Ambulatory Care Accreditation

Surveyor Survey Activity Guide

January, 2018
What’s New for AHC 2018

Note: Updates effective in 2018 are identified by underlined text throughout this document. All content specific to Ambulatory Surgery Center (ASC) Deemed Status Surveys is highlighted in yellow, Advanced Diagnostic Imaging for CMS recognition is highlighted in blue and Primary Care Medical Home (PCMH) is highlighted in pink. In the print copy this content will appear with a grey background.

Changes effective January 1, 2018

Individual Tracer Addendum – Updated to include guidance for evaluating compliance with the new Sleep Center EP effective in January 2018

Appendix M – 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 X – 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

Changes effective November 15, 2017

Orientation to the Organization – Includes additional topics for discussion related to preparedness for cyber emergencies and mitigating the impact on patient care services

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

Environment of Care and 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

Report Preparation – Corrected contents to reflect current procedures

Appendix A – Immediate Threat to Health or Safety – Updated to include additional procedures 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 W – Evaluating Aspects of Health Information Management Requirements – New appendix added to support AHC program surveyors in exploring organization compliance with the information management standards, with increased emphasis on the topic of cyber emergency preparedness

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
Surveyors
As needed:
• Account Executive
• Field Director

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.

NOTE: Accreditation surveys are unannounced unless they meet an exception rule

Exceptions: The following survey types are announced.
• Initial surveys, unless deemed status requirements specify unannounced surveys
• Early Survey Option (ESO) surveys
• Intracycle Monitoring (ICM) FSA Option 2 and 3 surveys

7 day “short notice” is given to:
• Department of Defense facilities
• Bureau of Prisons facilities and contracted facilities
• Immigration facilities (AHC)
• Office-based surgical practices
• Telehealth services
• Sleep centers
• Ambulatory surgery centers that are not using accreditation for deemed status purposes

An organization that has only one of the following services (unless deemed status requirements specify unannounced surveys):
• Surgery/anesthesia services
• Medical/dental services with fewer than 5,000 annual visits

Before
• Review itinerary and confirm type of survey (unannounced or announced) and whether it is a solo or team survey
• Note the Account Executive name and extension

Four weeks prior to the survey
• Download the following information:
  o Survey agenda
  o E-application data
  o Survey Process Rules for Surveyor Planning
• Begin planning activity using above noted documents.
• If this is a team survey and you are the team leader:
  o Review and follow the Team Leader Responsibilities document in Appendix D of this guide or that is posted on the Surveyor Portal
  o Coordinate travel arrangements with team members
  o Determine a team meeting place and arrival time for survey day one. All team members should arrive at the HCO together unless circumstances dictate otherwise.
• If this is a team survey:
  o Note the team leader’s name and extension
  o 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.)
• Check the internet for an HCO web site. Often these sites provide driving directions and other useful information for surveyors.
• Make travel arrangements

Two weeks prior to survey:
• Access the organization’s ICM Profile
  o View the list of program risk areas
  o View the organization-specific risk areas, when available
  o View the Focused Standards Assessment, if the organization has granted surveyor access
  o View report(s) from the previous full accreditation cycle(s)
  o Note the previous accreditation events/activity
• 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.
or less than three licensed independent practitioners

- Specified diagnostic/therapeutic services* with fewer than 3,000 annual visits or four or fewer licensed independent practitioners
- Mobile diagnostic services

*Refer to the CAMAC, ACC chapter, Unannounced Surveys section, for the list of specified services

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.

- Review the SAFER™ matrix(s) associated with surveys that have occurred since the organization’s last triennial (or initial if applicable) survey.
- 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.
- 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.
- 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.

- 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 a copy of Appendix F: Handout for the AHC Organization for Preliminary Planning Session

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

Review special resources…

For Mobile Diagnostic Imaging and Telehealth
- Review The American College of Radiology website (www.acr.org)
- American Telemedicine Association (www.americantelemed.org)

For Sleep Centers

For Telemedicine Surveys
- Reference the Standards Applicability Table for Telehealth located in the appendix of the CAMAC
- Review the American Telemedicine Association website (www.americantelemed.org)
Surveyor Arrival & Preliminary Planning Session
Applies to: All accreditation programs, except Laboratory.

<table>
<thead>
<tr>
<th>Duration</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 minutes</td>
<td>1. Announce the start of the survey</td>
</tr>
<tr>
<td></td>
<td>2. Allow the organization time to gather documents and staff in order to</td>
</tr>
<tr>
<td></td>
<td>proceed with the survey</td>
</tr>
<tr>
<td></td>
<td>3. Review, and adjust as necessary, any pre-survey planning; begin</td>
</tr>
<tr>
<td></td>
<td>review of documents as they become available</td>
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</tbody>
</table>

**Beginning**

- Review the hours of business on the e-app and plan to arrive no earlier than 10 minutes before the organization opens; survey start times are determined by the organization’s hours of business.
- If the organization is not open when you arrive:
  - Check the e-app for hours of operation and the survey coordinator’s name and phone number
  - Try calling the organization to see if there is any message indicating a change in hours of operation, reason for closure, or emergency contact number
  - If the above does not produce results, call the Account Executive or the Field Director on-call for assistance and further direction.
- If more than one surveyor is conducting the survey, enter the organization together on the first day of survey.

### For providers of Advanced Diagnostic Imaging who serve Medicare beneficiaries:

- Organizations will receive no notice of the survey event prior to surveyor arrival
- Surveys will notify the Field Director On-call of arrival at the organization
- The Field Director On-call will notify the ACO Manager On-call who will contact the organization to validate the survey event

**For Ambulatory Surgery Center (ASC) Deemed Status surveys:**

- 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](http://www.jointcommission.org) to verify the survey.
- 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-App. Positions might include the owner, 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:

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**Participants**

Joint Commission: All surveyors on site.

Organization: Survey Coordinator, Senior leadership

Organizations have been asked to have the following documents available for this session.

- Performance / Quality Improvement Data from the past
- Infection Control surveillance data
- Infection Control Plan
- Environment of Care data including the Statement of Conditions (SOC)
- Environment of Care, Plans for Improvement from last survey, if applicable
- Access to a computer for surveyor to sign off on current Environment of Care, Plans for Improvement
- Environment of Care management plans and annual evaluations
- Environment of Care team meeting minutes for the
- An organization chart
- A map of the organization, if available
- List of all sites that are eligible for survey (AHC only, as applicable)
- List of locations where services are provided, including anesthetizing locations (AHC only, as applicable)
- Any reports or lists of patient appointment schedules or surgery schedules for each day of the survey
- A list of all contracted services
- Name and extension of key contacts who can assist surveyors in planning tracer selection

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• List of surgeries from the past six months
• List of cases in the past 12 months, if any, where the patient was transferred to a hospital or the patient died (Note: The 12-month time frame for this data applies to all ASC organizations seeking deemed status, whether undergoing a Joint Commission initial survey or resurvey.)
• Documents related to the infection control program (e.g., description, policy, procedures, surveillance data)
• Surgery schedule for each survey day

For BPHC surveys, review the following:
• The Health Center’s responses to the “Health Center Self-Report Tool for BPHC Program Expectations”
• The list of Board of Directors membership, including the user/patient/consumer status, occupational/areas of expertise, geographic location, and special population representation.
• Board minutes (past 12 months on all surveys); annual Uniform Data System (UDS) report
• Most recent BPHC Notice of Grant Award (with any conditions or management assessment items)
• Items from most recent BPHC Grant Application: Health Care Plan, Scope of Services; Overall Summary (if available)
• Health Center’s bylaws, strategic plan, and needs assessment

For PCMH Surveys
• Review the “Primary Care Medical Home Self Assessment Tool”

• Notification of scheduled Joint Commission event authorizing your presence
• Surveyor name(s), picture and biographical sketch
• 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 location where you can work and secure your belongings.
  • Begin document review activity if the organization has materials readily available
    • 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.
• If you discover that the organization has a significant change in volume, sites, and services, before or upon your arrival onsite:
  • Call the Account Executive or the Field Director On-Call immediately. Do not assume new service(s) will be included in the scope of 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:
    • APR.01.03.01 being scored (If a discrepancy exists between the organization and central office about whether the organization notified The Joint Commission, score APR.01.03.01and flag it for review.)
    • Extension survey after the full survey
    • Subscription billing fee issues
• If you are onsite, 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 helpful includes:
  • Date service/program started, expanded or discontinued
  • Scope of services/programs, including locations, if applicable
  • Volume
• 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 states: The organization informs the public it serves about how to contact its management to report concerns about patient safety and quality of care. Note: 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.

*For ASC Deemed Status Surveys*

Use the list of scheduled surgeries for each survey day to identify possible candidates for start to finish observation.

Use the list of surgeries from the past six months to select a sample of closed medical records for review. **At a minimum:**

- Select 20 records for a facility with a monthly case volume exceeding 50.
- For lower volume ASCs select at least 10 records.
- The sample size may be expanded as needed.

Inform the organization when you would like these records available. Review records to determine the time elapsed between admission or registration and discharge, specifically identify cases that exceeded 23 hours and 59 minutes. Request and review closed records for all patient deaths or transfers to a hospital within the past 12-months. If possible, review with the physician and discuss the criteria used to assess the patient for surgery and anesthesia in the ambulatory setting. From your review of these records you are evaluating the organization’s processes for identifying appropriate cases for the ASC environment.
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 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. (Same attendees as for the Orientation to the Organization session.)

Attendees may include:
- At least one member of the governing body, or organization trustee. (In single owner organizations, this individual may also be the CEO.)
- Senior organization leaders from all programs/settings. (e.g., Administrator, CEO, Executive Director, Quality Coordinator, etc.)
- Medical staff leaders

For Complex Organization Surveys
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.

Other information
The survey team leader serves as the facilitator for this session.

Objectives
1. Describe the structure of the survey.
2. Answer any questions the organization has about the survey.

During
- 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 standards and provide education/consultation. For PCMH Surveys: Explain that the survey will include an evaluation of compliance with PCMH-specific requirements.
- Ask organization attendees to introduce themselves and make a note of each person’s name and title/functional responsibility
- 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 what care treatment and services they are providing and the locations as reported in their e-application.
- 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 standards 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) 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 standards. 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:

- Daily Briefings
- Special Issue Resolution
- Team Meetings
- Report Preparation Time
- 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.
  - 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.
  - 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.
  - This determination is completed by surveyor(s) onsite and will result in the standard and EP being noted within the matrix.
  - 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
  - All ESCs will be due 60 days after the final survey report is received (there is no longer a 45 day ESC)
  - A SAFER™ matrix generates for each accreditation program if this is a tailored survey

- 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.

- 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, answer those questions 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**
Joint Commission: All surveyors on site.
Organization: Same attendees as for the Opening Conference.

**Other information**
In complex organizations, all services should be addressed in this session.

**Objective**
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 your asking questions throughout as they pertain to topics being discussed. If they indicate a preference for questions at the end, 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
- **For PCMH Surveys:** Ask about the scope of services provided, (i.e., acute, chronic and urgent care) and the types of services available, (i.e., pediatrics, obstetrics/gynecology, behavioral health, dentistry)
  - Determine how the organization uses health information technology (HIT) to support continuity of care, and the provision of comprehensive and coordinated care
- **For ASC Deemed Status Surveys:** Verify that the governing body has full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation
- Operational management structure
- **For ASC Deemed Status Surveys:** Identify who is responsible for directing nursing services and is this individual a registered nurse
- The types of radiologic procedures performed in the ASC
- Are they limited to those that are integral to the procedures performed?
- Whether the organization has designated someone to be responsible for oversight of radiologic services

For ASC Deemed Status Surveys
Request and review governing body meeting minutes or other documents to verify governing body oversight and accountability for the ASC’s QAPI program. This review can occur during the Surveyor Planning Session or Special Issue Resolution.

If applicable, select a sample of contractors working with the ASC and request to see documentation of the most recent contractor performance assessment conducted by the ASC. This review can occur during the Surveyor Planning Session or Special Issue Resolution.
For providers of Advanced Diagnostic Imaging who serve Medicare beneficiaries: Identify who serves as the medical director or supervising physician for advanced diagnostic imaging services

- 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
- Organization efforts to reduce health care errors and other safety initiatives
- Organization performance adhering to National Patient Safety Goals
- Community involvement initiatives
- Leaders’ roles in emergency management planning
- Review with the organization any activities related to risk awareness, detection and response as it relates to cyber emergencies. Suggested discussion topics include:
  - Identification of any medical equipment and care, treatment or service devices that connect the internet.
  - 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 service 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).

