documented, as applicable. | RC.02.01.01  
PC.01.02.01 |
|   | 17 | Safety checks/time outs are completed and documented, as applicable. | UP.01.01.01  
UP.01.03.01 |
|   | 18 | Patient complications and subsequent interventions are reported to the ordering physician and documented in the medical record or treatment flow sheet. | RC.01.01.01 |
|   | 19 | Variations from treatment orders are reported to the physicians and documented in the medical record or treatment flow sheet. | RC.01.01.01 |
|   | 20 | Patient/family education is documented. | PC.02.03.01 |
|   | 21 | Discuss/observe waived testing procedures, explore compliance with WT standards | WT standards |

### Competence Assessment/Credentialing & Privileging

<table>
<thead>
<tr>
<th>Areas to explore</th>
<th>Related Standards</th>
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</thead>
</table>
| 22 | Review personnel files for documentation of staff orientation and ongoing education. | HR.01.01.04  
HR.01.05.03 |
| 23 | Documentation of assessment of staff competency | HR.01.06.01 |
| 24 | **Review job descriptions for any organization requirements for licensure or certification. For IONM, technicians may have Certification in Neurophysiologic Intraoperative Monitoring (CNIM) from the American Board of Registered or the American Board of Neurophysiologic Monitoring (ABNM).** | HR.01.02.01  
HR.01.02.05  
HR.01.02.07 |

### Environment of Care/Infection Control

<table>
<thead>
<tr>
<th>Areas to explore</th>
<th>Related Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Equipment and beds/chairs (if applicable) are disinfected with appropriate agent, and in accordance with manufacturers' recommendations.</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>26</td>
<td>All equipment preventive maintenance, quality checks, and associated documentation are up-to-date and accessible.</td>
</tr>
<tr>
<td>27</td>
<td>The organization inspects, tests, and maintains medical equipment. Are there processes in place to check transported equipment and supplies to ensure they remain safe to use?</td>
</tr>
<tr>
<td>28</td>
<td>High-level disinfection or sterilization</td>
</tr>
</tbody>
</table>

**Data Use**

<table>
<thead>
<tr>
<th>Areas to explore</th>
<th>Related Standards</th>
</tr>
</thead>
</table>
| 29 | What data is collected and used to access its performance? For IONM, for staff that provide in-person care, what events are tracked (e.g. electrode needle sticks)? Are post-procedural infections/patient &/or staff injuries tracked? | PI.01.01.01  
PI.02.01.01 |
### Appendix Z – The Office of Quality and Patient Safety (OQPS)

**Applies to:** All accreditation programs

<table>
<thead>
<tr>
<th>Duration</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| Complement and survey length is determined by TJC Leaders and Field Directors based on the patient safety concern. | 1. Explore the organization’s response to potential issues of patient safety in relationship to standards compliance  
2. Determine if actions have resolved the potential patient safety issues and that a mitigation strategy is in place for similar events |

<table>
<thead>
<tr>
<th>Participants</th>
<th>Before</th>
</tr>
</thead>
</table>
| Joint Commission: Surveyors  
Organization: Survey coordinator, senior leadership, others | 1. The Office of Quality and Patient Safety (OQPS) will conduct an analysis of the incident and any related information such as prior survey reports, sentinel event and complaint profile, and other available documents. OQPS will recommend next steps in response to the patient safety issue identified in the incident.  
2. TJC Leaders will determine if the OQPS incident:  
   a. Warrants pulling the organization’s full survey forward,  
   b. Can be assessed on an already scheduled full survey, or  
   c. Needs to be a separate OQPS survey event, i.e., a For-Cause survey.  
3. Leaders and Field Directors will determine the type of survey event to best evaluate the patient safety issue. Your itinerary will indicate the type of event.  
4. A Field Director will be designated as your contact person for all pre-survey planning and strategizing related to the survey event. Their name will be noted on the GSAP.  
5. A pre-survey conference call may be required at the directive of leadership, or at the request of the Field Director or surveyor.  
6. Review the application for information about the organization (e.g. days and hours of operation), travel directions, hotel accommodations, and other logistics. Document the organization's survey coordinator name and phone number for easy reference.  
7. Review the following items in preparation for the survey. All of these items are viewable through web-based survey technology (WST) under the OQPS tab, by clicking on the Edit button.  
   - OQPS incident  
   - Supporting documents, when available (e.g., SIG Assessment map)  
   - Gold Sheet Approval Process template (GSAP)  
   - Other relevant resources that may be provided  
   - Previous survey reports (use Quick Links)  
8. Check for recent email from your Field Director to locate the high-risk findings report for the organization. Review the report and use the information to prioritize the issues to cover during this on-site event.  
9. When reviewing allegations pre-survey, consider what standards areas may be vulnerable and what clinical settings need to be visited. Also, consider what types of patients you need to trace within the setting.  
10. Be cautious and use discretion if printing any materials related to the OQPS incident. Do not leave these items visible and unattended in any location. Do not bring hard copies of any of the above noted items into the organization. |

**What is an OQPS incident?**

A: An allegation or report of patient safety or quality of care concern from members of the public or other entity or agency. TJC assigns a unique numeric identifier and conducts follow-up activity.

**What’s a Surveyor To Do If...**

**Q: What should you do if you:  
1. Meet with any resistance from the organization?  
2. Identify a potential Immediate Threat to Life?  
3. Need more time to complete the survey (or more time to finish the report and transmit)?  
4. Identify that other field staff or surveyor disciplines (RN, MD, LSCS) are needed?  
5. Are anticipating an early departure?  
6. Need assistance in determining if HCOs actions have addressed potential compliance issues?**

**A: The following resources are available to you in the Central Office.**

- Field Director on-call at 800.965.5888 option 2 then option 1.
- SIG for standards related questions at 1-800-965-5888 option 2 three times, then option specific to program.
- TJC Engineers 1-800-965-5888 option 2 twice, then option 1.

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HAP SAG January 2018 FOR INTERNAL USE ONLY!
Q: What should you do if you discover non-compliant performance while conducting the OQPS For Cause Survey?
A: The surveyor records all observations and findings related to any standard or EP found non-compliant, whether or not they are related to the incident.

the organization. The organization is not told the specifics of the complaint to ensure the complainant’s confidentiality. See the attachment to this section for sample scripting to assist you in discussing the purpose for your visit.

**Conducting an OQPS For-Cause Survey**

1. Arrive at the organization no earlier than 10-minutes before the designated start time for an unannounced survey. If the survey includes multiple surveyors, all surveyors should enter the organization together.

2. Report to the reception area, security officer, information desk, administrative office or area that TJC leadership has directed upon arrival and:
   a. Provide your name and the purpose for your visit.
   b. Display your Joint Commission identification badge.
   c. Ask to speak with the survey coordinator, by name. If the coordinator is unavailable, ask to speak with an administrator or the most senior leader available. See the attachment to this section for sample scripting to assist you in discussing the purpose for your visit.

3. Direct the survey coordinator or administrative contact to access the Joint Commission’s web page at [www.jointcommission.org](http://www.jointcommission.org). Once there, they should select ‘Log-In-Joint Commission Connect’ under the Action Center section. They will need the user ID and password to sign-on. Ask them to view the following information:
   a. Notification of scheduled Joint Commission event
   b. Surveyor/Reviewer picture and biographical sketch

4. After the organization validates the authenticity of your visit, ask if they have a space where you can get settled and begin the survey. Be respectful of the organization, but indicate you need to begin your activity. If this is an issue for the organization, call the Field Director on-call.

5. Review your plan for the day with the organization. Explain the activities you will be conducting and what you will need from the organization to complete your survey. For example, an active patient list, patients discharged in the past 72 hours, certain policies and procedures, QAPI data, personnel or credentials files, etc. Prioritize tracer activity to occur early in the day. Note that the plan may be adjusted throughout the day based on the progress of the survey and observations.

6. Use the OQPS incident to explore standards compliance and to evaluate processes in place to support patient safety.

7. Select tracers based on the standard areas related to the incident.
8. Review at least ten patient records, active or a combination of active and closed as applicable to the incident you are exploring.

9. You are performing an assessment of systems, looking for vulnerabilities that could contribute to incidents where patient safety has the potential to be compromised.

10. Take time to consider your progress at this point. Use discretion and reassess your plan for the remaining time. Seek guidance on whether additional time may be needed for exploration of the OQPS incident.

11. Consult with SIG or Engineers if there are any questions about whether or not to score and where to score a particular concern you observe.

12. At the close of the visit, a written survey report is not made available to the organization at the conclusion of the survey. Explain that the report will be reviewed carefully in Central Office to ensure that it is conveying accurate messaging back to you.

13. You will provide a verbal summary of the survey observing the following guidelines:
   a. Focus on areas for improvement, and be direct about what has been observed.
   b. You may note standards areas explored, but do not provide specific standard numbers and EPs.
   c. Do not offer any conclusions as to the survey outcome or provide an indication of whether or not the allegation has been substantiated.

14. Score RFIs in WST, click the OQPS tab. Click Edit next to the corresponding Incident Number to enter your supporting text in the Findings drop-down field.
   a. Enter all observations made, whether or not they relate to the original OQPS incident; this will provide the organization with as accurate an assessment as possible.
   b. Check all RFIs which were cited related to the OQPS incident.
   c. Do not check any RFIs which were generated unrelated to the OQPS incident.

15. Use the OQPS notes feature to state whether the OQPS incident has been substantiated or not substantiated. Do not write any narrative notes.

16. Use the Additional Event Information box to select relevant information regarding the organization.

17. Use discretion on whether or not the Field Director on-call should be contacted given the survey conclusions.

Post Survey Process

- Lock and transmit your report as soon as possible following the conclusion of the survey via air card or internet connection. Note: This activity can be completed off-site should you require additional time to formulate and document your findings. However, this should be completed within 24 hours of the Exit Conference.
- Survey reports will be reviewed in Central Office by SIG and OQPS.
Exploring an OQPS Incident During a Full-Survey Event

When TJC leadership has determined an OQPS incident will be evaluated during a full survey or other type of scheduled survey event:

- A Field Director will be designated as your contact person for all pre-survey planning and strategizing related to the survey event. Their name will be noted on the GSAP.
- The team leader and team members will have access to the OQPS incident report under the OQPS tab in WST. To view the details of the incident report you must click on the blue highlighted Gold Sheet link in the lower right corner of the OQPS Incident screen.
- The Field Director on-call will still remain your primary contact to assist with any needs or concerns during the on-site visit.

Before

1. Review the following items in preparation for the survey. All of these items are viewable through web-based survey technology (WST) under the OQPS tab, by clicking on the Edit button.
   - OQPS incident
   - Supporting documents, when available (e.g., SIG Assessment map)
   - Gold Sheet Approval Process template (GSAP)
   - Other relevant resources that may be provided
   - Previous survey reports (use Quick Links)
2. Check for recent email from your Field Director to locate the high-risk findings report for the organization. Review the report and use the information to prioritize the issues to cover during this on-site event.
3. Review the organization demographics data to prepare for the survey. Consider at what points throughout the agenda the incident is most likely to be explored.
4. If you have any questions after reviewing the available material, contact the designated Field Director for the incident. The name will be noted on the Gold Sheet. This is your contact for all pre-event questions or concerns related to the incident.
5. Be cautious and use discretion if printing any materials related to the OQPS incident. Do not leave these items visible and unattended in any location. Do not bring hard copies of any of the above noted items into the organization. The organization is not told the specifics of the complaint to ensure the complainant’s confidentiality.

During

1. At the start of the survey, it is appropriate to mention to the CEO or other designated senior leader that the full survey event will include exploration of a specific patient safety and quality issue received and reviewed by Joint Commission leaders.
2. Organizations may be surprised to see you, especially if Joint Commission leadership has decided to pull an organization’s full survey forward. This can sometimes be 12-18 months before the organization is expecting a survey. See the attachment to this section for sample scripting to assist you in discussing the purpose for your visit.
3. Survey the organization integrating OQPS incident exploration into your tracer and other on-site activities to explore standards compliance and to evaluate processes in place to support patient safety. If a particular name is noted in the incident, please include the medical record, credentials or staff personnel file in your review sample.

4. You are performing an assessment of systems, looking for vulnerabilities that could contribute to incidents where patient safety has the potential to be compromised.

5. Consult with SIG or Engineers if there are any questions about whether or not to score and where to score a particular concern you observe.

6. If you are unable to evaluate the OQPS incident, call the Field Director on-call for direction.

7. Click the OQPS tab. Click Edit next to the corresponding Incident Number to enter your supporting text in the Findings drop-down field.
   - Enter all observations made, whether or not they relate to the original complaint; this will provide the organization with as accurate an assessment as possible.
   - Check all RFIs which were cited related to the OQPS incident.
   - Do not check any RFIs which were generated unrelated to the incident.

8. Use the OQPS notes feature to state whether the OQPS incident has been substantiated or not substantiated. Do not write any narrative notes.

9. Complete the full survey report according to the routine Report Preparation activity.

10. At the conclusion of the survey you will conduct an Exit Conference with the organization according to the procedure outlined for any full survey event.

11. In relation to the OQPS incident exploration, do not offer any conclusions as to the outcome. You may note that the results of all standards compliance evaluation activity are reflected in the survey report.

12. Inform the organization that the Central Office will need to review the report and that the final report will be available on their extranet site within ten calendar days.
Appendix Z – Attachment: Scripts for OQPS Survey Activity

Suggested Comments during Opening Session with Leadership (related to an OQPS Incident being the trigger of a For-cause (OQPS) Survey or related to an OQPS Incident being a component of a Full or other type Survey)

The guiding principle is to be as transparent as possible, while still to be thoughtful in not inadvertently disclosing either the complainant, or even, the nature of the complainant, i.e. “an employee,” or “a physician.” The HCO should be made aware, at the onset, of the nature of the allegation. It may be easiest to use standards areas, or focus areas, as well as clinical service categories, such as Medication Management in the PICU, or OPPE/FPPE processes for non-physician LIPs, etc. Here are some examples:

For a for-cause (OQPS) survey: "Information representing a possible patient safety issue has come in to The Joint Commission’s Office of Quality and Patient Safety. It has been analyzed thoroughly, and reviewed by Joint Commission leadership, who has asked that we spend some time with you today evaluating systems and processes related to the patient safety issue. The main focus of our assessment will start in the NICU, related to Infection Control processes, although we may look at other areas throughout the day.”

For a ‘feed to full survey’: "We want for you to know that during this full survey, we also will be evaluating information which has come into The Joint Commission’s Office of Quality and Patient Safety. This information, which represents a possible patient safety issue, has been analyzed thoroughly and reviewed by Joint Commission leadership. They have asked that during the course of your full survey, we evaluate the systems and processes related to the patient safety concern. The area of focus in the information is the process for Competency Assessment in the critical care area. As you know, looking into your competency assessment processes is a customary part of a full survey, so this will be incorporated into our time with you. ”

For a Pull-Full Forward, with an OQPS Incident attached- if asked why the survey has come early: " As you know, the full survey can come anytime within a 18-36 month window. While we’ll be conducting a full survey, we want to share with you that The Joint Commission’s Office of Quality and Patient Safety has received information about a potential patient safety issue. This has been analyzed thoroughly and reviewed by Joint Commission leadership who has asked that we evaluate the systems and processes involved in the patient safety issue as a component of our full survey. The area of focus in what we received has to do with the credentialing and privileging processes particularly in the surgical service line. As you know, a customary part of a full survey includes a review of these processes, so we will incorporate this into our survey day.”

If it is a media article, its okay to say: “We know you’ve had some press coverage recently, and along with related information, this has been analyzed thoroughly and reviewed by leadership, who has asked that we spend some time reviewing this issue. We will focus, at least initially, on the cleaning, disinfection and sterilization processes related to endoscopy, and we’d like to begin there now.”

If it has to do with a government agency report, we can say: "We know you’ve had some recent visits from your State Agency [or CMS]. These reports came in to The Joint Commission’s Office of Quality and Patient Safety and have been analyzed thoroughly there. Joint Commission leadership has reviewed the information and asked that we review some of the follow up actions which have been undertaken since that CMS visit. The main area of our evaluation is restraint practices in your geru-seych unit.”

If there is a written organizational response attached to the OQPS Incident: "We understand that you’ve been working with The Joint Commission’s Office of Quality and Patient Safety on a patient safety issue which came into that Office. Your response was thoroughly reviewed by Joint Commission
leadership who has asked that we spend some time looking at that area during survey. The focus of our assessment will be in the ED, and how care, security and communication practices work in that environment, particularly with boarded patients."
Appendix AA – Guide for Evaluating Dietetic and Food Services
Applies to: Hospital Accreditation Program

Surveyor Tips & Tools

Patient Tracer Selection
When selecting patients to trace consider including a sample
- with special nutrition needs
- who need assistance with eating
- needing specially prepared meals

Organization
Suggested individuals to speak with during patient tracer activity include:
- Organizational manager for dietetic service department
- Organizational manager for staff development
- Foodservice manager
- Clinical nutrition care manager
- Staff representatives for maintenance and environmental services
- Staff representative for infection control/surveillance

Documentation
1. Review most recent local health department kitchen inspection report
2. Review any contracts related to food and nutrition services
3. Review HR file for food service director/manager
4. Training records for food service staff

Other Resources*
Clinical – American Dietetic Association (www.eatright.org)
Food handling and sanitation – Food and Drug Administration (FDA) Food Code, published every two years (www.fda.gov)

This is not intended to be a stand-alone service tracer. Incorporate review of these services into patient tracer activity. Use this guide and the data collection tool to help you perform a thorough review of these services and cover the topics addressed in the standards.