- Determine what the leaders are doing to assess the organization’s culture and attention to safety
- Ask leaders about performance improvement to help you better understand:
  - How they set expectations, plan, assess and measure initiatives to improve the quality of services
  - Their approach to safety, including use of information about system or process failures and, when conducted, results of proactive risk assessment
- Board member involvement in safety issues
- Provision of resources including personnel, information systems, data management, and staff training
- The organization's approach to Focused Standards Assessment and methods used to address areas needing improvement

For PCMH Surveys: Ask leaders to describe processes and infrastructure in place to support the provision of coordinated and comprehensive care, including:

- How the organization uses a certified electronic health record to support:
  - Continuity of care, and the provision of comprehensive and coordinated care
  - 24/7 patient access to prescription renewal requests, test results, clinical advice for urgent health care needs, and appointment availability
  - Responding to patient urgent health care needs 24/7
  - Identification of interdisciplinary team members
- Use of an electronic prescribing process and in what locations/areas; is it used for at least 50% of allowable prescriptions?
- Computerized order entry of lab, radiology and medication orders
- Use of a patient portal or secure messaging process to support patient online access to their health information
- The type of providers that serve in the role of primary care clinician (PCC)
- Any sites that have non-physicians serving in the role of PCC
- Processes in place to support patient selection of a PCC
- Patient involvement in performance improvement activities
- Ask about how non-physicians serving as PCCs collaborate with physicians, as needed, to meet patient needs

For Diagnostic Imaging Centers
- Ask about the types of services provided. Typically they consist of:
  - MRI (Open or closed) Magnetic Resonance Imaging
  - CT - Computerized tomography
  - R/F - Radiographic/Fluoroscopic
  - Mammography
  - Ultrasound
  - P.E.T. - Positron Emission Tomography
  - PET/CT – Advanced modality, integrates above with CT
For Mobile Diagnostic Imaging Organizations: Ask about their mobile structures. Typical structures are:
- Trailer type
- Self-propelled
- Semi-fixed (and Fixed) Units

For Teleradiology
- Ask about the services that are provided through electronic or phone communications and if a list of these is available
- 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
(at your request)

Other organization surveyors may participate when cooperative evaluations are in place (e.g., BPHC Financial Reviewer, etc.).

For BPHC surveys, review the following:
The Health Center’s responses to the Governance and Mission & Strategy sections in their “Health Center Self-Report Tool for BPHC Program Expectations”

The list of Governing Board members provided, including the user/patient status, occupational/areas of expertise, geographic location, and special population representation.

The board minutes, BPHC Notice of Grant Award (and any conditions or management assessment items).

If pertinent, review the Health Center’s Bylaws Strategic Plan, Needs Assessment and Board-approved Policies and Procedures.

Surveyor Tips
During performance review, think about possible relationships between negative data problematic issues in the organization. Select patient tracers from locations and services experiencing negative outcomes.

Objectives
1. Begin the review of requested documentation, especially material that is critical to guiding subsequent onsite survey activity
2. Begin the selection of individuals served 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

During
Tracer Selection (25% of session)
• Using the ICM Profile data (services, previous RFIs), identify individual tracers for the day based on the organization’s visit schedule or a patient list. See the Survey Process Rules for Surveyor Planning in Appendix C for guidance.

For ASC Deemed Status Surveys:
Select one surgical procedure to observe from start to finish. Use the list of scheduled surgeries taking place on the days of survey to make this selection.

• If this is a Complex Organization survey, identify surveyors from each program to conduct the system tracers.

Performance Review (50% of session)
• Complete the review of materials listed in the Surveyor Arrival and Preliminary Planning Session. Note: Evaluate all quality management activities (the organization may have different terminology, such as quality control, quality assurance, quality improvement, performance management, etc.)
  o For Providers of Diagnostic Imaging: Look for information about daily Phantoms (and other QC), Densitometry vs. Dosimetry and Radiation Physicist Surveys (State requirements and follow-up).

• Discuss the scope of the survey and which sessions will be conducted by which surveyors. Under the direction of the team leader, review organization data.

• Surveyors conducting the Data System Tracer should complete a review of performance improvement data including aggregation, analysis and action related reports.

• Identify which system tracers, and if possible, which program-specific tracers will be conducted.
  o If this is a Complex Organization survey, one surveyor from each program responsible for conducting the Individual-based System Tracer for Medication Management should review the program specific medication related performance reports, such as medication errors and adverse drug events.
- If this is a Complex Organization survey, one surveyor from each program responsible for conducting the Individual System-based Tracer for Infection Control should review the program specific infection control related performance reports.

- If this is a Complex Organization survey, and you are conducting a system tracer for multiple programs, you must review the necessary information for all programs.

Planning Discussion (25% of session)

- Surveyors review, and when applicable discuss with each other, their findings from the performance review. Take the time to consider what was discovered and where attention should be focused during individual tracers. If this is a Complex Organization survey, surveyors may begin a preliminary comparison of issues that cross the organization.

- Identify the focus for this organization’s 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

- Communicate information to the organization about subsequent tracer activity.
### Individual Tracer

**Applies to:** All accreditation programs.

<table>
<thead>
<tr>
<th><strong>Duration</strong></th>
<th>60-120 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participants</strong></td>
<td>One surveyor</td>
</tr>
<tr>
<td><strong>Organization:</strong> Staff and management who have been involved in the individual’s care, treatment, or services.</td>
<td></td>
</tr>
<tr>
<td><strong>Other information</strong></td>
<td>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 client/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 staff about data collection and use, performance improvement, and, when applicable, medication management, and infection control activities. 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.</td>
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</tbody>
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### 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

- Select Individual Tracer candidates based on the organization’s ICM Profile risk areas, and information discovered during the Orientation session:
- Patients with more complex situations and more contact with various parts of the organizations to assess continuity of care issues
- Patients related to Systems Tracer topics. Refer to the planned system tracers and select at least one individual tracer that pertains to the system.
- Patients that cross programs (e.g. a patient admitted from or discharged to an ambulatory care setting)
- Select patients who are scheduled for, or who have had a Computerized Tomography (CT) diagnostic imaging exam.
- Patients that have been admitted from or discharged to an outpatient service

**For PCMH Surveys:** Select a patient that has had a test ordered or a referral issued

**For ASC Deemed Status Surveys:** Select one surgical procedure to observe from start to finish.

- Patients that cover multiple additional criteria
- You do not need to visit every location of the organization as long as you follow the Survey Process Rules for Surveyor Planning located in Appendix C. All important aspects in the Individual Tracer should be addressed.
- Think ahead: Prepare for upcoming system and program specific tracers by identifying patients or equipment to trace.

### During

- 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.
- 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:

- Compliance with other applicable standards pertinent to the individual being traced.
to obtain it for the next scheduled issue resolution time.

REMEMBER!
Reference the System Tracers and Program Specific Tracers matrix in the appendix to determine which system tracers will be a part of this survey.
- Surveyors conducting the Individual Infection Control Tracer must select to trace a patient with an infection.
- Surveyors conducting the Individual Tracer for Medication Management must select to trace a patient taking a high risk medication.

Surveyor MRI Precaution!
REMOVE your magnetic hotel room key and all other cards with magnetic strips from your pocket before entering the magnet area.

- Intradepartmental and interdepartmental communication for coordination of patient care. (Pay particular attention to handoffs – these are critical points in time when errors occur.)
- Ask about data collection in units/departments, e.g. turnaround time, wait time
- Determine if improvements in flow have been made
- Processes and role to minimize risk
- National Patient Safety Goals (NPSGs) Reminder: All applicable NPSGs must be evaluated during the course of survey

- Patient education processes
- Orientation, training and competency testing
- Emergency management roles and responsibilities, including mitigation, preparedness, response and recovery/business continuity related to the following:
  - Communication with patients
  - Communication with staff
  - Communication with relevant external entities (such as vendors, contracted providers, parent company, public health or other public authorities, other health care organizations, alternative care sites, etc.
- Awareness of content of APR.09.02.01 (staff are permitted to contact The Joint Commission with concerns of patient safety without fear of recrimination)
- The 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 or service 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 service
- Other issues, relative to care, treatment or services
- Validation of information learned during other survey activity

For PCMH Surveys:
- How non-physicians serving as PCCs collaborate with physicians as needed to meet patient needs
- How physicians are included in patient interdisciplinary teams
- The use of computerized order entry and electronic prescribing including when and how often they are used
- What processes are in place to support patients getting a same or next day appointment
- Processes to provide patients online access to their health information
- The electronic health record and whether or not it provides patient reminders, and which patients are sent these reminders
- How they facilitate patient access to optical health and rehabilitative services and equipment
- The collection and documentation of patient information, such as gender, blood pressure (for patient ages 3 years and older), and smoking status (for ages 13 and older)
- Information provided to patients about the credentials and educational background of individuals serving in the role of PCC within the PCMH
- How they track and follow-up on test results and referrals; validate this through review of clinical records
- Recommendations or results from referrals are available to the PCC
- The members of the patient’s interdisciplinary team
- How the interdisciplinary team works to collaborate on patient care; ask staff to describe, perhaps through examples
- How patient self-management goals are incorporated into the treatment plan; ask to see examples in the clinical record

Interview patients and when appropriate, family members, about:
- Coordination of services including timeliness,
- Education provided
- Response time when call bell is initiated or alarms ring
- Perception of services
- Understanding of discharge instructions
- Staff compliance with NPSGs
- Other issues, relative to care, treatment or services
- Validation of information learned during other survey activity
- Receipt of patient rights information

For ASC Deemed Surveys
• How and when the organization provided them with patient rights information—verbally and in writing and prior to their surgical procedure
• If they received financial disclosure information in writing
• If prior to the start of their surgical procedure were they provided with written information concerning organization policies on advance directives, including a description of applicable state health and safety laws and a copy of the official state advance directive forms

For PCMH Surveys
• Information provided to them in support of their selecting a PCC
• Information provided to them about how the organization functions and the available services
• Directions they received about obtaining urgent care after the office/clinic is closed and if they have ever needed such care

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.
• Clinicians (including physicians, APNs and PAs) providing direct patient/client care. Note: Clinician observation is required.

Observation of surgical procedures is permitted after patient and organization permission has been obtained.

Surveyors must enter the surgical suite to observe procedures. If the organization is not willing to allow you to observe, remind them that evaluating compliance with a number of the standards and NPSGs requires observation in the surgical setting. Also, Accreditation Participation Requirements (APR.02.01.01) indicates that the organization permits the performance of the survey, which includes observing all aspects of the care, treatment and services being provided. This is the time to evaluate compliance with the NPSGs including time out and hand hygiene guidelines, terminal cleaning, instrument sterilization, etc.

For ASC Deemed Status Surveys: Surveyors must observe at least one surgical procedure from start to finish.

Do not observe long surgical procedures as this will interfere with your ability to conduct other necessary survey activity.
• Medication processes (e.g. preparation and administration of medications, storage, and control 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.

For PCMH Surveys: Ask clinicians how they assess patient health literacy—This activity should not be limited to a “repeat back” process
After

- Review pertinent meeting minutes and procedures if needed.
- As necessary, pull additional records to verify standards compliance issues identified during the Individual Tracer.
- Consider the relationship of your observations to system level issues.
- 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 following represent areas that are based upon current literature and Joint Commission standards. These suggestions are not all inclusive of the issues and topics that can or should be covered in a tracer.

DO NOT use this as a checklist of topics to cover, but rather let the tracers guide you to these issues.
DO NOT over survey in these areas but if issues are identified, follow through with drill down activity.

Clinical services

- Discuss and review clinical/medical records:
  - Review the timing of patient care assessments
  - Evaluate the comprehensiveness of history and physical documentation against the scope and content defined by the organization [2/18/10], and determine who performs the history and physical
  - 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)

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 breast feeding
- 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 the 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).
  Appendices T 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
- 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.

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.

Discharge Planning
Active Review
- Ask for a list of patients who are going to be discharged during the survey.
- Review the patient’s medical/clinical record for post encounter instructions.
- 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)
  - 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 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
  - 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, physician therapy)
- Interview the nurse/clinician about the discharge process, including:
  - Origination of discharge information (physician-nurse communication regarding discharge instruction)
  - Evaluation of the patient for anesthesia recovery and who performs the evaluation
    - For ASC Deemed Surveys—Identify who discharges the patient
- Hand-off communication.

Discharge Planning – Retrospective Review
- Ask for a list of patients who received services during the past 48 hours; for ASC Deemed Surveys—list of cases in the past 12 months, if any, where the patient was transferred to a hospital or the patient died, and list of surgeries from the past six months.
- Review the patient’s previous medical/clinical record for discharge orders; for ASC Deemed Surveys—identify who discharged the patient.
- 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 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, physician therapy)

• For ASC Deemed Surveys – determine if the organization provided the patient with any supplies
• Explore the patient’s perception of their discharge instructions. Do they believe they were given all of the information needed?

Emergency Services
• Discuss:
  o The immediate availability of services, equipment (for ASC Deemed Surveys: hyperthermia cart), personnel and resources for providing patient care; ask to see the policy on emergency equipment
  o The integration and communication of emergency services with other departments (e.g., surgery, laboratory, diagnostic services, etc.)
  o Process for transfer of patients to the hospital; review the transfer order
  o Provisions for follow-up care of emergency services to patients who were not transferred to the hospital
  o EMS services: Time to arrival at AHC location and time to hospital

Environment of Care
• Observe the condition of the facility areas used by patients (e.g., safe, clean, functional, and comfortable)
• Discuss:
  o The process for conducting environmental tours to identify environmental deficiencies, hazards, and unsafe practices
    ▪ Management of hazardous materials and waste
• Ask various staff members to explain their role in fire management.

Emergency Management
• Ask various staff members to explain their role in emergency management
• Ask various staff members to explain their role and responsibilities during an emergency, including:
  o Information, education or training they’ve received
  o Understanding of medical and non-medical supplies, equipment, and any personal protective equipment needed for their role
  o Understanding and planning for emergency incidents that go on for a week or more
• Ask leaders about chain of command and communication processes in the event of an emergency
• Ask leaders and staff about their participation in exercises of the Emergency Management Plan and evaluations of the exercises.