Objectives
1. Assess and determine the degree of compliance with standards and elements of performance relating to nutrition care
2. Increase organization’s awareness of any identified risks in nutrition care practices and food service operations

Process
- Patient tracer activity begins in the area where the patient is currently located; review the patients record for
  o Physician orders for specific diets
  o Nutrition screening and dietitian assessments
  o Evidence of written orders demonstrating that dietitian recommendations are being followed
- The surveyor(s) will follow referrals pertaining to clinical nutrition care for patient(s)
- The surveyor(s) will move to other settings as appropriate and applicable to tracing any safety, sanitation and therapeutic issues related to the storage, preparation, service and distribution of food
- The surveyor(s) will observe dietetic service staff and engage them in discussion focused on the quality and consistency of service which has been observed and as it relates to the patient(s) being traced

Observation
Key aspects of this care and service that should be observed include:
- Meal being served to patients; patient receives assistance with eating, when needed; staff monitoring patient food consumption
- Staff practices relative to food safety such as monitoring food temperatures, transportation practices, potential food borne infections, etc.
- Kitchen and food preparation areas focusing on sanitation, maintenance, and safety
- Food preparation (recipes, special diet preparation, food nutrient retention considered in preparing) and serving (portion size served, system staff follows to serve correct diet)
- Therapeutic diet meal preparation process (e.g., fat free, low salt, restricted/increased calorie count) or mechanical preparation (e.g., pureed, thickened)

Topics to Discuss Throughout Patient Tracer Activity
Surveyors should cover the following topics with participants as they trace patients’ clinical nutrition needs:
- Assessment, care planning and instruction by qualified staff
- Identification of nutrition risk
- Nutrition screening criteria
- Timeframes for nutrition assessment and re-evaluation of nutritional risk
- Measuring food consumption (methods for doing, responsible staff, use of the data)
Standards/EPs
PC.02.02.03
HR.01.04.01
HR.01.05.03

Related Systems
- Patient Care, Treatment and Services
- Infection Control
- Record of Care, Treatment and Services
- Environment of Care
- Performance Improvement
- Emergency Management

- Specific population needs, such as patients that are NPO, receiving hyperalimentation, on vents, in isolation, suffering from burns
- Process for obtaining meals for patients after food service hours
- Procedures followed for patients refusing meals
- Consultations and referrals
- Nutritional adequacy of patient diets
- Discharge education plans and referrals
- Dietetic service staff training (departmental and inter-departmental)
- Communication between dietitians and food service if not considered the same department
- Dietitians included and participating in care planning process

Surveyors should speak with leaders and management about day-to-day operations of Dietary and Food Services, including:
- Qualifications of dietary services leader/daily management
- Responsibilities of dietary and food services leadership and management
- Disciplines involved in developing policies and procedures
- Scheduling of food service and clinical nutrition care staff
- Safe food-handling and health of food service staff
- Contracts for services, food, nutrition support supplies and formulas
- Emergency/disaster plans—provision planning for patients and staff
- Hospital diets and menus
  - selective or non-selective
  - nourishment choices
  - planning considers
    - diets commonly ordered
    - foods common to the culture/diet philosophy of the community
    - nutritional balance
- Alternate methods in dietetic services (outsourcing, advanced technology)
- Maintenance of space, equipment and supplies
- Sanitation and infection control (pest control, chemicals)
- Food preparation and storage procedures
- Standards of practice* being followed
- Quality control activities, quality assessment and performance improvement processes—aspects of performance being monitored, recently implemented improvements
## Dietetic Service and Food Service Tracer Data Collection Tool

### Patient Observation at Meal Time & Interview

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is patient receiving assistance at meal time when needed?</td>
<td></td>
</tr>
<tr>
<td>Does the patient’s meal reflect dietary orders?</td>
<td>Y or N</td>
</tr>
<tr>
<td>Does the patient have any cultural or religious based dietary needs/preferences?</td>
<td>Y or N</td>
</tr>
<tr>
<td>Did org provide accommodations for patient needs/preferences?</td>
<td></td>
</tr>
<tr>
<td>Is patient aware of special diet?</td>
<td></td>
</tr>
<tr>
<td>Is patient consuming special diet?</td>
<td></td>
</tr>
</tbody>
</table>

### Dietary/Nutrition Services

- **Qualified dietitian (FT, PT or consultant)**<br>  If not FT, are patients nutritional needs being met: Y or N
- **Approves menus & nutritional supplements**  
- **Provides staff training**  
- **Works with food service, if not same department**  
- **Review credentials, licensure (if needed), job description or contract**

### Food Service Visit

- **Leadership**
  - Full-time employee
  - Qualified by experience/training
  - Responsible for daily management

- **Clinical**
  - Explore processes for tracking dietary orders
  - Observe meal preparation, including mechanical preparation
  - Observe meal plating and prep for delivery
  - Nutritionally balanced meal guides in use:_________
  - Recipes used (to provide planned nutrients & calories)
  - Infection-control practices minimize food borne illness

- **Environment**
  - Written menus planned for diets commonly ordered: Y or N
  - Written menus include foods common to community culture/diet: Y or N
  - Staff
    - Orientation, training and education received  
    - Staff complying with food safety practices

### Unit Visit

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Nutrition Screening Performed:________________</td>
<td></td>
</tr>
<tr>
<td>Nutrition risks identified:___________________________________________</td>
<td></td>
</tr>
<tr>
<td>By Who:______________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Date Nutrition Consult Ordered:_______________________________________</td>
<td></td>
</tr>
<tr>
<td>Dietitian:___________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Date Nutrition Assessment Completed:___________________________________</td>
<td></td>
</tr>
<tr>
<td>Nutrition risks confirmed:___________________________________________</td>
<td></td>
</tr>
<tr>
<td>Nutrition recommendations:___________________________________________</td>
<td></td>
</tr>
<tr>
<td>Date Dietary Orders Written:_________________________________________</td>
<td></td>
</tr>
<tr>
<td>Orders Reflect Nutrition Consult Recommendations?______________________</td>
<td></td>
</tr>
<tr>
<td>Type of diet ordered for patient:____________________________________</td>
<td></td>
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<tr>
<td>Patient education provided: Y or N</td>
<td></td>
</tr>
<tr>
<td>Special preparation required:________________________________________</td>
<td></td>
</tr>
<tr>
<td>Is patient intake being monitored?___________________________________</td>
<td></td>
</tr>
<tr>
<td>How often?__________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>By Who:______________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Has patient nutrition been reassessed?_______________________________</td>
<td></td>
</tr>
<tr>
<td>How often?__________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Does patient need assistance at meal time? Y or N</td>
<td></td>
</tr>
</tbody>
</table>

### Notes:

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Appendix CC – Immediate Threat to Health or Safety Abatement Survey

Applies to: All accreditation and certification programs

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>When a surveyor identifies an Immediate Threat to Health or Safety during an on-site event, The Joint Commission conducts a follow-up survey within 23 days.</td>
<td>1. To evaluate the organization’s follow-up actions in response to an identified Immediate Threat to Health or Safety.</td>
</tr>
<tr>
<td>Duration</td>
<td>2. To evaluate current compliance with standards related to the Immediate Threat to Health or Safety.</td>
</tr>
<tr>
<td>Per itinerary. One day in most cases.</td>
<td>3. To validate that the organization implemented corrective actions to eliminate the Immediate Threat and have a documented Joint Commission record.</td>
</tr>
</tbody>
</table>

Pre-Survey Planning

1. Through your itinerary, locate the organization and click on the event ID. When the event is displayed, click on Quick Links to view:
   a. Previous Requirements for Improvement and findings that led to the Immediate Threat to Health and Safety determination
   b. Available ESC submissions
   c. Organization’s application

2. Review the application for accreditation to locate information about the organization, travel directions, hotel accommodations, and other logistical information. Make note of the survey coordinator name and phone number.

3. **Do not contact the organization.** Call the Joint Commission Account Executive or Field Director On-Call with any questions.

4. Review the last survey report (Previous Recommendations under Quick Links).

5. Identify survey activities that would evaluate the element(s) of performance previously found out of compliance. **The primary focus of this follow-up survey is on the area(s) identified as posing a serious threat to public or patient health or safety.** However, if additional areas of non-compliance are discovered during the follow-up survey, document the additional observations in survey technology.

6. Plan for the on-site visit. While not required, consider selecting an agenda template from those available in WST that closely matches the survey length and complement for the assigned event. Revise the template to reflect activities that will allow for evaluation of the non-compliant standards related to the immediate threat. The agenda can include individual tracers, system tracers, building tours and review of documents.

7. One to two days before the scheduled survey date, access the organization’s extranet site and check the last survey report for any Central Office updates.

Conducting the Survey

8. Arrive at the organization no earlier than 10 minutes before the designated start time for the unannounced survey. If the survey includes multiple surveyors, all surveyors should enter the organization together.
9. Report to the reception area, security officer, information desk or administrative office upon arrival and:
   a. Provide your name and the purpose for your visit.
   b. Display your Joint Commission identification badge.
   c. Ask to speak with the survey coordinator, by name. If the coordinator is unavailable, ask to speak with an administrator or the most senior leader available.
   d. Clearly explain the purpose of the survey to the organization.

10. Direct the survey coordinator or administrative contact to access the Joint Commission’s web page at www.jointcommission.org. Once there, select the “Click here to access The Joint Commission Connect”. They will need the user ID and password to sign-on. They should find the following information:
   a. Notification of scheduled Joint Commission event authorizing your presence
   b. Your picture and biographical sketch

11. After the organization validates the authenticity of your visit, ask if they have a space where you can get settled.

12. Begin the opening conference. At a minimum, discuss the schedule for the visit (the activities you want to conduct and an approximate time for each) and work with the organization to make any necessary adjustments. The organization needs to know your plan to effectively facilitate the visit. If you have prepared an agenda, provide the organization with a copy. NOTE: If the organization requires additional time to gather staff or obtain coverage for staff attending the opening conference:
   a. Suggest postponing the opening conference to mid-morning;
   b. Proceed with an individual tracer, conduct a building tour, or request and review documents.

13. Select tracers based on the reason for the Immediate Threat to Health or Safety Abatement survey. For example, proceed to the care setting(s) that was identified in a Requirement for Improvement (RFI), select individuals currently receiving care and services in the area, and trace a patient there, focusing on the condition associated with the immediate threat RFI(s). Document all tracers in WST.

14. Focus interviews and group discussion on the conditions associated with the immediate threat to health or safety.

15. If the conditions related to the Immediate Threat to Health or Safety have not been corrected, that is, standards continue to be non-compliant, or if there are new standards identified as being non-compliant, document and flag the observations as required. Call SIG to discuss the situation and to receive further direction.

16. If activities are completed in less than 8-hours, the surveyor should enter a note in the CO Comments tab indicating their time of departure from the organization and notify the FD on Call.

17. At the conclusion of the survey, provide organization leadership with the evaluation results, focusing on the abatement of the immediate threat to health or safety.
   a. Explain that follow-up questions should be directed to the organization’s Account Executive.
b. Indicate that you will not be posting a preliminary report to the HCO’s extranet site for this on-site survey.

c. Indicate that Joint Commission Central Office will review the findings and will then post a final report to the organization’s extranet site indicating the results of this event.

18. If the Immediate Threat to Health or Safety is resolved, send an email to Andrea Coffaro in Central Office at the conclusion of the survey stating this conclusion. Email address: acoffaro@jointcommission.org.

19. If the condition related to the immediate threat still exists, call the central office (FD on Call or SIG) to discuss and document findings in WST.

20. Enter a note in CO Comments in WST that provides a brief overview of what was looked at and any information that would be helpful to paint a picture of this organization. The note needs to reflect an affirmative observation of each Standard/EP related to the ITL survey.

21. Your survey activity should focus on determining that the immediate threat was abated. However, if during the course of the survey you identify new instances of standards non-compliance, this should be documented in WST.

22. Lock and transmit a report for the event to Central Office within 24 hours of the exit. The event type automatically stops the report.
Appendix DD – Life Safety & Environment of Care Document List and Review Tool

Revised: 11/29/2017

<table>
<thead>
<tr>
<th>Survey Date:</th>
<th>HCO Number:</th>
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<tbody>
<tr>
<td>Facility Location/Building</td>
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<tr>
<td>BBI</td>
<td></td>
</tr>
<tr>
<td>History Audit Trail</td>
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<tr>
<td>CMS Categorical Waivers</td>
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<tr>
<td>Previous Findings</td>
<td></td>
</tr>
<tr>
<td>Team</td>
<td></td>
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</tbody>
</table>
### Legend:
C = Compliant; NC = Not compliant; NA = Not applicable; IOU = Surveyor awaiting documentation

<table>
<thead>
<tr>
<th>STANDARD - EPs</th>
<th>See Legend</th>
<th>Document / Requirement</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>LS.01.01.01</td>
<td></td>
<td>Buildings serving patients comply with NFPA 101 (2012 edition)</td>
<td>Yes</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Individual assigned to assess Life Safety Code® compliance</td>
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<tr>
<td></td>
<td></td>
<td>Building Assessment to determine compliance with Life Safety Code®</td>
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<tr>
<td></td>
<td></td>
<td>(frequency of assessment is defined by the hospital)</td>
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</tr>
<tr>
<td>EP 1</td>
<td></td>
<td>Current and accurate drawings w/ fire safety features &amp; related square footage</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>a. Areas of building fully sprinklered (if building only partially sprinklered)</td>
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<td></td>
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<td>b. Locations of all hazardous storage areas</td>
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<td></td>
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<td>c. Locations of all fire-rated barriers</td>
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<td></td>
<td></td>
<td>d. Locations of all smoke-rated barriers</td>
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<tr>
<td></td>
<td></td>
<td>e. Sleeping and non-sleeping suite boundaries, including size of identified suites</td>
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<td></td>
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<td>f. Locations of designated smoke compartments</td>
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<td></td>
<td></td>
<td>g. Locations of chutes and shafts</td>
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<tr>
<td></td>
<td></td>
<td>h. Any approved equivalencies or waivers</td>
<td></td>
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</tr>
<tr>
<td>EP 5</td>
<td></td>
<td>Deemed Hospitals: Documentation of inspections and approvals made by state or local AHJs</td>
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**COMMENTS:**

<table>
<thead>
<tr>
<th>STANDARD - EPs</th>
<th>See Legend</th>
<th>Document / Requirement</th>
<th>Addressed in policy?</th>
<th>Implemented as required?</th>
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<tbody>
<tr>
<td>LS.01.02.01</td>
<td></td>
<td>Interim Life Safety Measures (ILSM)</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>EP 1</td>
<td></td>
<td>ILSM policy identifying when and to what extent ILSM implemented</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>EP 2</td>
<td></td>
<td>Alarms out of service 4 or more hours in 24 hours or sprinklers out of service more than 10 hours in 24 hours in an occupied building - Fire watch / Fire Dept. notification</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>EP 3</td>
<td></td>
<td>Signs for alternate exits posted</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>EP 4</td>
<td></td>
<td>Daily inspection of routes of egress (See also 19.7.9.2 RE: daily inspections)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>EP 5</td>
<td></td>
<td>Temporary but equivalent systems while system is impaired</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>EP 6</td>
<td></td>
<td>Additional firefighting equipment provided</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>EP 7</td>
<td></td>
<td>Smoke tight non-combustible temporary barriers</td>
<td>Yes</td>
<td>No</td>
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<td>EP 8</td>
<td></td>
<td>Increased surveillance implemented</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>EP 9</td>
<td></td>
<td>Storage and debris removal</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>STANDARDS - EPs</td>
<td>See Legend</td>
<td>Document / Requirement</td>
<td>Addressed in policy?</td>
<td>Implemented as required?</td>
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<td>IOU</td>
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<td>LS.01.02.01</td>
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<td>EP 10</td>
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<td>EP 12</td>
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<td>EP 13</td>
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<td>EP 14</td>
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<td>EP 15</td>
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<tr>
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<th>See Legend</th>
<th>Document / Requirement</th>
<th>Frequency</th>
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<th>Q 3</th>
<th>Q 4/ Annual</th>
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<td>Q1</td>
<td>Q2</td>
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<tr>
<td>EC.02.03.01</td>
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<td></td>
<td></td>
<td></td>
<td>Hospital Manages Fire Risk – Fire Response Plan</td>
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<tr>
<td>EP 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The written fire response plan describes the specific roles of staff and LIPs at and away from fire including</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• When and how to sound and report fire alarms</td>
<td></td>
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<td></td>
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<td></td>
<td>• How to contain smoke and fire</td>
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<td></td>
<td>• How to use a fire extinguisher</td>
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<td>• How to assist and relocate patients</td>
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<td>• How to evacuate to areas of refuge</td>
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<tr>
<td>COMMENTS:</td>
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<th>Document / Requirement</th>
<th>Frequency</th>
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<th>Q 2</th>
<th>Q 3</th>
<th>Q 4/ Annual</th>
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<tr>
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<td>NA</td>
<td>IOU</td>
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<td>Q1</td>
<td>Q2</td>
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<td>EC.02.03.03</td>
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<td></td>
<td></td>
<td></td>
<td>Fire Drills</td>
<td></td>
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</tr>
<tr>
<td>EP 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fire drills once per shift per quarter: Health Care and Ambulatory Health Care (If available, please provide five quarters of fire drill data)</td>
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<td></td>
<td>Quarterly</td>
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<tr>
<td>EP 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fire drills every 12 months from date of last drill: Business Occupancies</td>
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<td></td>
<td>Annually</td>
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### EC.02.03.03 - Fire Drills