Hand Hygiene - Observe clinicians (this includes surgeons, anesthesiologists, nurses, etc.) 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:
  o Having direct contact with patients (e.g. medication administration, physical exam etc.)
  o Inserting invasive devices that do not require a surgical procedure
• After:
  o Contact with a patient’s intact skin, e.g. when taking a pulse or blood pressure, administering medications and lifting a patient
  o Contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings
Removing gloves
o Before donning sterile gloves when performing surgical procedures

Infection Control
- Observe surgeons, anesthesiologists, nurses, etc., for compliance with CDC or WHO hand hygiene techniques
- Interview and observe, as appropriate, sterilization of equipment, disinfection, food sanitation, housekeeping cleaning processes, 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)
- 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
- Discuss with staff
  o Surveillance, and testing and isolation precautions
  o Awareness of organizational outcomes data (surgical site infection rates, etc.)

For ASC Deemed Status Surveys: Complete the Infection Control Surveyor Worksheet – See Appendix L

Laboratory Integration
- 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 (AHC, OBS)
Trace a patient (active or discharged) who received blood or blood products. 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:
  o communication
  o patient identification
  o blood product identification
  o 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:
- Protocol for ordering and issuance, including:
  o communication
  o patient identification
  o blood product identification
  o 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

Medical/clinical Record Content
- Verify that:
  o Information (e.g., 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 and authenticated (as required by law)
  o A complete informed consent is obtained, when applicable
  o Orders for care, treatment and services are in compliance with organization policy (timing of the order in comparison to when care, treatment and services are initiated)
The organization has a medical record retention policy and how the timeframe was determined

- Review medical/clinical records for:
  - The presence of sufficient information to identify the patient, support the diagnosis, justify continued hospitalization, describe the patient's progress, and respond to care, treatment, and services
  - Authentication of the history and physical exam, operative report, consultation, and discharge summary

Medication Management

- 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:
  - Proper emergency medication storage (sealed or locked containers; in a locked room; or under constant supervision)
  - Appropriate labeling of medications
  - The presence of a list of medications approved for dispensing or administering (must be readily available)
  - Safe storage of medications, including controlled substances
  - Process for clarifying unclear medication orders
  - 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; and other relevant medication-related issues or concerns
- Discuss:
  - Process for ensuring safety with high risk/high alert medications
- Discuss the process for:
  - Dealing with medications brought into the organization by the patient.
  - Access to medications when the pharmacy is closed (if applicable)
  - Control and transportation process for unused, expired, or returned drugs are controlled by the pharmacy
- Review medication orders for:
  - Clarity and completeness
  - Adherence to safety standards (e.g., no blanket reinstatement of previous orders).
- Observe:
  - Preparation of hazardous medication, e.g. chemotherapy
  - Preparation and storage of high risk medications

Patient Rights

- Staff discussion and observation:
  - Patient rights posting, note where these are posted and determine if they contain the requirement elements
  - Brochures and other printed matter provided to patients that contains patient rights information. For ASC Deemed Surveys: Determine if the patient rights information is provided to patients verbally and in writing and prior to their surgical procedure.
  - 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
  - Processes in place to ensure compliance with their policy on privacy of health information
  - Financial interest disclosure to patients and the timing and documentation of such notification. For ASC Deemed Surveys: Determine if the financial disclosure information is provided in writing to patients.
  - Complaint and grievance process, including a review of the policies and procedures, tracking system, and patient notification of status or resolution of grievances
  - Awareness of abuse and neglect policies and procedures, review actual documentation and ask if there have been any allegations during the past year
  - ForASC Deemed Surveys: Determine if the organization provides patients prior to the start of their surgical procedure with written information concerning its policies on advance directives, including a description of applicable state health and safety laws and, if requested, official state advance directive forms.
For PCMH Surveys: Determine if patients are allowed to select their PCC or does the organization assign patients to a PCC.

(For ASC Deemed Status Surveys: Exceptions to patient rights notification prior to the date of the procedure are as follows: a) the referral to the ASC for surgery is made on that same date; b) and the referring physician indicates, in writing, that it is medically necessary for the patient to have the surgery on the same day; c) and surgery in an ASC setting is suitable for that patient.)

- Patient and family understanding of:
  - Rights, including advanced directive and end of life decisions, review medical record to validate the provision of the information to the patient
  - Process to register a complaint or grievance
  - Patient safety and personal / health information privacy
  - Financial interest disclosures, and when they received such notice. For ASC Deemed Surveys: Determine if the financial disclosure information is provided in writing to patients.

Performance Improvement
- Discuss, as appropriate, with staff involved in day-to-day clinical and operations activities:
  - Data collection process and responsibilities (e.g., medication management, blood and blood product use, restraints and seclusion, behavior management and treatment)
  - Performance being monitored for patterns or trends
  - Any changes made as a result of performance improvement activities
  - 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 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 staffing effectiveness and patient health outcomes, high-volume, high-risk, or problem prone processes, significant changes in the internal or external environment
  - Proactive activities for identifying and reducing unanticipated adverse events and safety risks to patients

Point of Care Testing
- Under Development

Radiology, Nuclear Medicine and Other Imaging Services
- General Radiology and Imaging Services
  - Interview patients, technicians and clinicians
  - Evaluate all steps in the diagnosis/treatment process. The following is not all inclusive but provides examples of what can be included:
    - Referral – orders, admission criteria (if applicable), timeframes
    - Assessment – safety issues from metal, pacemakers, aneurism clips or other implants (if the patient worked with metal in the past, there could be a risk for embedded metal shavings), claustrophobia, sedative or alcohol use the day of the study, pain management, allergies to contrast media, medication reconciliation
    - Patient communication (if applicable) – education content and format (includes language and diagrams), coordination of information, liaison between the organization and patient
    - Patient Rights including the organization’s process for assisting patients with obtaining copies of their imaging records
    - Use of sedation
    - Waived testing (e.g. glucose testing in PET "Hot Lab" area)
    - Information Management – flow of information within the organization and externally including from and to the originating organization, process for having test results read, communication of critical values (if applicable), record keeping, security, privacy
    - Performance Improvement - ALARA (As Low As Reasonably Achievable), routine monitoring of over-radiation and duplicate studies (retakes)
    - Contracts, clinical practice guidelines, policies and procedures
    - Processes in place to ensure safe handling of hazardous materials and waste
    - Radiation exposure monitoring procedures
- The organization’s timeframe for record maintenance. **For ASC Surveys:** The ambulatory surgical center must retain the original of legally reproduced medical record for at least five years.
  - Discuss and observe, as applicable:
    - Patient and staff safety (e.g., safety with patient transfers or lifts, shielding, lead aprons, pregnant patients, radiation safety including wearing radiation exposure meters, chemical storage, etc.)
    - Exposure meter testing documentation to verify compliance with organizational policy
    - Dissemination of reports
  - **For providers of Advanced Diagnostic Imaging who serve Medicare beneficiaries:**
    - Documentation of activities and frequencies to maintain the reliability, clarity, and accuracy of the technical quality of diagnostic images produced.

- **Magnetic Resonance Imaging (MRI) Services**
  - Discuss and observe, as applicable, how the organization manages safety risks in the Magnetic resonance imaging (MRI) environment associated with the following:
    - Patients who may experience claustrophobia, anxiety, or emotional distress
    - Patients who may require urgent or emergent medical care
    - Metallic implants and devices (including pacemakers and aneurism clips)
    - Ferrous objects entering the MRI environment

- **Mobile Diagnostic Imaging Services**
  - Identify the types of service(s) provided by the mobile unit.
  - Review equipment transportation and delivery, set-up, maintenance, removal processes.

**Rehabilitation Services**
- Review and discuss:
  - Documented (Medicare only) plan of treatment prior to the beginning of treatment
  - 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)
  - Role of interdisciplinary team

**Respiratory Care Services**
- Discuss:
  - Safety practices, including infection control measures for equipment, sterile supplies, biohazard waste, posting of signs and gas line identification
  - Medication storage, ordering, dispensing and administration
  - Procedure for treatment of adverse reactions
  - Review preventive maintenance logs
- Review and observe:
  - handling, storage, and dispensing of therapeutic gases
  - Cardiopulmonary resuscitation
  - Testing protocols, e.g. pulmonary function testing, bronchopulmonary drainage, mechanical ventilation and oxygenation support, aerosol, humidification and therapeutic gas administration

**Sleep Centers**
- Identify a variety of individuals for tracing. For example, consider reviewing different patient populations (age, diagnoses, referral sources).
- Evaluate all steps in the process. The following is not all inclusive but provides examples of what can be included:
  - Referral – orders, admission criteria (if applicable), timeframes.
  - Equipment – transportation and delivery, set-up, maintenance, removal—Note: This evaluation could possibly include coordination with a home care surveyor.
  - Patient communication – education content and format, coordination of information from the Sleep Center and the referring organization.
  - Information Management – flow of information within the organization and externally including from and to the referring organization, process for having test results read, communication of critical values (if applicable), record keeping, security, privacy.
  - Contracts, clinical practice guidelines, policies and procedures.
- Conduct interview with patients, technicians and clinicians.
- Review a sample of credentialing files to verify that the credentials of physicians responsible for interpreting sleep studies:
o Are board-certified in Sleep Medicine by the American Board of Sleep Medicine (ABSM) or by a member board of either the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA), or

o Have completed an ACGME-accredited sleep medicine fellowship, and obtained board certification within two examination cycles through the American Board of Sleep Medicine (ABSM) or a member board of either the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Surgery and Anesthesia

- **For ASC Deemed Surveys:**
  - Review the timing of pre-surgical assessments
  - Determine if the pre-surgical assessment includes allergies to drugs and biologicals
  - Determine who is conducting the pre-surgical assessment
  - Determine that both the pre- and post-surgical assessments include discharge requirements

- Discuss and review protocols for supportive life functions such as:
  - Cardiac and respiratory emergencies
  - Resuscitative techniques and equipment
  - Availability of age appropriate emergency medications, supplies and equipment
  - Process for handling Advance Directives

- Observe Universal Protocol in action (patient permission required)
  - observe for any physical exams that take place immediately prior to anesthesia administration or the procedure

- Evaluate other processes related to surgery and anesthesia such as:
  - Informed consent process; **For ASC Deemed Surveys: Review the timing for when this process takes place**
  - Pre-operative care, including policies and procedures for assessment of anesthesia and procedural risk, particularly the criteria ASC physicians use in making the assessments
  - Procedural monitoring
  - Post operative care

- Verify in the medical record that:
  - A provisional diagnosis is recorded before the operative procedure
  - A current H & P is in the record prior to surgery as per law and regulation; for ASC Deemed Surveys—the H & P is performance not more than 30 days prior to surgery
  - A pre-procedural assessment is performed by a physician and includes the patient’s risk for the planned surgery and anesthesia
  - Patient evaluation for recovery from anesthesia occurred prior to discharge

Telehealth

- Identify a variety of individuals for tracing. For example, consider tracing different types of tests, branch offices and patient populations (age, diagnoses, referral sources).
- Evaluate all steps in the process. The following is not all inclusive but provides examples of what can be included:
  - Evaluate all steps in the process. The following is not all inclusive but provides examples of what can be included:
    - Referral – orders, admission criteria (if applicable), timeframes.
    - Equipment – transportation and delivery, set-up, maintenance, removal.
    - Patient communication (if applicable) – education content and format (includes language and diagrams), coordination of information, liaison between the organization and patient.
    - Information Management – flow of information within the organization and externally including from and to the originating organization, process for having test results read, communication of critical values (if applicable), record keeping, security, privacy.
    - Contracts, clinical practice guidelines, policies and procedures.
    - Interview patients, technicians and clinicians.
Special Issue Resolution
Applies to: All accreditation programs where 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.

Objective
Further investigate and resolve any open issues from previous survey activity

Before
• If necessary, inform your organization contact of who you would like to attend the session.
• 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 for your review.

During
• Discuss with attendees issues identified during the course of the survey for which you would like further information.
• Review documentation pertinent to the issues identified during the survey, such as:
  • Policies and procedures
  • Additional patient or specimens/tests to confirm an Individual Tracer finding
  • HR or credentials files
  • Measures of Success or implementation status of improvements shared with surveyors about plans of actions
  • Review of data, such as performance improvement projects and results
  • Review of contracts, as applicable, for performance expectations and information on how performance monitoring is conducted
Team Meeting / Surveyor Planning – End of Day
Applies to: All accreditation programs.

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

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
Surveyor(s) should:
- Review and discuss their observations with other surveyors when applicable
- Report on the National Patient Safety Goals they have evaluated
- Think about and review connections between observations and systems. Plan the approach to survey activities for the next day.
- Establish areas of focus for subsequent tracer activity based on identified concerns.
- 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 Preparation section for further information on how to edit the matrix.
- Identify topics for upcoming system tracer(s)
• Review and verify the status of 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 to the organization contact /liaison
**Daily Briefing**

*Applies to:* All accreditation programs where the survey lasts more than one day.

<table>
<thead>
<tr>
<th><strong>Duration</strong></th>
<th><strong>Objectives</strong></th>
</tr>
</thead>
</table>
| 30 to 45 minutes | • 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. |

**Discussion**

- 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 a systemic issue.
- Do not discuss in detail each survey activity, specific records, and discussions held with individuals during Individual Tracers.
- Address requests for consultation on findings 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 final findings for any given standard will be available only when all activities are complete and results are aggregated.
- Answer attendees’ questions and clarify your comments where requested.
- Review the agenda for the day (including identifying Individual Tracer candidates).
- 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 a finding.

**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. This is intended as a briefing, not a detailed report out. Be considerate of staff time. Do not make all organization representatives stay for a discussion that is specific to a small group of individuals.

  - Team Leaders need to serve as time keeper and other team members should serve in this role when the team leader is briefing.

  - Conclude the briefing and transition to the next activity(s) according to the agenda.

At the last day Daily Briefing

- 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 the start of the Report Preparation session
Competence Assessment / Credentialing of Licensed Independent Practitioners
Applies to: Ambulatory accreditation programs

<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: Staff responsible for:</td>
<td></td>
</tr>
<tr>
<td>• Aspects of the organization’s human resources processes.</td>
<td></td>
</tr>
<tr>
<td>• Orientation and education of staff.</td>
<td></td>
</tr>
<tr>
<td>• Assessing staff competency.</td>
<td></td>
</tr>
<tr>
<td>• Assessing licensed independent practitioner and other credentialed practitioner competency, when applicable.</td>
<td></td>
</tr>
</tbody>
</table>

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.

For ASC Deemed Status Surveys:
• Review a sample of personnel records for non-physician licensed practitioners (See Sampling Table 1) providing care in the ASC for evidence of:
  • Current licenses in good standing

Objectives
• Learn more about the organization’s competence assessment process for staff
• Learn more about the organization’s competence assessment process for licensed independent practitioners, and other credentialed practitioners
• Learn more about the organization’s orientation, education, and training processes as it relates to staff, licensed independent practitioners, and other credentialed practitioners encountered during Individual Tracers
• Identify competence assessment process-related strengths and potential risk points
• Understand the credentialing and privileging process for licensed independent practitioners

During
• Using data gathered during Individual Tracer activity, engage attendees in discussion of the following topics:
  o Internal processes for determining compliance with policies and procedures, applicable law and regulation, and Joint Commission standards.
  o Methods used to determine staffing adequacy; frequency of measurement; what is being done with the results.
  o Performance improvement initiatives related to competency assessment for staff
  o Performance improvement initiatives related to competency assessment for licensed independent practitioners, and other credentialed practitioners, as applicable.
  o Orientation of staff, licensed independent practitioners, and other credentialed practitioners to the organization, job responsibilities, and/or clinical responsibilities.
  o Experience, education, and abilities assessments
  o Ongoing education and training
  o Competence assessment, maintenance, and improvement.
  o Competence 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)
  o Qualifications, competence and experience of the medical physicist(s) supporting CT services
  o 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
Qualifications and Periodic evaluation in accordance with the ASC’s policies
- Review the personnel files of contract personnel to verify credentials, privileges, evidence of training, as applicable
- Review the qualifications of individuals authorized to deliver anesthesia in the ASC, to determine if they are consistent with regulatory requirements.
- Verify that the individuals performing procedures have privileges granted by the governing body.
- Review a sample of credentials files for medical staff (See Sampling Table 1) who have been granted privileges for the following:
  - state licensure, registration, or state certification as applicable
  - training and pertinent experience
  - scope of privileges granted
  - evidence that they are legally and professionally qualified to exercise privileges granted
  - evidence of reappraisal within the timeframe specified in the ASC’s policy
- Review the personnel file of the individual responsible for oversight of all radiologic services
- Review personnel files of selected practitioners and staff for qualifications and competency assessments related to assigned responsibilities
- Review personnel record of the person responsible for directing infection control activities for evidence of training in infection control

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.
- Process for granting of privileges to licensed independent practitioners and telemedicine practitioners, if applicable
- Other issues discovered during Individual Tracers.

- As you deem necessary, review the files of specific staff, licensed independent practitioners, and other credentialed practitioners.
- Summarize strengths and potential risk points in the organization’s competency assessment process.

After
- Verify through review of a sample of employee health files any documentation that staff has undergone required health screenings.
- 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
- Consider the relationship of your observations to system level performance.
- Share issues with other team members, if applicable, so they can be further explored in subsequent Individual Tracers.

Credentialing Considerations for Mobile Diagnostic Imaging
- Review the contracts. Identify who is reading and interpreting the studies.
- Credentialing standards do not apply to those providers reading the studies when the organization does not include reading and interpretation under their scope of services. Some organizations perform this service by employing or contracting with radiologist(s) and this is referred to as a retail setting.
  - If the organization reads the studies, the standards apply.
  - If the organization does not read the studies, the standards may not apply but you must review contracts to understand.

Competency Considerations for Providers of Diagnostic Imaging
- Review the personnel files for a sample of technologists for competency
- Defer to state law and regulation to answer questions about technologists performing intravenous medication injection
- Review the personnel files for a sample of drivers for evidence of competency and safety

**For providers of Advanced Diagnostic Imaging who serve Medicare beneficiaries:**
- Review the personnel/credential file of the medical director or supervising physician of advanced diagnostic imaging services for evidence of training in advanced diagnostic imaging services obtained through:
  - a residency program,
  - experience, or
  - continuing medical education courses

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**For ASC Deemed Status Surveys**

**Sampling Table 1**

Sampling guidelines for review of medical staff credentials files and non-physician licensed practitioner personnel records

<table>
<thead>
<tr>
<th>Total number of medical staff and non-physician licensed practitioners:</th>
<th>Minimum number of personnel records to review:</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 or less</td>
<td>19</td>
</tr>
<tr>
<td>31-99</td>
<td>22</td>
</tr>
<tr>
<td>100-999</td>
<td>25</td>
</tr>
<tr>
<td>1000+</td>
<td>29</td>
</tr>
</tbody>
</table>

**For PCMH Surveys:**
- Review the personnel or credentials files of one or more clinicians serving in the role of PCC for evidence of broad-based education and experience in the provision of primary care
Environment of Care & Emergency Management Session – AHC, OBS
Applies to: AHC, OBS accreditation programs.

Duration - Variable
60-120 minutes

Participants
Joint Commission: One surveyor.
Organization: Individuals able to address issues related to managing the environment of care and emergency management in all major areas within the organization
- Safety management coordinator
- Security management coordinator
- Facility manager(s)
- Responsible person for emergency management activities
- Building utility systems manager
- Responsible person for medical/laboratory maintenance
- Environment of care or safety team leader
- IT Representative
- Organization leadership

TIP: Be sure to include responsible staff members during the “out and about” portion of the tracer. 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.

Objective
Assess the organization’s degree of compliance with relevant standards and identify vulnerabilities and strengths in the organization’s environment of care and emergency management processes.

Note: Specific emergency management evaluation activities related to CMS Deemed Status requirements for ambulatory surgery centers (ASC) and federal requirements for rural health clinics (RHC) and federally qualified health centers (FQHC), are indicated with appropriate headers.

Before
Review the following documents.
- Annual evaluations of the Environment of Care (EC) management plans (EC.04.01.03) *Not applicable to initial surveys*
- CMS Deemed Status ASC, and RHC/FQHC only: Annual review and update of the Emergency Management Plan.
- CMS Deemed Status ASC, and RHC/FQHC 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 organization performing non-clinical functions, or may be skilled providers who regularly volunteer or come in response to particular events or incidents. Training should be consistent with their usual responsibilities and role (if any) in the emergency response plan.
- CMS Deemed Status ASC, and RHC/FQHC 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.
  - Review the organization’s performance from emergency management drill activity. Drills are required for addressing the emergency management requirements of standard EM.03.01.03.
  - Review any changes to the Emergency Management Plan based on the organization’s evaluation of exercises and responses to actual events.
  - Review the organization’s performance from fire drills and fire response activity
  - Review EC-related issues observed and discovered in previous survey activities (including those made by other survey team members, when applicable). Analyze the data

Special Consideration for Magnetic Resonance Imaging (MRI) Services:
Evaluate how the organization manages safety risks for:
- Patients who may experience claustrophobia, anxiety, or emotional distress
- Patients who may require urgent medical care
- Metallic implants and devices (including pacemakers and aneurism clips)
- Ferrous objects entering the MRI environment
collected on survey up to this point and identify strengths and patterns of weakness in management processes related to EC-risks to review with the organization.

- Management processes include:
  - Plan
  - Teach
  - Implement
  - Respond
  - Monitor
  - Improve

- EC-risks include:
  - Safety
  - Security
  - Hazardous materials and wastes
  - Emergency management
  - Fire safety
  - Medical/Laboratory equipment
  - Utilities
  - Construction

During Environment of Care and Emergency Management Discussion

Engage attendees in discussion about environment of care risks that have been addressed in each of the 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 residents, 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

Review the organization’s performance in addressing the Emergency Management standards including:

- Identifying potential risks and emergencies that may affect the need for their services or the ability to provide those services (sometimes referred to as a Hazard Vulnerability Analysis (HVA))
- Determining their response strategies (e.g., maintaining or expanding services, curtailing services, working with alternative care site, closing and reopening after emergency, evacuation) and how the Emergency Management Plan supports these strategies
- Identifying its role in relation to the community’s, county’s or region’s emergency response plan;
- CMS Deemed Status for ASC only: The organization’s identification of alternative site(s) for care, treatment, and services that meets the needs of its 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.
  - Ask the organization to describe its process for transporting patients (and required medication, support staff, supplies, equipment, etc.) to the alternate care site(s).

- CMS Deemed Status ASC, and RHC/FQHC only: The emergency preparedness plans addressing patient care and clinical support activities, including:
  - Services for any vulnerable patients (geriatric, disabled, chronic conditions, etc.) served by the organization.
  - Additional populations that could be cared for based on the organization’s capabilities.
  - 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.
  - Safety procedures for patient evacuation, including decision-making regarding where patients will be evacuated to based on clinical needs, transportation arrangements, etc.

- CMS Deemed Status for ASC only: Ask about their process for determining if they will shelter in place vs evacuating or closing. If sheltering:
  - Inquire about how they determine which staff (and if relevant, volunteers) will remain on-site.
  - Inquire about how provisions for necessary space, utilities, and supplies will be made.

- CMS Deemed Status ASC, and RHC/FQHC only: Maintaining essential communication and location capabilities and processes:
  - Tracking the location of on-duty staff during emergencies.
  - Tracking the location of patients sheltered on-site.

  - Facilities are not required to track the location of patients who have voluntarily left on their own or have been appropriately discharged, since they are no longer in the facility’s care. However, this information must be documented in the patient’s medical record should any questions later arise as to the patient’s whereabouts.

  - If an ambulatory surgery center is able to cancel surgeries and close (meaning there are no patients or staff in the ASC), this
Special Considerations for Dental Services:
Explore safety concerns with dental services, such as radiation hygiene including equipment, shielding, processing, selection criteria and technician training/competence. Other environmental issues include:
- handling of Hg (Hazmat)
- laboratory and clinical fumes

- requirement of tracking patients and staff would no longer be applicable.

- Incorporating volunteers and federally designated health care professionals into staffing strategy during emergencies as relevant to the emergency and organization need. For volunteers from official government response agencies (DMAT, Medical Reserve Corps, etc), the agency-issued identification can be used to help validate the individual’s eligibility to volunteer.

- CMS Deemed Status ASC, and RHC/FQHC only: Processes for communicating during an emergency, including back up communication mechanisms, with patients, their families, staff, physicians, and key response entities such as:
  - suppliers of essential services, equipment, and supplies during an emergency.
  - third parties such as other health care organizations, the state health department, police, FBI, etc (regarding patients under their care)
  - emergency response authorities and incident command centers (regarding the organization’s needs or ability to provide assistance)

- CMS Deemed Status ASC, and RHC/FQHC only: Documentation of completed and attempted contact with local, state, tribal, regional, and federal emergency preparedness officials in the organization’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.

- CMS Deemed Status ASC, and RHC/FQHC only: Leadership succession planning, delegation of authority, continuity of facilities and communication, and other strategies for continuity of operations.

- CMS Deemed Status ASC, and RHC/FQHC only: Review the communication plans for the names and contact information of staff, physicians, other ambulatory organizations, 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 ASC, and RHC/FQHC only: 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. Ask how staff demonstrate knowledge of emergency procedures (for example, through post-training tests, instructor Q&A, simulations, drills, exercises). Discuss how staff performance in emergency exercises or actual responses is used to inform additional education or training. Review attendance lists for orientation and training activities.
Designing and performing exercises consistent with patient care and service plans defined in the Emergency Management Plan. Exercise design should be demanding enough to surface weaknesses, gaps, or opportunities for improvement in the organization’s response effort.

CMS Deemed Status ASC, and RHC/FQHC only: Participation in community-level exercises: The organization is expected to reach out to community response partners to participate in at least one community-level exercise each year. Review documentation of the organization’s attempt to identify and participate in such an exercise, and if such participation was not possible, the reason why.

Making any necessary improvements to its Emergency Management Plan based on critiques of emergency management drills and response to actual emergencies.

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 and 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.
- Staff training, drills or exercises that support effective response and recovery relative to cyber emergencies that impact care, treatment, or service.

CMS Deemed Status ASC, and RHC/FQHC 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:

- Organization chart or similar document describing the system’s integrated emergency preparedness program
- 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:

- Ask how they were involved in developing the system’s integrated emergency preparedness program.
- Ask who has been designated to facilitate coordination with the system on integrated emergency preparedness planning.
- 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.
- 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.
- 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.
- Ask how the organization participated in the annual review of the system’s integrated emergency management program. Review supporting documentation.
- 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.

Environment of Care and Emergency Management Tracer

- Select an environment of care risk for further evaluation and observation. The EC risk selection should be based upon what has been learned from EC documentation previously reviewed and observations made during tracer activities.
- Trace the EC risk to the services and locations that could potentially leave the organization exposed and vulnerable.