<table>
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<tr>
<th>Document / Requirement</th>
<th>Frequency</th>
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<th>Q 2</th>
<th>Q 3</th>
<th>Q 4/Annual</th>
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<tbody>
<tr>
<td>EP 3</td>
<td></td>
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<tr>
<td>When quarterly fire drills are required, <strong>ALL are unannounced</strong></td>
<td>Quarterly (See fire drill matrix)</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>- Drills held at unexpected times and under varying conditions – greater than one hour apart</td>
<td></td>
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<tr>
<td>- Drills include transmission of fire alarm signal and simulation of emergency fire conditions</td>
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</tr>
<tr>
<td>EP 4</td>
<td></td>
<td>YES</td>
<td></td>
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<tr>
<td>Staff participate in the drills according to the hospital’s fire response plan</td>
<td></td>
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<tr>
<td>EP 5</td>
<td></td>
<td>YES</td>
<td></td>
<td></td>
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<tr>
<td>Critiques include fire safety equipment and building features, and staff response</td>
<td></td>
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**COMMENTS:**

### EC.02.03.05 - Fire Protection and Suppression Testing and Inspection

<table>
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<tr>
<th>Document / Requirement</th>
<th>Frequency</th>
<th>Q 1/ Semi</th>
<th>Q 2</th>
<th>Q 3/ Semi</th>
<th>Q 4/ Annual</th>
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<tbody>
<tr>
<td>EP 1</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Supervisory Signals-including: Control valves; pressure supervisory; pressure tank, pressure supervisory for a dry pipe (both high and low conditions), steam pressure; water level supervisory signal initiating device; water temperature supervisory; and room temperature supervisory.</td>
<td>Quarterly</td>
<td></td>
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</tr>
<tr>
<td>EP 2</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Water flow devices</td>
<td>Semiannually</td>
<td></td>
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<tr>
<td>Tamper switches</td>
<td>Semiannually</td>
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<tr>
<td>EP 3</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Duct, heat, smoke detectors, and manual fire alarm boxes</td>
<td>Annually</td>
<td></td>
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<tr>
<td>EP 4</td>
<td></td>
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<tr>
<td>Notification devices (audible &amp; visual), and door-releasing devices</td>
<td>Annually</td>
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<tr>
<td>EP 5</td>
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<tr>
<td>Emergency services notification transmission equipment</td>
<td>Annually</td>
<td></td>
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<td>EP 6</td>
<td></td>
<td></td>
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<tr>
<td>Electric motor-driven fire pumps tested under no-flow conditions</td>
<td>Monthly</td>
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<tr>
<td>Diesel-engine-driven fire pumps tested under no-flow conditions</td>
<td>Weekly</td>
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<td>EP 7</td>
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<tr>
<td>Water storage tank high and low level alarms</td>
<td>Semiannually</td>
<td></td>
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<tr>
<td>EP 8</td>
<td></td>
<td></td>
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<tr>
<td>Water storage tank low water temp alarms (cold weather only)</td>
<td>Monthly</td>
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<td>STANDARD - EPs</td>
<td>See Legend</td>
<td>Document / Requirement</td>
<td>Frequency</td>
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<td>EC.02.03.05</td>
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<td>Fire Protection and Suppression Testing and Inspection</td>
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<td>NO / Missing Date</td>
<td>NO / Missing Date</td>
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<td>EP 9</td>
<td></td>
<td>Sprinkler systems main drain tests on all risers</td>
<td>Annually</td>
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<tr>
<td>EP 10</td>
<td></td>
<td>Fire department connections inspected (Fire hose connections N/A)</td>
<td>Quarterly</td>
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<tr>
<td>EP 11</td>
<td></td>
<td>Fire pump(s) tested – under flow</td>
<td>Annually</td>
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<td>EP 12</td>
<td></td>
<td>Standpipe flow test every 5 years</td>
<td>5 years</td>
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<td>EP 13</td>
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<td>Kitchen suppression semi-annual testing</td>
<td>Semiannually</td>
<td></td>
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<tr>
<td>EP 14</td>
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<td>Gaseous extinguishing systems inspected (no discharge req.)</td>
<td>Annually</td>
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<td>EP 15</td>
<td></td>
<td>Portable fire extinguishers inspected monthly</td>
<td>Monthly</td>
<td></td>
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<tr>
<td>EP 16</td>
<td></td>
<td>Portable fire extinguishers maintained annually</td>
<td>Annually</td>
<td></td>
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<tr>
<td>EP 17</td>
<td></td>
<td>Fire hoses hydro tested 5 years after install; every 3 years thereafter</td>
<td>5 years / 3 years</td>
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<tr>
<td>EP 18</td>
<td></td>
<td>Smoke and fire dampers tested to verify full closure</td>
<td>1 year after install</td>
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<tr>
<td>EP 19</td>
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<td>Smoke detection shutdown devices for HVAC tested</td>
<td>Annually</td>
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<tr>
<td>EP 20</td>
<td></td>
<td>All horizontal and vertical roller and slider doors tested</td>
<td>Annually</td>
<td></td>
<td></td>
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<td>EP 25</td>
<td></td>
<td>Inspection and testing of door assemblies by qualified person</td>
<td>Annually</td>
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<td>EP 27</td>
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<td>Documentation of maintenance testing and inspection activities for EPs 1-20 and 25 includes: activity name; date; inventory of devices, equipment or other items; frequency; contact info for person performing activity; NFPA standard; activity results</td>
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**COMMENTS:**

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<th>Document / Requirement</th>
<th>Frequency</th>
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<th>NO / Missing Date</th>
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<tbody>
<tr>
<td>EC.02.04.03</td>
<td></td>
<td>Medical equipment inspection, testing and maintenance</td>
<td></td>
<td></td>
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<tr>
<td>EP 10</td>
<td></td>
<td>All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99-2012: Chapter 14.</td>
<td></td>
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**COMMENTS:**
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<thead>
<tr>
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<th>Document / Requirement</th>
<th>Frequency</th>
<th>YES</th>
<th>NO / Missing Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC.02.05.01</td>
<td></td>
<td>Manages risks associated with utility systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identifies activities and associated frequencies, in writing, for inspecting, testing, and maintaining all operating components of utility systems on the inventory. These activities and associated frequencies are in accordance with manufacturers recommendations or with strategies of an alternative equipment maintenance (AEM) program.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note 1: The strategies of an AEM program must not reduce the safety of equipment and must be based on accepted standards of practice. *</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note 2: For guidance on maintenance and testing activities for Essential Electric Systems (Type I), see NFPA 99-2012: 6.4.4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Footnote *: An example of guidelines for physical plant equipment maintenance is the American Society for Healthcare Engineering (ASHE) book Maintenance Management for Health Care Facilities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP 5</td>
<td></td>
<td>Minimizes pathogenic biological agents in cooling towers, domestic hot- and cold-water systems, and other aerosolizing water systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For hospitals that use Joint Commission accreditation for deemed status purposes the following policies, procedures and reports will be reviewed:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Water management program that considers the ASHRAE industry standard and the CDC toolkit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Testing protocols and acceptable ranges for control measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Documented results of testing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Corrective actions taken when control limits are not maintained</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature and humidity. (form of and frequency of assessment per hospital policy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD - EPs</td>
<td>See Legend</td>
<td>Document / Requirement</td>
<td>Frequency</td>
<td>YES</td>
<td>NO / Missing Date</td>
</tr>
<tr>
<td>----------------</td>
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</tr>
<tr>
<td>EC.02.05.01</td>
<td></td>
<td>Manages risks associated with utility systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EC.02.05.07</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STANDARD - EPs**

<table>
<thead>
<tr>
<th>Document / Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Battery powered egress lights tested monthly – 30 seconds; visual inspection of EXIT signs</td>
</tr>
<tr>
<td>Battery powered egress lights tested annually – 90 minutes; or replace all batteries every 12 months and during replacement, perform random test of 10% of all batteries for 1 ½ hours</td>
</tr>
<tr>
<td>Functional test of Level 1 SEPSS, monthly; Level 2 SEPSS, quarterly, for 5 minutes or as specified for its class; Annual test at full load for 60% of full duration of its class</td>
</tr>
<tr>
<td>Emergency power supply system (EPSS) inspected weekly, including all associated components and batteries</td>
</tr>
<tr>
<td>Emergency generators tested monthly for 30 continuous minutes under load (plus cool-down)</td>
</tr>
<tr>
<td>Monthly load test for diesel-powered emergency generators conducted with dynamic load at least 30% of nameplate rating or meets mfr. recommended prime movers’ exhaust gas temperature; OR</td>
</tr>
<tr>
<td>Emergency generators tested once every 12 months using supplemental loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes for total of 1 ½ continuous hours</td>
</tr>
<tr>
<td>All transfer switches monthly/12 times per year</td>
</tr>
</tbody>
</table>