For example:
• Safety – trace the organization’s process for environmental tours using their tools, if created; trace the use of a potential medical device, nutrient or medication that could be recalled

• Security – trace the controls established by the organization for one of its risks, identified in its proactive risk assessment; trace the processes for access to the building by visitors or VIPs

• Hazardous Materials – trace a hazardous material or waste from receipt or generation through to disposal, e.g. chemotherapeutic drugs, bloodied surgical dressings

• Fire Safety – use the outcomes of the organization’s fire drills to trace identified problematic issues; trace a fire response plan in a high risk area; trace the storage of combustible materials

• Equipment Management – trace the use of organization owned equipment for multiple patient use; trace the medical equipment management process from purchase through decommissioning.

For providers of Advanced Diagnostic Imaging who serve Medicare beneficiaries: Documentation of activities and frequencies to maintain the reliability, clarity, and accuracy of the technical quality of diagnostic images produced

• Diagnostic Imaging:

• The results of quarterly staff dosimetry monitoring

• Utilities – trace how piped medical gas systems are resupplied and maintained; trace the planned actions for a power failure including the emergency back up generator’s state of readiness; trace the process for reacting to a water pipe rupture in a certain unit

• CMS Deemed Status ASC, and RHC/FQHC only:

Conclude the session by summarizing strengths and risk

After

• 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
# Emergency Management Lessons Learned
## Tips and Examples

<table>
<thead>
<tr>
<th><strong>PLANNING</strong></th>
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<tbody>
<tr>
<td><strong>Planning</strong></td>
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<tr>
<td>In considering risks and planning, the organization should consider not only the emergencies that impact the immediate area, but also emergencies that might impact their suppliers in adjacent communities (for example, contamination of community’s water supply might affect off-site laundry service). Where alternate suppliers may be indicated, pre-planning with such suppliers can be initiated.</td>
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<thead>
<tr>
<th><strong>COMMUNICATION</strong></th>
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<tbody>
<tr>
<td><strong>Communication with physicians</strong></td>
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<tr>
<td>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.</td>
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<table>
<thead>
<tr>
<th><strong>Communication via social media</strong></th>
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<tbody>
<tr>
<td>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:</td>
</tr>
<tr>
<td>• One organization developed a ‘disaster blog’ to keep internal staff apprised of information from the command center.</td>
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<td>• Another organization began sending out regular updates on the number of patients treated, types of injuries, etc., and media outlets stopped inundating them with phone calls.</td>
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<tr>
<td>• Another organization requested blood donors on its Facebook site, and over 250 people came to donate.</td>
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<tr>
<th><strong>Communication via Media - national and international</strong></th>
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<tr>
<td>Many large health care organizations often have established relationships with local media, but a high level of interest from national and international media can consume a great deal of leaders’ time and attention. In high profile emergencies, some organizations utilize a proactive media outreach plan in which leadership:</td>
</tr>
<tr>
<td>• Provides media some access to facilitate accuracy of reporting and mitigate excessive distraction in and around the facility</td>
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<tr>
<td>• 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; organization can then aid patients or family members in the interaction with local, national, or international media.</td>
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<thead>
<tr>
<th><strong>Communication Systems</strong></th>
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<tr>
<td>Organizations have found it useful in planning and response to:</td>
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<tr>
<td>• establish a line of communication solely for command/control and a separate channel for communication with staff</td>
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<tr>
<td>• switch to satellite phones, if necessary; and employ two-way radio communication via walkie-talkies, which can be more reliable devices in stormy conditions</td>
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<tr>
<td>• contact government agencies in their area to request access to backup telecommunications towers.</td>
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<tr>
<th><strong>INFECTIOUS DISEASE</strong></th>
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<tr>
<td><strong>Emerging infectious diseases: training and exercises</strong></td>
</tr>
<tr>
<td>• 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.</td>
</tr>
</tbody>
</table>
- 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.)

**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 incident command system (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.

**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:
- 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 forces had a different understanding of what it meant to lock down a facility than did staff and physicians in the health care organization - what was lock down at some organizations was just limited access in others. Organizations 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 coordinate procedures and terminology essential in emergency response.

**STAFF**

Staff Support
In planning for community disasters where staff’s homes may be compromised (such as tornados, hurricanes, wildfires), create a plan for staff sheltering, meals, and transportation. Adjust staff rotations and schedules. Provide support for longer days or transportation where possible.

Staff Planning
Communicate proactively with staff at the start of response and throughout as early each day as possible so that a sufficient number and type of staff deploy to the right location when needed for services being provided that day. In a community explosion, each of three satellite facilities had additional off duty employees report for work unsolicited when the explosion was reported through the media; many were sent home.

**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 - utilities**
Ambulatory providers have partnered effectively 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.

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**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.

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**Health care partners – mass casualty event**
Organizations can consider how physician practices, home care agencies, nursing homes, and behavioral health providers 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 ENT specialists were mobilized for care in the community via the state’s Regional Advisory Council (RAC).
- Hospitals utilized in-house behavioral health staff, employee assistance programs, pastoral services and grief counselors to support patients, first responders, staff and community.
- 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.
- Hospital case managers helped with patient placement for two weeks post event, including coordination with affiliated home care providers.

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**Evacuation**
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 with mobility challenges 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 departments, floors, units, etc.) who needs to be trained to use it are all important considerations.

---

**Recovery**
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
Life Safety Code<sup>®</sup> Building Assessment - AHC
Applies to:  AHC, BHC, CAP, HAP, NCC, OBS, OME accreditation programs

<table>
<thead>
<tr>
<th>Duration</th>
<th>Objectives</th>
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<tbody>
<tr>
<td>60 – 90 minutes</td>
<td>• Evaluate the effectiveness of the organization’s processes for designing and maintaining buildings to LSC requirements.</td>
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<tr>
<td></td>
<td>• Evaluate the effectiveness of the organization’s processes for identifying and resolving LSC problems.</td>
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<tr>
<td></td>
<td>• Determine the organization’s degree of compliance with relevant LSC requirements.</td>
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<tr>
<td></td>
<td>• Educate attendees on potential actions to take to address any identified LSC vulnerabilities.</td>
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</table>

### Participants
One surveyor

### Organization:
- Person who manages the organization’s facility
- Other staff at the discretion of the organization

### Other information
Devote your time in this session entirely to evaluation of LSC requirements and not other EC-related issues.

At each location, conduct an “above the ceiling” survey by observing the space above the ceiling to identify:
- Penetrations of smoke, fire, or corridor walls;
- Smoke or fire walls that are not continuous from slab-to-slab and outside wall to outside wall;
- Penetrations or discontinuities of rated enclosures, including hazardous areas, stairwells, chutes, shafts, and floor or roof slabs.
- Corridor walls that are not slab-to-slab or do not terminate at a monolithic ceiling. (If the building is fully sprinklered and the ceiling is smoke tight, the walls may terminate at the ceiling line.)
- The presence or absence of required smoke detectors or fire dampers.
- The presence or absence of required fire proofing on structural members such as columns, beams, and trusses.

### Documentation
All LSC deficiencies should be recorded as a finding in the accreditation report.

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**Before**
- Inform your organizational 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. Identify where you will meet the facility manager and other attendees to initiate this session.

**During**

**Conducting the LSC Building Assessment**
- Complete the following activities to evaluate organizational compliance with the LSC, based upon occupancy requirements:
  - Assess hazardous areas, such as soiled linen rooms, trash collection rooms, oxygen storage rooms, and kitchens.
  - Assess required fire separations.
  - Assess at least two required smoke separations.
  - Pick at least two exits per building and verify that they are continuous from the highest level they serve to the outside of the building.
  - Assess the integrity of access doors and exit doors, including laundry and trash chutes if present.
  - Assess the main fire alarm panel to verify that it is functional.
  - Assess the automatic sprinkler pump (if any) to verify that it is functional.

**Life Safety Code findings for deemed Ambulatory Surgery Centers:** 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)

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.
- Conclude the session by summarizing identified strengths and weaknesses in managing Life Safety Code compliance.

After
- Consider the relationship of your observations to system level issues.
- Share problematic issues with other team members, if applicable, so they can be further explored in subsequent survey activity.

LSC Guidelines 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 in the Life Safety (LS) chapter, focusing on “operational type” deficiencies. Required repair and/or replacement deficiencies may be corrected while you 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. 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

Copyright: 2018 The Joint Commission
- 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 – Continuity of Care
Applies to: AHC Applicability – Medical/Dental organizations only. May also be conducted during PCMH surveys, based on the size of the organization.

Duration
60 minutes

Participants
One surveyor

Organization:
Staff and management who have been involved in the individual’s care, treatment, or services

Other: Patient, internal and external caregivers

Rationale:
Community Health Centers and Primary Care Providers, by design, have clients returning for ongoing care. Clients often receive care from multiple clinicians. A frequently cited concern of care providers is missing an abnormal test result and failing to coordinate necessary follow up. This tracer targets a patient/client with a known abnormal test result. Surveyors conduct an in-depth evaluation of the communication, coordination and continuity of care in a situation known to be problematic for the industry.

Objectives
1. To evaluate the effectiveness of the organization’s processes from prescribing a diagnostic study through to patient follow up.
2. To identify process and possibly system level issues contributing to missed follow up of diagnostic studies.

Before
• Identify a patient/client with multiple diagnostic testing episodes and at least one episode of abnormal results in the past 12 months.
• Whenever possible, the patient should be selected from the organization’s clinical services, ICM Profile risk areas, and information discovered during the Orientation session.

During
• Begin the Individual Tracer where the record is maintained.
• Review the clinical record with a staff member noting diagnosis, visit pattern, testing and pay particular attention to all communications to and from the patient.
• Interview staff about the following issues:
  - Patient assessment and care planning
    o Assessment of patient communication and learning needs
    o Plan for evaluation of disease processes and medications (Be cautious of not conducting a peer review however you can ask questions about how the physician/LIP or organization determines what follow up is needed for a condition or medication. You can also ask the organization to delineate their established procedure for physician/LIP follow up. Then use the clinical record to find out if the physician/ LIP did or did not follow his/her plan)
    o Test orders
    o Organization’s process for testing related to medications or diagnosis and implementation of same
    o Communication of information to test site.
    o Receipt of results from test site, including critical test results.
    o Communication of test results to:
      ▪ Physician (LIP).
      ▪ Patient
      ▪ Other care providers, if applicable
    o Use of test results to revise plans for care, treatment and services

Pay Close Attention to Hand Offs
**Patient education**
- Process for educating patients about their condition
- Use of information for promoting health

**Coordination**
- Interdisciplinary approach to patient care
- Communication with other internal and external care providers
- Resolving duplication / conflict with other resources
- Interview the patient:
  - Determine knowledge of their condition, plan for care, etc.
  - Information provided relative to same
  - Perception of care providers having an up-to-date understanding of their issues
- Interview others involved with patient care, e.g. family, lab testing sites, other healthcare organization staff about the same issues

**After**
- Identify and evaluate the effectiveness of the organization’s standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.
- As necessary:
  - Springboard to other patients to:
    - Validate findings
    - Verify standards compliance issues identified during this tracer
  - Review other documents, e.g. policies, to drill down on problem areas.
- Consider the pervasiveness of identified issues. Evaluate possible systems issues.
- Discuss issues with surveyor team during the next surveyor planning session, if applicable
- Discuss findings with the organization at the conclusion of the tracer activity and/or at the next daily briefing.
## System Tracer – Data Management

**Applies to:** All accreditation programs

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<thead>
<tr>
<th>Duration</th>
<th>60 – 90 minutes</th>
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<tbody>
<tr>
<td><strong>Participants</strong></td>
<td>One surveyor (at minimum) Other surveyors may participate as available</td>
</tr>
<tr>
<td><strong>Organization:</strong></td>
<td>Participants vary depending on the focus of the tracer. To be discussed with the surveyor(s) after the Planning Session.</td>
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</table>

### Objective
1. To understand and assess the organization’s performance improvement process.

### Before
- Discuss and confirm the planned focus for this System Tracer with team members and obtain additional input for use at the session
- Review performance improvement 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.
- Additional performance improvement related topics to explore include:
  - Ambulatory Surgery – cases of patient transferred from the ASC to the hospital, appropriateness of measures to the surgery performed, infection rates
  - Medical/Dental – medication management and quality control, such as walk-offs
  - Diagnostic/therapeutic – quality control, such as imaging retake rates

### For PCMH Surveys:
- Verify that the organization is collecting the following data:
  - Patient experience and satisfaction related to access to care, treatment, or services
  - 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

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**FOR ALL Ambulatory Surgery Centers:**

Determine that:
- Measurement includes cases of patients transferred from the ASC to the hospital
- Measures are appropriate for the surgery performed
- Measures address infection control
How they are using data collected to improve their performance

How they monitor the use of computerized order entry and electronic prescribing to ensure they are in compliance with the required percentages

How the monitor their compliance with providing patients appointment reminders

How they monitor their compliance with providing patient access to their health information within four business days

About use of the certified electronic health record to create and submit reports – determine the types of reports created and how they are being used

How they monitor their compliance with the collection and documentation of patient information, such as gender, blood pressure (for patient ages 3 years and older), and smoking status (for ages 13 and older)

Other performance improvement topics that should be covered in the discussion include:

- Infection prevention and control, collection and use of surveillance data
- Risk assessment/management activities
- National Patient Safety Goals – including monitoring of CDC or WHO hand hygiene compliance
- Monitoring staff compliance with employee health screening requirements

- Determine if the organization’s infection control plan includes a goal of improving influenza vaccination rates
  - Ask about the organization’s strategy to incorporate incremental influenza vaccination goals into their plan with a focus on reaching the 90% target in 2020

- Inquire about the influenza vaccination program for staff. Seek specifics about:
  - The education provided to staff 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 plans to prepare a written description of the methodology used to determine influenza vaccination rates for staff
  - The organization’s process for evaluating staff reasons for declining the influenza vaccination
  - The organization’s plans to improve its vaccination rates
  - Dissemination of influenza vaccination rate data throughout the organization

- 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

- Follow up on any identified issues or remaining topics during subsequent survey activity
- Verify through review of a sample of employee health files, documentation that staff has undergone required health screenings
- Consider the relationship of your observations to system level issues.
- Share performance observations with other surveyors, as applicable.
General Tips for Conducting the Data Management Session

1. Success with the Data 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:
   1. Planning
   2. Collecting
   3. Aggregation and Analysis
   4. Use of data.

4. The focus of the organization’s data 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 data tracer is planning
   - If the organization has data but the amount of data is questionable or partially missing, the focus of the data tracer is data collection.
   - If the organization is data rich but has no evidence of aggregation and analysis (reports, charts etc.), then the focus of the data tracer is aggregation and analysis.
   - If the organization has data which is aggregated and analyzed but problem areas are unchanged, then the focus of the data tracer is 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 data tracer 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 and 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.

Key Points

- 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 populations served in order that they can 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

- PI.01.01.01 (planning for and prioritizing data collection, patient perception of care, high risk processes)
- PI.02.01.01 (benchmarking Internal and External database)
- LD.04.04.01 (re prioritization of data collection)
- IM.01.01.01 (thorough analysis of data needs)
- IM.02.02.01 (uniform data definitions)
- HR.02.01.03 (practitioner-specific performance 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 clinical records
  - For a population size 31 to 100 ADC, sample 30 clinical records
  - For a population size of 101 to 500 ADC, sample 50 clinical records
  - For a population size of more than 500 ADC, sample 70 clinical 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
- PI.01.01.01 (data collection)
- IM.01.01.03 (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)
- PI.01.01.01 (data collection)
- HR.02.01.03 (practitioner-specific performance 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 is 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
- PI.02.01.01 (systematic aggregation and analysis)
- LD.04.04.05 (analysis of undesirable trends)
- 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)
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 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 that 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)
- 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)
System Tracer – Infection Control
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</td>
</tr>
</tbody>
</table>
| Organization: | • Individual staff at various locations encountered during tracer activity  
• Infection control coordinators and staff  
• If applicable, and available, a physician member of the IC committee  
• Individuals able to address issues related to the infection control program in all major departments or areas of the organization  
• Clinicians knowledgeable about the selection of medications available for use and pharmacokinetic monitoring  
• Clinicians from or who interact with the laboratory  
• Physical plant staff  
• Organization leadership |
| Note: When a separate Infection Control Systems Tracer is not scheduled, surveyors should address infection prevention and control during Individual Tracers and during the Data Management system tracer. |

For ASC Deemed Status Surveys:
Use the Infection Control Surveyor Worksheet while conducting all aspects of this survey activity. Doing so will guide you in the evaluation of all the relevant issues around infection control and will help you gather all the information needed to complete the tool for submission.

Individual Tracer Selection Tips
In settings where there are no infected patients, pull a discharge record of a patient with an infection, review the record and use this patient’s experience as your scenario for the infection control system tracer.

Objectives
1. Learn about the planning, implementation and evaluation of the organization’s infection control program
2. Evaluate the organization’s process for developing the infection control plan, review and discuss the outcome of the annual infection prevention and control plan evaluation, and discuss oversight of opportunities for improvement
3. Understand the processes employed throughout the organization to reduce infection

Before
While conducting individual tracers:
• Identify a patient being treated for an infection such as a respiratory illness or a multi-drug resistant organism or other potentially communicable disease
• Review the record. Note any opportunities to trace a related laboratory testing process through the organization.

During
Discussion (15 to 20 minutes)
• Review the infection prevention and control plan with the individual responsible for the organization’s program
• For ASC Deemed Status Surveys: Determine if the infection control plan contains the required program components, that is, action plan for managing infections and immediate implementation of preventive and corrective measures.

• Determine if the infection control plan includes a goal of improving influenza vaccination rates
  o Ask about the organization’s strategy to incorporate incremental influenza vaccination goals into their plan with a focus on reaching the 90% target in 2020
• Inquire about the influenza vaccination program for staff. Seek specifics about:
  o The education provided to staff about the influenza vaccine, non-vaccine control and prevention measures and the diagnosis, transmission, and impact of influenza
  o Organization offering of influenza vaccinations on-site or facilitation of off-site vaccinations
  o The organization’s plans to prepare a written description of the methodology used to determine influenza vaccination rates for staff
  o The organization’s process for evaluating staff reasons for declining the influenza vaccination
  o The organization’s plans to improve its vaccination rates
  o Dissemination of influenza vaccination rate data throughout the organization
If the organization cannot identify an individual that they are actively treatment or have treated in the past, or are monitoring for an infection, create a realistic scenario for this session. For example:

- A client coming into the clinic is coughing excessively. Two weeks later you receive a call from the Public Health Department indicating that this client has active TB.

**Potentially Problematic Areas**
- Local and regional outbreaks – ask the organization, reference current literature and websites, e.g., [www.cdc.gov/mmwr](http://www.cdc.gov/mmwr)
- Hazard Vulnerability Analysis re: Bioterrorism or local industry
- Governing Body involvement and accountability
- Hand hygiene
- Medication administration
- Phlebotomy
- Provider IC practices
- PPE availability/use
- Supply storage
- Reusing single use devices
- Cleaning, disinfection and sterilization—especially the use of immediate use steam sterilization (IUSS)

**If this is a complex organization survey:** Conduct this session with representatives from all programs being surveyed. If not possible, due to distance constraints, the 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.

**Tracing (40 to 45 minutes)**
- Conduct this tracer in various locations / rooms throughout the organization
- For programs with no sites to visit - discuss the planning and implemented practices in relation to scenarios relevant to the setting and/or services.
- Using the patient experience, engage front line staff in a discussion about their infection control processes. For example:
  - How this individual’s (potential) infection was identified, e.g., part of surveillance or other
  - The processes that are followed for laboratory confirmation. Trace that process in the record and with interviews including physician request for testing, physician order, communication to lab, collection of specimen, transportation to the lab, turn around time for results, communication of results from lab to organization to physician, follow up orders and monitoring.
  - Staff orientation and training activities: e.g. the processes in place to ensure the appropriate care of infected patients (includes staff behavior and attitudes ensuring compliance with patient rights)
  - Reporting of infection control data – responsibility, methodology, dissemination and feedback
  - Prevention and control activities (e.g., staff training, housekeeping procedures, organization-wide hand hygiene, employee health, food sanitation and the appropriate storage, if applicable, cleaning, disinfection, sterilization and/or other disposal of supplies and equipment)
  - Interventions for licensed independent practitioner, 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.
  - Identification and management of outbreaks
  - Physical facility changes, either completed or in progress, that have an impact on infection control.
  - Actions taken as a result of surveillance and the outcomes of those actions.
- Inform organization participants about observations that need to be further explored in subsequent tracer activity

**After**
- Verify through review of a sample of employee health files documentation that staff has undergone required health screenings
- Seek additional information, if necessary, during an Issue Resolution session
- Interview staff during individual tracers about infection control issues. Observe practices in place.
- Consider the relationship of your observations to system level issues
- Share observations and performance concerns with other surveyors, if applicable, so they can be further explored in subsequent survey activities
System Tracer – Medication Management

Applies to: All accreditation programs

Duration
60 minutes (The data collection for this drug is conducted as part of an individual tracer conducted prior to this session.)

Participants
All surveyors available to participate should do so

Organization:
Clinical and support staff in the units and departments visited.

Planning:
1. Begin at the surveyor planning session to consider the organization’s programs and services
   - Identify a patient receiving a medication on the organization’s high risk medication list
2. As part of the individual patient tracer, review the record or care, treatment or services
3. Collect necessary data using the work tool.
   - Have the organization assist you in this process, if possible.

For Complex Organization Surveys
1. 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

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 process to receive and share information on medications when the patient is referred to other internal or external providers of care, treatment and services

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/dispensing, administration, monitoring and evaluation). This discussion should include pharmacy review, use of NPSG requirements, and assimilation of pertinent literature.
- **For PCMH Surveys:** Determine how the organization uses 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.)
- Check the FDA website for safety alerts and recall notices [www.fda.gov/medwatch](http://www.fda.gov/medwatch)

During
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 pre-procedure, procedure room, post procedure recovery areas
- The clinics or other locations where patients are being seen
  - Ask about the last time the organization was informed of a drug recall; can the clinic director or staff remember how they were notified; ask to see any recent recall notices
- **For PCMH Surveys:** Ask staff whether or not patients are able to leave prescription refill requests 24/7
- The pharmacy, if applicable to the organization
  - Explore this 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
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. Surveyor team discretion can be used to move this "wrap up" to an upcoming issues resolution time. If the agenda does not permit a medication management tracer in some programs, surveyors will 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 the literature, include:

- heparin, insulin, coumadin or antibiotics
- sedatives and hypnotics
- intravenous or intrathecal medication
- TPN

- Evaluate the oversight of this drug – formulary, P&T committee reviews etc.
- Ask how the organization and, if applicable, 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
- Interview the consultant pharmacist, if applicable
- Other important considerations for this tracer
  - Different 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

- Ask organizational participants to describe their evaluation of the medication management system.
- 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.

Other 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
- Data collection, analysis, systems evaluation, and performance improvement initiatives
- Education of staff about medication safety
- Education of patients about medication safety
- Patient involvement in safe medication management
- Information management systems related to medication management
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 surveyors, if applicable, to potential issues and problems, so they can be further explored during other survey activities
Leadership Session

Applies to: All accreditation programs.

<table>
<thead>
<tr>
<th>Duration</th>
<th>60 minutes</th>
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<tbody>
<tr>
<td>Participants</td>
<td>All surveyors on site</td>
</tr>
<tr>
<td>Organization:</td>
<td>• Leaders with responsibility and accountability for design, planning, and successful implementation of organization processes</td>
</tr>
<tr>
<td>Typically participants include the following:</td>
<td></td>
</tr>
<tr>
<td>• At least one member of the governing body or an organization trustee (in single-owner organizations, this individual may also be the CEO).</td>
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<tr>
<td>• Senior organization leaders (CEO, COO, CNO, CFO, CIO, Laboratory Medical Director, VP for Clinical Services, Director of Patient Services or Branch Manager, Administrator).</td>
<td></td>
</tr>
<tr>
<td>• Senior leaders from all surveyed programs (Ambulatory Care, Behavioral Health, Home Care, Laboratory, and Nursing Care Center).</td>
<td></td>
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<tr>
<td>• Elected and appointed leaders of the medical staff.</td>
<td></td>
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<tr>
<td>• Other organization leaders (Director of Human Resources and Performance Improvement).</td>
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</tbody>
</table>

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.

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.

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.

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 widespread 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.
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.
- Review survey observations and patterns of performance in relation to important components of organization effectiveness, that is, the system performance standards.
- By referencing observations made throughout the survey you are pulling the outcome together in a useful way for the organization.

For PCMH Surveys: Ask how leaders evaluate the effectiveness of the interdisciplinary teams.

- 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.

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
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 widespread 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
Governance Discussion Session
Applies to: Federal Bureau of Primary Health Care – Supported Health Center surveys ONLY

Duration
60 minutes

Participants
Joint Commission: Surveyor
Organization: Attendance should include, at a minimum, the following representatives of the governing body:
- Chairperson/President or Vice-Chair/Vice-President
- Treasurer or Chair of the Finance Committee
- Another board member who represents users/patients/consumers served by the Health Center (if one of the above officers is not a user/patient/consumer), especially if the Health Center receives funding for any special population groups (e.g., migrant and seasonal farm workers, homeless, public housing residents).
Other board members may attend if available and space permits, and any board member may participate by teleconference as necessary.

Other information
If the option of reviewing the completed “Health Center Self-Report Tool for BPHC Program Expectations” is selected, then evaluating compliance with BPHC statutory and regulatory requirements may also occur. All findings related to BPHC statutory/regulatory requirements should be scored at LD.04.01.01, EP 2 and flagged for central office review.

Objectives [NOTE: As of April, 2012 Health Center completion & surveyor review of the “Health Center Self-Report Tool for BPHC Program Expectations” is no longer a requirement; it is an option.]
1. Understand the governing body’s perception and implementation of its role in the organization, especially regarding its governance, mission and strategy expectations as described in the Leadership chapter.
2. Evaluate the governing body’s understanding of performance improvement approaches and methods, and their involvement in the organization’s approach to performance improvement.
3. If the Health Center has completed the “Health Center Self-Report Tool for BPHC Program Expectations” and as an option requests a review and assessment of its accuracy, evaluate the knowledge of the governing body members with respect to federal law and regulations as identified in the “Health Center Self-Report Tool for BPHC Program Expectations.”
4. If the Health Center selects the Primary Care Medical Home certification option, assess applicable PCMH requirements.

Before
Review information outlined in the Planning session for BPHC.