**COMMENTS:**

Note: For more information about areas designed for control of airborne contaminants, the basis for design compliance is the Guidelines for Design and Construction of Health Care Facilities, based on the edition used at the time of design (if available).
### Emergency Power Systems are Maintained and Tested

<table>
<thead>
<tr>
<th>STANDARD - EPs</th>
<th>See Legend</th>
<th>Document / Requirement</th>
<th>Frequency</th>
<th>YES</th>
<th>NO / Missing Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC.02.05.07</td>
<td></td>
<td><strong>Emergency Power Systems are Maintained and Tested</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP 8</td>
<td></td>
<td>Fuel quality test to ASTM standards</td>
<td>Annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP 9</td>
<td></td>
<td>Generator load test once every 36 months for 4 hours</td>
<td>36 Months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP 10</td>
<td></td>
<td>Generator 4 hour test performed at, at least 30% nameplate</td>
<td>36 Months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medical Gas and Vacuum Systems are Inspected and Tested

<table>
<thead>
<tr>
<th>STANDARD - EPs</th>
<th>See Legend</th>
<th>Document / Requirement</th>
<th>THIS MAY BE SCORED AS CONDITIONAL OR STANDARD</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC.02.05.09</td>
<td></td>
<td><strong>Medical Gas and Vacuum Systems are Inspected and Tested</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP 1</td>
<td></td>
<td>Test, inspect and maintain critical components of piped medical gas systems: Source, distribution, master panels, area alarms, automatic pressure switches, shut-off valves, flexible connectors and outlets</td>
<td>Per policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No prescribed frequency; recommend risk assessment if &lt; annual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP 2</td>
<td></td>
<td>Location of and signage for bulk oxygen systems</td>
<td>On Bldg. Tour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP 3</td>
<td></td>
<td>Emergency oxygen supply connection</td>
<td>On Bldg. Tour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP 4</td>
<td></td>
<td>Review medical gas installation/modification/breach certification results for cross connection, purity, correct gas, and pressure</td>
<td>As applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP 5</td>
<td></td>
<td>Medical gas supply and zone valves are accessible and clearly labeled</td>
<td>On Bldg. Tour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP 6</td>
<td></td>
<td>Handling, transfer, storage, labeling, transfilling of cylinders</td>
<td>Per policy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legend:**  C=Compliant; NC=Not compliant; NA=Not applicable; IOU=Surveyor awaiting documentation
Guidelines for Conducting Environment of Care (EC) and Emergency Management (EM) Activities

- For Critical Access Hospitals (CAH), always survey EC and EM
- For all Psychiatric Hospitals, always survey EC
- For other Hospitals, only survey EC and EM if time permits

### Two Day Life Safety Survey (0 to 1.5 million square feet)

<table>
<thead>
<tr>
<th>Area</th>
<th>Life Safety</th>
<th>Environment of Care</th>
<th>Emergency Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 200,000 sq. ft.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>200,001 to 500,000 sq. ft.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>&gt;500,000 sq. ft.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Three Day Life Safety Survey (> 1.5 million square feet)

<table>
<thead>
<tr>
<th>Area</th>
<th>Life Safety</th>
<th>Environment of Care</th>
<th>Emergency Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5 to 1.7 million sq. ft.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>&gt;1.7 million sq. ft.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Four Day Life Safety Survey

<table>
<thead>
<tr>
<th>Area</th>
<th>Life Safety</th>
<th>Environment of Care</th>
<th>Emergency Management</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

### Five Day and Greater Life Safety Survey

<table>
<thead>
<tr>
<th>Area</th>
<th>Life Safety</th>
<th>Environment of Care</th>
<th>Emergency Management</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
### Appendix EE – Building Tour Guidance Document

<table>
<thead>
<tr>
<th><strong>MAIN Fire Alarm Control Panels</strong></th>
</tr>
</thead>
</table>
| a. If panel is not working/in trouble without staff knowledge | LS.01.02.01 EP 2  
LS.02.01.34 EP 2 |
| b. Installed in properly protected area | LS.02.01.34 EP 2 |

<table>
<thead>
<tr>
<th><strong>MAIN Piped Medical Gas Panels</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Working condition of main medical gas alarm panels (i.e., trouble indications)</td>
</tr>
<tr>
<td>b. Not at a continuously attended location (e.g., PBX, ED, etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Bulk Oxygen/Medical Gas Tank Farm or Main Medical Gas Storage Area</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Condition of equipment – status, open valves, piping, tanks flexible attached connections</td>
</tr>
<tr>
<td>b. Storage configuration and labeling (i.e., cylinder, precautionary room/are signage, full/empty)</td>
</tr>
<tr>
<td>c. Outdoor storage (weather protection for outside cylinders)</td>
</tr>
<tr>
<td>d. Proper labeling and accessibility of main control and source valves</td>
</tr>
<tr>
<td>e. Testing piped medical gas and vacuum systems and oxygen supply connection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>OR Suite</strong> - Done early in the survey to allow the organization time to correct while on site. The review of corrective action must include documentation that other areas supplied by same air handler were not negatively impacted by corrective work.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Pressure relationships (check during survey), air exchange rates (balance reports)</td>
</tr>
<tr>
<td>b. Temperature/humidity levels</td>
</tr>
<tr>
<td>c. Surgical fire prevention activities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>MAIN Engineering Locations – boilers, chillers, electrical distribution hub</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Equipment - leaks, general maintenance issues, equipment out of service (ask about risk to patients)</td>
</tr>
<tr>
<td>b. Room - rated wall separation, penetrations, opening protection, fire proofing damage</td>
</tr>
<tr>
<td>c. Minimal storage in Air Handling Control rooms (i.e., only AHU filters)</td>
</tr>
<tr>
<td>d. Eye wash station (and shower if required)</td>
</tr>
<tr>
<td>e. Open J-boxes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>All Generators</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Overall condition/readiness of the generators - is it on auto start? Oil and coolant leaks, clearances, check how batteries are maintained, amount of fuel on hand, cold weather protection</td>
</tr>
<tr>
<td>b. Battery powered task lighting lacking</td>
</tr>
<tr>
<td>c. Room – rated wall separations, sealed penetrations, opening protection, fire proofing damage</td>
</tr>
<tr>
<td>d. Sprinkler/heat detectors (if required)</td>
</tr>
<tr>
<td>e. Open J-boxes</td>
</tr>
<tr>
<td>f. Remote annunciator alarm panel - continuously attended location (e.g., PBX, ED)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Automatic Transfer Switches</strong></th>
</tr>
</thead>
</table>
| i. Explore ATS’s (inventory circuit diagrams, interview) | EC.02.05.07 EP 7  
EC.02.05.01 EP 1 |

<table>
<thead>
<tr>
<th><strong>Fire Pump(s)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Equipment overall condition/readiness of the fire pump – status, valves supervised/secure, leaks</td>
</tr>
<tr>
<td>b. Room condition – rated separation, opening protective</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Kitchen</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Sprinkler head clearance over high storage</td>
</tr>
<tr>
<td>b. “K” extinguisher distance with signage; staff knowledge on proper use</td>
</tr>
<tr>
<td>c. Range hood extinguishing system – direction of nozzles, cleanliness, proper placement of filters</td>
</tr>
<tr>
<td>d. Ansul Systems activates fire alarm system</td>
</tr>
<tr>
<td>e. Fuel source disconnects upon activation of the Ansul system</td>
</tr>
<tr>
<td>Section</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>f.</td>
</tr>
<tr>
<td>g.</td>
</tr>
<tr>
<td><strong>Main Entries/Lobby</strong></td>
</tr>
<tr>
<td>a.</td>
</tr>
<tr>
<td>b.</td>
</tr>
<tr>
<td>c.</td>
</tr>
<tr>
<td><strong>Construction Areas</strong></td>
</tr>
<tr>
<td>a.</td>
</tr>
<tr>
<td><strong>Loading Dock and Receiving Dept.</strong></td>
</tr>
<tr>
<td>a.</td>
</tr>
<tr>
<td>b.</td>
</tr>
<tr>
<td><strong>Roof</strong></td>
</tr>
<tr>
<td>a.</td>
</tr>
<tr>
<td><strong>Empty Patient Rooms</strong></td>
</tr>
<tr>
<td>a.</td>
</tr>
<tr>
<td>b.</td>
</tr>
<tr>
<td>c.</td>
</tr>
<tr>
<td><strong>Exit Stairs, Rated Exit Passageways, Exterior Discharge Areas</strong></td>
</tr>
<tr>
<td>a.</td>
</tr>
<tr>
<td>b.</td>
</tr>
<tr>
<td>c.</td>
</tr>
<tr>
<td>d.</td>
</tr>
<tr>
<td>e.</td>
</tr>
<tr>
<td>f.</td>
</tr>
<tr>
<td>g.</td>
</tr>
<tr>
<td><strong>Smoke Barriers</strong></td>
</tr>
<tr>
<td>a.</td>
</tr>
<tr>
<td>b.</td>
</tr>
<tr>
<td><strong>Two-hour Rated Barriers</strong></td>
</tr>
<tr>
<td>a.</td>
</tr>
<tr>
<td>b.</td>
</tr>
<tr>
<td><strong>Hazardous Areas</strong></td>
</tr>
<tr>
<td>a.</td>
</tr>
<tr>
<td>b.</td>
</tr>
<tr>
<td>c.</td>
</tr>
<tr>
<td><strong>Corridors</strong></td>
</tr>
<tr>
<td>a.</td>
</tr>
<tr>
<td>b.</td>
</tr>
<tr>
<td>c.</td>
</tr>
<tr>
<td>Electrical Closets</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>a. Storage blocking panels</td>
</tr>
<tr>
<td>b. Properly sealed floor, ceiling penetrations if not a shaft properly sealed wall penetrations if a shaft</td>
</tr>
<tr>
<td>c. Check sub-electrical panel schedules to see if they correct</td>
</tr>
<tr>
<td>d. Open junction boxes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Various Indoor Air Quality Locations Areas</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Sterile supply, endoscopy, bronchoscopy, cath labs</td>
<td>EC.02.05.01 EP 15</td>
</tr>
<tr>
<td>b. Isolation rooms</td>
<td>EC.02.05.01 EP 15</td>
</tr>
<tr>
<td>c. Special storage spaces with hazardous materials</td>
<td>EC.02.05.01 EP 16</td>
</tr>
</tbody>
</table>
# Sterile Medication Compounding Survey Guidance

## Appendix FF – Sterile Medication Compounding Survey Guidance

<table>
<thead>
<tr>
<th>Assessment Item</th>
<th>Guidance</th>
<th>Joint Commission Standard</th>
<th>CMS CoP to crosswalk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Certification/Testing Report Evaluation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Engineering Control ISO Level</td>
<td>• Must be ISO 5 or less</td>
<td>MM.05.01.07 EP 4</td>
<td>482.23(c)</td>
</tr>
<tr>
<td>Primary Engineering Control Viable Particle Testing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surface</td>
<td>• Value must be at or less than 3 CFU/cubic meter</td>
<td>IC.02.01.01 EP 1</td>
<td>482.42</td>
</tr>
<tr>
<td>Primary Engineering Control Viable Particle Testing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air</td>
<td>• Value must be at or less than 1 CFU/cubic meter</td>
<td>IC.02.01.01 EP 1</td>
<td>482.42</td>
</tr>
<tr>
<td>Primary Engineering Control HEPA filter leak test</td>
<td>• Must show passed or evidence that holes were patched.</td>
<td>IC.02.01.01 EP 1</td>
<td>482.42</td>
</tr>
<tr>
<td>Secondary Engineering Control Air Exchanges per Hour</td>
<td>• Must have 30/hour. Compounding hood can contribute up to 15 to complete the 30.</td>
<td>EC.02.05.01 EP 15</td>
<td>482.42</td>
</tr>
<tr>
<td>Secondary Engineering Control Air Pressure Differential</td>
<td>• Buffer area=</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Non-hazardous = + 0.02-0.05” H20 to unclassified space</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Hazardous = - 0.01” H20</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ante area = positive to unclassified space</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Engineering Control ISO Level</td>
<td>• Buffer area must ISO 7 or less</td>
<td>EC.02.06.01 EP 1</td>
<td>482.41(a)</td>
</tr>
<tr>
<td></td>
<td>• Ante area must be ISO 8 or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Engineering Control Viable Particle Testing</td>
<td>• Buffer area value must be at or less than 5 CFU/cubic meter</td>
<td>IC.02.01.01 EP 1</td>
<td>482.42</td>
</tr>
<tr>
<td>Surface</td>
<td>• Ante area value must be at or less than 100 CFU/cubic meter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Engineering Control Viable particle testing</td>
<td>• Buffer area value must be at or less than 10 CFU/cubic meter</td>
<td>IC.02.01.01 EP 1</td>
<td>482.42</td>
</tr>
<tr>
<td>Air</td>
<td>• Ante area value must be at or less than 100 CFU/cubic meter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Engineering Control HEPA filter leak test</td>
<td>• Must show passed or evidence that holes were patched.</td>
<td>IC.02.01.01 EP 1</td>
<td>482.42</td>
</tr>
<tr>
<td>Evidence of action taken by organization when any</td>
<td>• There must be evidence of remediation actions taken when items do not pass and subsequent testing to ensure compliance. If this is not present then must be scored.</td>
<td>LD.04.01.01 EP 3</td>
<td>N/A</td>
</tr>
<tr>
<td>item is out of range</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Engineering Control certification / testing frequency</td>
<td>• Each component listed above must be tested and certified every 6 months. Lack of 6 month interval must be scored</td>
<td>EC.02.04.01 EP 4</td>
<td>483.41(d)(2)</td>
</tr>
<tr>
<td></td>
<td>• Also any time PEC is moved or relocated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Engineering Control certification / testing frequency</td>
<td>• Each component listed above must be tested and certified every 6 months. Lack of 6 month interval must be scored</td>
<td>EC.02.06.01 ep 1</td>
<td>482.41(a)</td>
</tr>
<tr>
<td>Compounding Evaluation</td>
<td>• must have continuous monitoring</td>
<td>EC.02.05.01 EP 15</td>
<td>482.42</td>
</tr>
<tr>
<td>Room Structure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Floors</td>
<td>• Must be solid and coved on corners to prevent 90 degree angles where floor meets wall</td>
<td>EC.02.06.01 EP 1</td>
<td>482.41(a)</td>
</tr>
<tr>
<td></td>
<td>• No rips/tears ; check corners for dust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ceiling</td>
<td>• Must be solid material or with sealed drown in ceiling tiles (tiles must be caulked into place)</td>
<td>EC.02.06.01 EP 1</td>
<td>482.41(a)</td>
</tr>
<tr>
<td></td>
<td>• Sprinkler heads should be inset with pop outs, if not check for dust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walls</td>
<td>• Must be smooth with no cracks</td>
<td>EC.02.06.01 EP 1</td>
<td>482.41(a)</td>
</tr>
<tr>
<td></td>
<td>• Where flooring meets walls must not have a ledge</td>
<td></td>
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</tr>
</tbody>
</table>
## Sterile Medication Compounding Survey Guidance