During
Facilitated Discussion Points
- This discussion session is an evaluation activity: information gained during the session will be used to primarily evaluate levels of compliance with Joint Commission standards,
- Ask open ended questions that encourage an exchange among participants. Do not ask questions that call for a "yes" or "no".
- Discuss governance related issues.

- **For PCMH Surveys:** Explore the organization’s reasons for pursuing PCMH certification. Determine if this certification fits with the organization’s mission and goals.
- If the Health Center has also selected the option of completing the “Health Center Self-Report Tool for BPHC Program Expectations”, then evaluate compliance with BPHC statutory and regulatory requirements including issues identified in the review of:
  - The health Center’s responses to the Governance and Mission & Strategy sections in their “Health Center Self-Report Tool for BPHC Program Expectations”
  - Board Minutes
  - BPHC Notice of Grant Award (and any conditions or management assessment items and Health Care Plan.)
o The Health Center’s Bylaws Strategic Plan, Needs Assessment and any Board-approved Policies and Procedures, if pertinent.

- At the conclusion, review and summarize the issues or opportunities for improvement that related to standards, and if applicable, BPHC’s statutory and regulatory requirements and PCMH certification requirements.

After

- Consider the relationship of your observations to system level issues.
- Share problematic issues with other team members, if applicable, so they can be further explored in subsequent survey activity.
Clinical Leadership and Staff Discussion
Applies to: Federal Bureau of Primary Health Care – Supported Health Center surveys ONLY

Duration
60 minutes

Participants
Joint Commission: Clinician Surveyor

Organization:
At a minimum the organization should select individuals who represent the following:
- Clinical leadership
- One licensed independent practitioner or clinical staff member from each site that is not scheduled for a visit
- If applicable, one clinical staff member responsible for providing direct care to any special population for which the Health Center receives specific funding support (e.g., homeless, migrant & seasonal farm workers)
- A cross-section of providers including physicians, dentists, other licensed independent practitioners, nurses, social workers, nutritionists, and other categories of staff who provide direct care to patients
- If all sites are scheduled for a visit, at least one clinical staff person who may not otherwise be available to participate in the site visit, e.g., part-time individual with clinical responsibilities who is not scheduled to work on the day of the site visit, individual(s) with a schedule conflict which would otherwise preclude participation

The size of the group is limited only by availability of staff and meeting room space. Staff from the organization may also participate in the discussion session by teleconference.

Objectives

[NOTE: As of April, 2012 Health Center completion and surveyor review of the “Health Center Self-Report Tool for BPHC Program Expectations” is no longer a requirement; it is an option.]

1. Focus on the clinical staff's role in the organization, especially regarding the clinical expectations described in the Provision of Care, Waived Testing, Infection Prevention and Control, Record of Care, and Medication Management chapters.

2. Learn about the clinicians' understanding of performance improvement approaches and methods, and their involvement in the organization's approach to performance improvement.

3. If the Health Center has completed the “Health Center Self-Report Tool for BPHC Program Expectations”, and as an option requests a review and assessment of its accuracy, focus on the clinical staff's understanding of the clinical expectations described in the “Tool”.

4. If the Health Center selects the Primary Care Medical Home certification option, assess applicable PCMH requirements.

Before
- During the surveyor planning session, the scheduled date, time and participation for this session should be discussed.
- If the Health Center has completed the optional “Health Center Self-Report Tool for BPHC Program Expectations”,
- Review the responses to the Clinical section with the intent of focusing on all NO responses. (A validation of all the YES responses in the Self-Report Tool should occur either during this session or other survey activities.)
- Review the Health Center’s Health Care Plan and BPHC Notice of Grant Award (including any conditions or management assessment items)
- Other materials that may be reviewed either prior to or during the session include:
  - Clinicians’ meeting minutes (if applicable)
  - FTCA attestation checklist
  - Credentialing and Privileging Policies
  - Risk Management Policies and Procedures
  - Clinical Practice Guidelines

During
- Introduce yourself if you have not previously met the attendees.
- Ask attendees to introduce themselves, as necessary, identifying their role at the and at which delivery site they work.
- Provide a brief overview of the Joint Commission’s mission and goals, and the value of the unified survey process with BPHC.
- Address issues that are still unresolved or not yet fully addressed
- Assess any issues based on the clinical expectations described in the pertinent CAMAC chapters, prior survey findings/observations,
Other Information
If the option of reviewing the completed “Health Center Self-Report Tool for BPHC Program Expectations” is selected, then evaluating compliance with BPHC statutory and regulatory requirements may also occur. All findings related to BPHC statutory/regulatory requirements should be scored at LD.04.01.01, EP 2 and flagged for central office review.

and the “Health Center Self-Report Tool for BPHC Program Expectations” (if optionally completed), according to the following framework:

- Pre-entry and entry phases of the care continuum
  
  o Linkage with and use of available information sources about the patient’s needs.
  
  o Linkages with other care settings within and outside the organization.
  
  o Availability and access of services consistent with the organization’s mission, populations, and treatment settings or services to meet the patient’s needs, including BPHC required services.
  
  o Arrangements with other organizations and the community to facilitate entry and access to comprehensive health and social services.
  
  o Referrals and transfers to meet the patient’s needs.
  
  o The use of clinical consultants and contractual arrangements.

- Care within the organization
  
  o Scope of services being provided directly or indirectly; including those required by BPHC.
  
  o Continuous flow of services from assessment through treatment and reassessment.
  
  o Coordination of care among providers.

- Pre-exit and exit phases of the continuum of care
  
  o Assessment of the patient’s status and need for provision of continuing care.
  
  o Direct referral to practitioners, settings, and organizations to meet the patient’s continuing needs.
  
  o Reassessment of the use and value of providing continuing care in meeting the patient’s needs.
  
  o Provision of information or data to help others meet the patient’s continuing needs.
  
  o Systems issues supporting the continuum of patient care.

- Make it clear that this discussion session is an assessment activity; use information gained during the session to assess levels of compliance with BPHC statutory and regulatory requirements and Joint Commission standards.

- Encourage each participant to respond to some, if not all issues during the discussion.

- Use open-ended questions to encourage an exchange among the participants.

- In conclusion, review and summarize the issues or opportunities for improvement that relate both to BPHC’s statutory and regulatory requirements, and those that are standards related.
Report Preparation
Applies to: All accreditation programs

**Duration**
60 – 90 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 SAFERTM 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).

**How will this affect my survey?**
• Accredited organizations will be notified about these changes through various modes of

**Objectives**
1. To allow the organization one final onsite opportunity to clarify and clear observations and findings, particularly from last day activity
2. To complete the entry of observations made throughout the survey
3. To clearly and accurately document requirements for improvement

**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.

**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.
• Remove any observations that the organization is able to clarify.
• Revise your documentation of findings that were observed, but the organization has corrected while you are onsite. Choose “Observed in survey activity but corrected on-site pending acceptable Evidence of Standards Compliance” from the “Observed in” dropdown 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 on-site finding(s) will remain in the final report and will require an ESC.

  o Observations that are appropriately documented as “Observed in survey activity but corrected on-site pending acceptable Evidence of Standards Compliance” 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
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.

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

- 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 SAFER™ 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 SAFER™ 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 (copy 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.

<table>
<thead>
<tr>
<th>Duration</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 minutes</td>
<td>1. Review the survey findings as represented in the Summary of Survey</td>
</tr>
<tr>
<td></td>
<td>Findings Report.</td>
</tr>
<tr>
<td></td>
<td>2. Discuss any concerns that the CEO may have with the report.</td>
</tr>
<tr>
<td></td>
<td>3. Determine if the CEO wishes to have an Organization Exit Conference</td>
</tr>
<tr>
<td></td>
<td>or if the CEO prefers to deliver the report privately to the organization.</td>
</tr>
<tr>
<td></td>
<td>4. Determine the need for any special arrangements for the Organization</td>
</tr>
<tr>
<td></td>
<td>Exit Conference.</td>
</tr>
</tbody>
</table>

Participants
All surveyors on site

Organization:
Senior Leader (CEO, Administrator, Executive Director, Owner) if available, or designee

Guidelines
The Summary of Survey Findings Report is organized by 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.

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 organization leader 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

**Duration**
30 minutes

**Participants**
All surveyors on site

**Organization:**
Leadership and staff invited to participate by the CEO

**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 that attendees may or may not have a copy of the Summary of Survey Findings Report, 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**
1. Present the preliminary Summary of Survey Findings Report (only if desired by the CEO)
2. Review identified standards compliance issues. Note that all findings of less than full compliance require resolution through an Evidence of Standards Compliance submission
3. Review required follow-up actions

**Before**
- Return the organization’s documents directly to the contact/liaison
- Determine with the surveyor team, if applicable, 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 leadership 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:
  o 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
  o 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.
- For PCMH Surveys: Identify those observations that directly relate to PCMH-specific requirements
  - 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.
o All Requirements for Improvement (RFIs) due in a 60-day ESC
o All findings will require an ESC
o Current ESC entry fields (who, what, when, and how) required for all RFIs
o 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:
  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.
  o 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
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 Commissions 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, 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.

**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.

**Applies to:** BHC (as applicable to the setting), CAH, HAP, and Psychiatric Hospitals

**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.
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 interface showing Records section with search options and standards]

2. **Then select Add New Record and the following window will open:**

   [Image of Record creation window with fields for Program, Record Number, and Record Comments]
3. Back on the Itinerary Home Page, select the Standard section:

![Standard Section]

- **Search By:** BHC
- **Search By:** Standard

4. After entering the information regarding the observation, click on the corresponding Record Number to link the observation to the record:

![Record Number Selection]

**Observation Text:**

---

<table>
<thead>
<tr>
<th>Record Number</th>
<th>Observed or Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>322</td>
<td>□ Observed □ Review</td>
</tr>
<tr>
<td>331</td>
<td>□ Observed □ Review</td>
</tr>
<tr>
<td>608</td>
<td>✓ Observed □ Review</td>
</tr>
<tr>
<td>679</td>
<td>□ Observed □ Review</td>
</tr>
</tbody>
</table>
Remember to attach the record, or records, reviewed during tracer activity when completing the tracer entry:

Program: BHC
Type of Tracer: -- Select --
Tracers to Review: -- Select --
Primary Record: -- Select --
Additional Record: -- Select --
Areas Reviewed: Admissions, Dietary, Home Visit, Vehicles, Dinning Room

Evaluated:
- NPSG.01.
- NPSG.07.
- NPSG.15.
- NPSG.03.

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 received 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.
## Appendix C – Surveyor Worksheet

### Ambulatory Health Care Surveyor Worksheet

#### Tracer Patient Selection

<table>
<thead>
<tr>
<th>Did you survey at least one patient in the category?</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinical Services</td>
</tr>
<tr>
<td></td>
<td>Patient taking a high risk medication</td>
</tr>
<tr>
<td></td>
<td>Patient with an infection</td>
</tr>
<tr>
<td></td>
<td>Patient being discharged</td>
</tr>
<tr>
<td></td>
<td>Surgical patient receiving anesthesia</td>
</tr>
<tr>
<td></td>
<td>Patient undergoing waived testing</td>
</tr>
<tr>
<td></td>
<td>Patients receiving diagnostic / laboratory services</td>
</tr>
</tbody>
</table>

#### Did you see the following data during the survey?

1. Blood and blood product use
2. Infection Prevention and Control
3. Medication Management
4. NPSG Data (hand hygiene monitoring) **Reminder: All applicable NPSGs must be evaluated during the course of the survey**
5. Operative and other invasive procedures
6. Patient perceptions of care, treatment and services (specific needs and expectations, how the organization will meet these needs and expectations, how the organization can improve patient safety, effectiveness of pain management, when applicable) **For PCMH Surveys: Note that additional data elements are required.**
7. Quality Control
8. Research, when conducted
9. Restraint Use
10. Risk Management
11. Staff opinions and needs*
12. Staff perceptions of risks to individuals and suggestions for improving patient safety*
13. Staff willingness to report unanticipated adverse outcomes*
14. Utilization Management
15. Environment of care issues
16. Other PI Activities
17. **For PCMH Surveys:** Review the organization's PCMH Self-Assessment Tool

#### AHC Survey Process Rules For Surveyor Planning

<table>
<thead>
<tr>
<th>Did you........</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Visit 100% of moderate sedation or general anesthesia sites</td>
</tr>
<tr>
<td></td>
<td>Visit 100% of sites where four or more patients (or, one or more patients for Medicare certified ambulatory surgery centers) are unable to self-evacuate, and conduct a Life Safety Code™ Building Tour</td>
</tr>
<tr>
<td></td>
<td>Visit a minimum of 50% of medical/dental sites</td>
</tr>
<tr>
<td></td>
<td>Visit a minimum 12.5% of diagnostic/ therapeutic sites</td>
</tr>
<tr>
<td></td>
<td>Sample a mix of large, medium, and small sites</td>
</tr>
<tr>
<td></td>
<td>Visit a mix of existing, well established sites and newly opened sites</td>
</tr>
<tr>
<td></td>
<td><strong>Every Advanced Diagnostic Imaging modality (CT, PET, MRI, and Nuclear Medicine) must be observed and surveyed if the organization is using accreditation to satisfy CMS recognition to bill for the technical component of these services; this may result in site sampling exceeding the 12.5% rule.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>For ASC Deemed Status Surveys:</strong> Observe at least one surgical procedure from start to finish.</td>
</tr>
</tbody>
</table>
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.
   - 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 – Not Applicable to Ambulatory
Appendix F – Handout for the Ambulatory Health Care Organization

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 an Ambulatory Care or Office-Based Surgery organization, 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.