<table>
<thead>
<tr>
<th>Assessment Item</th>
<th>Guidance</th>
<th>Joint Commission Standard</th>
<th>CMS CoP to crosswalk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Engineering Control placement</td>
<td>• Must be placed in an area with ISO 7 or less (if not then can only use a 12 hour BUD)</td>
<td></td>
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</tr>
<tr>
<td>Staff Handwashing/PPE Garbing</td>
<td></td>
<td>IC.02.01.01 EP 1 482.42</td>
<td></td>
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<tr>
<td></td>
<td>• Handwashing must occur to elbows minimum 30 seconds</td>
<td></td>
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<tr>
<td></td>
<td>• Observe order of donning of PPE which must be from dirtiest to cleanest</td>
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<tr>
<td></td>
<td>• Staff wear no make-up, jewelry, or outer garments (sweaters, hoodies, etc)</td>
<td></td>
<td>IC.02.01.01 EP 1 482.42</td>
</tr>
<tr>
<td>Primary Engineering Control Cleaning</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Sterile alcohol must be utilized to clean the hoods</td>
<td></td>
<td>IC.02.01.01 EP 2 482.42</td>
</tr>
<tr>
<td></td>
<td>• Direction of cleaning depends on airflow direction of hood</td>
<td></td>
<td>MM.05.01.07 EP 2 482.23 (c)</td>
</tr>
<tr>
<td></td>
<td>• Cleaning must be done with lint free cloths (not gauze)</td>
<td></td>
<td>MM.05.01.07 EP 2 482.23 (c)</td>
</tr>
<tr>
<td>Sterile Compounding Observation</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Item placement</td>
<td>• Items are wiped down with sterile alcohol as they enter the compounding hood</td>
<td></td>
<td>MM.05.01.07 EP 2 482.23 (c)</td>
</tr>
<tr>
<td></td>
<td>• Items must be placed 6 inches from all sides of the hood including the front</td>
<td></td>
<td>MM.05.01.07 EP 2 482.23 (c)</td>
</tr>
<tr>
<td>Protecting critical sites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The following sites can never be touch:</td>
<td></td>
<td>MM.05.01.07 EP 2 482.23 (c)</td>
</tr>
<tr>
<td></td>
<td>o Any part of the needle; septum of the vial; the sides of the plunger of syringe</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Placement of hands must never block first air to critical points</td>
<td></td>
<td></td>
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<tr>
<td>Single Dose Vial Use</td>
<td></td>
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<tr>
<td></td>
<td>• Single dose vials can be used for up to 6 hours if they are kept within the ISO 5 environment. If they are removed from the environment then they may be used for 1 hour from initial puncture</td>
<td></td>
<td>If not labeled: MM.03.01.01 EP 7 N/A</td>
</tr>
<tr>
<td></td>
<td>• 1 liter bags of sterile water for injection are usable for up to 6 hours if kept in the hood</td>
<td></td>
<td>If value is wrong: MM.03.01.01 EP 2 N/A</td>
</tr>
<tr>
<td></td>
<td>• If removed from ISO 5: MM.03.01.01 EP 2 N/A</td>
<td></td>
<td></td>
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<tr>
<td>Limited storage in buffer area</td>
<td></td>
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<tr>
<td></td>
<td>• Only the furniture, equipment, supplies, and other material required for the compounding activities to be performed shall be brought into the area</td>
<td></td>
<td>MM.05.01.07 EP 2 482.23 (c)</td>
</tr>
<tr>
<td>Compounder Glove cleaning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Should be conducted any time hands leave ISO 5</td>
<td></td>
<td>MM.05.01.07 EP 2 482.23 (c)</td>
</tr>
<tr>
<td></td>
<td>• Use sterile alcohol</td>
<td></td>
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<tr>
<td>CAI/CACI glove exchange</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• This should occur based on manufacturer IFU.</td>
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<tr>
<td>Product labeling</td>
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<tr>
<td></td>
<td>• If BUD is based on refrigeration then must have a store in refrigerator (or similar sticker) label</td>
<td></td>
<td>MM.05.01.09 EP 12 N/A</td>
</tr>
<tr>
<td>PEC/SEC Cleaning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning frequency for SEC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Daily – floors and easily cleanable work surfaces</td>
<td></td>
<td>IC.02.01.01 EP 1 482.42</td>
</tr>
<tr>
<td></td>
<td>• Monthly – walls, ceiling, storage shelves</td>
<td></td>
<td></td>
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<tr>
<td>Cleaning frequency for PEC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• At the beginning of each work shift</td>
<td></td>
<td>MM.05.01.07 EP 2</td>
</tr>
<tr>
<td></td>
<td>• Before each batch preparation is started</td>
<td></td>
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<tr>
<td></td>
<td>• Every 30 minutes during continuous compounding periods of individual CSPs</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• When there are spills</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• When surface contamination is known or suspected from procedural breaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning products</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ORG selects agent – ensure proper dilution</td>
<td></td>
<td>IC.02.01.01 EP 1 482.42</td>
</tr>
<tr>
<td>Cleaning order not correct for PEC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Based on direction of airflow of hood</td>
<td></td>
<td>MM.05.01.07 EP 2 482.23 (c)</td>
</tr>
<tr>
<td></td>
<td>• Always cleanest to dirtiest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning order not correct for SEC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Always cleanest to dirtiest</td>
<td></td>
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### High Risk Compounding Additions
## Sterile Medication Compounding Survey Guidance

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<tr>
<td>Sterilization Process Performed (if not: Call SIG)</td>
<td>• Any product which is classified as High Risk Compounding MUST go through a sterilization process</td>
<td>MM.05.01.07 EP 1</td>
<td>482.25(b)(1)</td>
</tr>
</tbody>
</table>
| Sterilization Record Keeping                        | • Records must have at minimum:  
  o Compounder Name  
  o Date of Products sterilization  
  o Identifier of products in this batch (Lot)  
  o Results of indicators (for biological must have evidence of control and tested BI)  
  o description of sterilization conditions and duration (if not by filtration)                                                                 | MM.05.01.11 EP 2           | 482.25(b)(1)          |
| Sterilization QA Process completed (if not: Call SIG)| • If sterilization by filtration  
  o Must have test of filter after sterilization completed based on IFU  
  • If sterilization by all other methods  
  • QA Testing required includes biological indicator in every load and temperature sensing device (can be part of hardware of sterilizer)                                                  | MM.05.01.07 EP 1           | 482.25(b)(1)          |
| Bacterial Endotoxin (Pyrogen) Testing               | • Required when High Risk Compounds are:  
  o Prepared in groups of more than 25 identical individual single-dose packages  
  o multiple-dose vials (MDVs) for administration to multiple patients  
  o Exposed longer than 12 hours at 2° to 8° and longer than 6 hours at warmer than 8° before they are sterilized before they are dispensed or administered.  
  • If required and not completed, call SIG                                                                                                      | MM.05.01.07 EP 1           | 482.25(b)(1)          |
| Sterility Testing                                   | • Required when High Risk Compounds are:  
  o Prepared in groups of more than 25 identical individual single-dose packages  
  o multiple-dose vials (MDVs) for administration to multiple patients  
  o Exposed longer than 12 hours at 2° to 8° and longer than 6 hours at warmer than 8° before they are sterilized before they are dispensed or administered.  
  • If required and not completed, call SIG                                                                                                      | MM.05.01.07 EP 1           | 482.25(b)(1)          |
| Hazardous Compounding Additions                     | • Must utilize either a biological safety cabinet or a CACI                                                                                                                                           | If in policy MM.01.01.03 EP 3 | N/A                  |
|                                                      | • Must wear 2 pairs of chemotherapy gloves (sterile)                                                                                                                                                  | If in policy MM.01.01.03 EP 3 | N/A                  |
|                                                      | • Must have limited access to only those who need to access area                                                                                                                                     | EC.02.02.01 EP 5            | 482.41(a)            |
| Beyond Use Dating (unless sterility testing has been done to extend the dating listed below)         |                                                                .tc                                                                                                                                          |                            |                       |
| Immediate Use                                       | • 1 hour from start of compounding                                                                                                                                                                   | TBA/DSSM                   |                       |
| Low Risk Compounding                                | • Room Temperature: 48 hours  
  • Refrigerator: 14 days  
  • Freezer: 45 days                                                                                                                                                                               | TBA/DSSM                   |                       |
| Medium Risk Compounding                             | • Room Temperature: 30 hours  
  • Refrigerator: 9 days  
  • Freezer: 45 days                                                                                                                                                                                  | TBA/DSSM                   |                       |

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</table>
| **High Risk Compounding** | Room Temperature: 24 hours  
Refrigerator: 3 days  
Freezer: 45 days | TBA/DSSM | | |
| **Single Dose Vials/Bags** | 6 hours within ISO 5 environment (cannot be removed) | If wrong time MM.03.01.01 EP 2  
If not labeled MM.03.01.01 EP 7 | N/A |
| **Large Volume Bags** | Follow manufacturer package insert | If wrong time MM.03.01.01 EP 2  
If not labeled MM.03.01.01 EP 7 | N/A |
| **Compounding Staff Competency Evaluation** | | | |
| Media-Fill Test | The test complexity must match the complexity level of compounding.  
Low/Medium Risk versus High Risk | Initial HR.01.06.01 EP 5  
Ongoing HR.01.06.01 EP 6 | N/A |
| Gloved Fingertip Testing Initial | 3 separate test required  
To pass test cannot exceed "0" CFU | HR.01.06.01 EP 5 | N/A |
| Gloved Fingertip Testing Ongoing | Ongoing test requires one sample only  
To pass test cannot exceed 3 CFU | HR.01.06.01 EP 6 | N/A |
| Observation Competency | Includes following items  
- Garbing of PPE  
- Aseptic Technique | Initial HR.01.06.01 EP 5  
Ongoing HR.01.06.01 EP 6 | N/A |
| Didactic Written testing | Organization must define “pass” score  
Hazardous compounding must be incorporated if applicable to compounder reviewed | Initial HR.01.06.01 EP 5  
Ongoing HR.01.06.01 EP 6 | N/A |
Important Telephone Numbers

Field Director (FD) on call
800-965-5888, then Option 2, then Option 1 (24 hours, 7 days/week)

Standards Interpretation Group (SIG) on call
HAP/CAH/AHC/OBS/DSC: 630-792-3016
OME/HOSPICE, NCC: 630-792-3013
BHC, LAB, HCSS: 630-792-3014
(On-Call Hours – M-F, 7 a.m. – 7 p.m. Central)

The Office of Quality and Patient Safety (OQPS) on call
800-965-5888, then Option 2, then Option 3

SIG Engineer on call
630-792-3002
(On-Call Hours – M-F, 7 a.m. – 7 p.m. Central)

Accounts Payable
(Expense Reporting & Reimbursement)
AP FAX: 630-792-4613 or
AP FAX: 630-792-4114
630-792-5613
(Steve Mazzone, Manager)

Help Desk
630-792-5599, 630-792-5522
Toll Free: 866-965-3977
(Open 24 / 7)

Survey Technology
630-669-4004
Toll Free: Dial same as for Help Desk
to be routed to Survey Technology
(On-Call Hours – M-F, 7:30 a.m. – 6:00 p.m. Central)

Travel and Transport
877-668-5834
(24 hours, 7-days /week)

Surveyor Management & Development
630-792-5813
(Suzanne Boylan-Murray)

Surveyor Education
630-792-5757
(Barbara Buturusis)