- Performance / Quality Improvement Data
- Infection Control surveillance data
- Infection Control Plan
- Environment of Care data
- Environment of Care management plans and annual evaluations
- Environment of Care team meeting minutes for the 12-months prior to survey
- An organization chart
- A map of the organization, if available
- List of all sites that are eligible for survey (AHC only, as applicable)
- List of locations where services are provided, including anesthetizing locations (AHC only, as applicable)
- List of sites where high-level disinfection and sterilization is in use
- Any reports or lists of patient appointment schedules or surgery schedules for each day of the survey
- A list of contracted services
- Name and extension of key contacts who can assist surveyors in planning tracer selection

For Ambulatory Surgery Center (ASC) Deemed Status surveys:

- List of surgeries from the past six months
- List of cases in the past 12-months, if any, where the patient was transferred to a hospital or the patient died *(Note: The 12-month time frame for this data applies to all ASC organizations seeking deemed status, whether undergoing a Joint Commission initial survey or resurvey.)*
- Documents related to the infection control program (e.g., description, policy, procedures, surveillance data)
- Infection Control Surveyor Worksheet

Documents Related to CMS Emergency Management Final Rule applies to Deemed Ambulatory Surgical Centers, Rural Health Clinics, and Federally Qualified Health Centers

Note: Document formats may vary, and many of the documents listed below may be included in the Emergency Management Plan.

- Prioritized Potential Emergencies (Hazard Vulnerability Analysis)
• Emergency Management Plan
  • Documentation of annual review and update of Emergency Management Plan, including communication plans
• Continuity of Operations Plan
  • Documentation of completed/attempted contacts with contact local, state, tribal, regional, federal EM officials in organization’s service area
• Annual training
• Patient evacuation procedures
• Tracking system for patients sheltered on-site and patients relocated to alternate site
• Integrated EM system risk assessments, plan, and annual review

For Bureau of Primary Health Care (BPHC) surveys:
• Health Center's responses to the “Health Center Self-Report Tool for BPHC Program Expectations”
• List of Board of Directors membership, including the user/patient/consumer status, occupational/areas of expertise, geographic location, and special population representation
• Board minutes (past 12 months on all surveys); annual Uniform Data System (UDS) report
• Most recent BPHC Notice of Grant Award (with any conditions or management assessment items)
• Items from most recent BPHC Grant Application: Health Care Plan, Scope of Services; Overall Summary (if available)
• Health Center's bylaws, strategic plan, and needs assessment

Please note that this is not intended to be a comprehensive list of documentation that may be requested during the survey. Surveyors may need to see additional documents throughout the survey to further explore or validate observations or discussions with staff.
## Appendix G – Ambulatory Health Care Accreditation Survey Activity List

<table>
<thead>
<tr>
<th>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>60 minutes</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; day, upon arrival</td>
</tr>
<tr>
<td>Opening Conference</td>
<td>15 minutes</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; day, as early as possible</td>
</tr>
<tr>
<td>Orientation to Organization</td>
<td>45 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 throughout the survey; the number of individuals who surveyors trace varies by organization</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 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 and 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 and 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>60-90 minutes</td>
<td>Last day of survey</td>
</tr>
<tr>
<td>CEO Exit Briefing</td>
<td>15 minutes</td>
<td>Last day of survey</td>
</tr>
<tr>
<td>Organization Exit Conference</td>
<td>30 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>Activity Name</th>
<th>Suggested Duration of Activity</th>
<th>Occurrence and Scheduling Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Safety Code Building Assessment</td>
<td>60-90 minutes</td>
<td>Occurs on all Ambulatory Surgery Center deemed status surveys; occurs on surveys where four or more individuals are simultaneously rendered incapable of self preservation</td>
</tr>
<tr>
<td>System Tracer – Infection Control</td>
<td>60 minutes</td>
<td>After some individual tracer activity has occurred; topic may be covered during the Data Management system tracer depending on the length of survey</td>
</tr>
<tr>
<td>System Tracer – Medication Management</td>
<td>60 minutes</td>
<td>After some individual tracer activity has occurred; topic may be covered during the Data Management system tracer depending on the length of survey</td>
</tr>
<tr>
<td>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>Bureau of Primary Health Care Surveys only – Governance Discussion</td>
<td>60 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization</td>
</tr>
<tr>
<td>Bureau of Primary Health Care Surveys only – Clinical Leadership &amp; Staff Discussion</td>
<td>60 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization</td>
</tr>
</tbody>
</table>
Appendix H – Accreditation with Follow-up Survey
Applies to: All accreditation programs

<table>
<thead>
<tr>
<th>Duration</th>
<th>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).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Participants</td>
<td>Joint Commission: Surveyors</td>
</tr>
<tr>
<td>Organization: Survey coordinator, senior leadership, others</td>
<td></td>
</tr>
</tbody>
</table>

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.

Q: What should you do if you discover other non-compliant performance while conducting

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 Survey (RUV)

**Applies to:** All accreditation programs except LAB.

<table>
<thead>
<tr>
<th>Duration</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per itinerary; one day in most cases.</td>
<td>1. To validate that the organization has implemented the corrective action, documented in their evidence of standards compliance (ESC) as reported to the Joint Commission.</td>
</tr>
<tr>
<td></td>
<td>2. To evaluate current compliance with the standards found non-compliant in the last survey.</td>
</tr>
<tr>
<td></td>
<td>3. When time permits, to evaluate other critical issues, as identified by the Joint Commission central office (see Conducting the Survey #11).</td>
</tr>
</tbody>
</table>

**Participants**

Joint Commission: Surveyor

Organization: Survey Coordinator, senior leadership, staff throughout the organization, licensed independent practitioners if part of the organization.

### What happens if the surveyor finds that the organization is not compliant with the same standards that resulted in an RFI during the last survey event?

- Document your findings
- Flag the standard and enter the following comment: “This finding is a previous requirement for improvement from the organization’s last full-like survey event.”

### 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:
   - Previous Recommendations
   - Available ESC submissions, Basic Building Information (BBI) data
   - 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/OAH – 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)

**Timeframe**

When condition-level deficiencies are found, The Joint Commission conducts a follow-up survey within 45 days.

**Duration**

Per itinerary; one day in most cases. The length will be dependent on the volume of condition-level deficiencies.

**Participants**

Joint Commission: Surveyor

This type of survey is designated as Medicare Condition-Level Deficiency (MED DEF) on the surveyor itinerary.

The surveyor class type is Condition Level Deficiency (CLD).

Organization: Survey coordinator, senior leadership, and others

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**Purpose**

1. To evaluate the organization’s follow-up actions in response to Medicare Condition-Level Deficiencies.

2. To evaluate current compliance with requirements that generated Condition-Level Deficiencies.

3. To document that an evaluation of the Condition-Level Deficiencies (CLD) occurred (see survey technology instructions on next page).

**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
   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

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**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

updates. If an ESC was not available at the time of assignment, also check to see if the organization has since submitted one.

**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:
   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.

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:
   a. Notification of scheduled Joint Commission event authorizing your presence
   b. 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:
   a. Suggest postponing the opening conference to mid-morning;
   b. 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, use the remainder of the time to discuss other RFIs with the organization, or offer to review and discuss aspects of their planned ESC submission, if requested. 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 – Understanding Sleep Disorders

NOTE: These guidelines from the American Academy of Sleep Medicine are provided solely to familiarize surveyors with commonly observed structures. These ARE NOT Joint Commission requirements.

What are sleep disorders?
- Obstructive sleep apnea syndrome
- Insomnia
- Narcolepsy
- Restless Leg Syndrome / Periodic Limb Movement Disorder
- Sleep–Wake Rhythm Disorders

What do typical sleep study rooms look like?
- Size – 140 sq ft. Availability of at least two sleep rooms is preferred.
- Rooms are equipped with two-way intercom – low light or infrared video monitoring/ recording instruments.
- Recording/monitoring equipment should be well separated from the sleeping rooms.
- Wiring should be in the walls or ceiling – nothing should hang from the ceiling.
- Each patient room should have a bed, chair, place to hang clothes and an appealing environment
- (similar to a pleasant hotel room or private home). Patients should not share sleeping quarters.
- One sleeping room and bath should be handicap accessible.

What equipment is in the sleeping rooms?
- A polysomnographic machine with 12 or more channels (EEG, EOG / EMG) capable of continuous recording to assess severity, effect on sleep architecture/continuity, and the effects on gas exchange, cardiac function, etc.
- A monitor for airflow, respiratory effort, oxygen saturation, heart rate and rhythm and snoring sound.
- A device to record Nasal CPAP
- A position indication.
- Fire safety equipment
- Cardio-respiratory resuscitation equipment

What staff work in a sleep lab?
- Professional Staff
  - Medical Director – Diplomat of the American Board of Sleep Medicine (MD, DO, PhD) (http://www.absm.org/) or Board Certification in Sleep Medicine (the American Academy of Sleep Medicine (http://www.aasmnet.org/ABMS.aspx)
  - Budget Coordinator
- Technical Staff
  - Familiar with the operation of a polygraph; EEG experience is helpful
  - Training in CPR
  - Night Tech responsibilities – ensure artifact free polysomnograph.
  - Day Tech responsibilities – Reduces polysomnography into standardized tabular form
  - (Software expert). Conducts Multiple Sleep Latency Testing (MSLT) as well as
  - Maintenance of wakefulness testing (MVT).
Appendix L – ASC Deemed Status – Infection Control Surveyor Worksheet

1. Please complete the following form in its entirety when conducting an Ambulatory Surgery Center deemed status survey.

2. The form is available electronically and can be accessed in WST.

If you have any questions about these procedures, please contact the AHC field director for further direction.
Exhibit 351
ASC INFECTION CONTROL SURVEYOR WORKSHEET
(Rev.)

Name of State Agency or AO (please specify) __________________________________________________________

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the infection control Condition for Coverage. Items are to be assessed primarily by surveyor observation, with interviews used to provide additional confirming evidence of observations. In some cases information gained from interviews may provide sufficient evidence to support a deficiency citation.

The interviews and observations should be performed with the most appropriate staff person(s) for the items of interest (e.g., the staff person responsible for sterilization should answer the sterilization questions). A minimum of one surgical procedure must be observed during the site visit. The surveyor(s) must identify at least one patient and follow that case from registration to discharge to observe pertinent practices. For facilities that perform brief procedures, e.g., colonoscopies, it is preferable to follow at least two cases. When performing interviews and observations, any single instance of a breach in infection control would constitute a breach for that practice.

*Citation instructions are provided throughout this instrument, indicating the applicable regulatory provision to be cited on the Form CMS-2567 when deficient practices are observed.*

## PART 1 – ASC CHARACTERISTICS

1. ASC Name

2. Address, State and Zip Code

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>Zip</td>
</tr>
</tbody>
</table>

3. 10-digit CMS Certification Number

4. What year did the ASC open for operation?

5. Please list date(s) of site visit:

<table>
<thead>
<tr>
<th>m</th>
<th>m</th>
<th>d</th>
<th>d</th>
<th>y</th>
<th>y</th>
<th>y</th>
<th>y</th>
</tr>
</thead>
</table>

6. What was the date of the most recent previous federal (CMS) survey:

<table>
<thead>
<tr>
<th>m</th>
<th>m</th>
<th>d</th>
<th>d</th>
<th>y</th>
<th>y</th>
<th>y</th>
<th>y</th>
</tr>
</thead>
</table>

7. Does the ASC participate in Medicare via accredited “deemed” status?  

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

7a. If YES, by which CMS-recognized accreditation organization(s)?

<table>
<thead>
<tr>
<th></th>
<th>Accreditation Association for Ambulatory Health Care (AAAHC)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>American Associate for Accred. of Ambulatory Surgery Facilities (AAAASF)</td>
</tr>
<tr>
<td></td>
<td>American Osteopathic Association (AOA)</td>
</tr>
<tr>
<td></td>
<td>The Joint Commission (TJC)</td>
</tr>
</tbody>
</table>

2 of 18
7b. If YES, according to the ASC, what was the date of the most recent accreditation survey?  

8. What is the ownership of the facility?  
(Select only ONE bubble)  
- Physician-owned  
- Hospital-owned  
- National corporation (including joint ventures with physicians)  
- Other (please print): ____________________________________________________________________

9. What is the primary procedure performed at the ASC (i.e., what procedure type reflects the majority of procedures performed at the ASC)?  
(Select only ONE bubble)  
- Dental  
- Endoscopy  
- Ear/Nose/Throat  
- OB/Gyn  
- Ophthalmologic  
- Orthopedic  
- Pain  
- Plastic/reconstructive  
- Podiatry  
- Other (please specify): ____________________________________________________________________

10. What additional procedures are performed at the ASC?  
(Select all that apply)  
Do not include the procedure type indicated in question 9.  

- Dental  
- Endoscopy  
- Ear/Nose/Throat  
- OB/Gyn  
- Ophthalmologic  
- Orthopedic  
- Pain  
- Plastic/reconstructive  
- Podiatry  
- Other (please specify): ____________________________________________________________________

- N/A  

11. Who does the ASC perform procedures on?  
(Select only ONE bubble)  
- Pediatric patients only  
- Adult patients only  
- Both pediatric and adult patients

12. What is the average number of procedures performed at the ASC per month?  

13. How many Operating Rooms (including procedure rooms) does the ASC have?  

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>O O O O O O O O O</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>actively</td>
<td>1 2 3 4 5 6 7 8 9+</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
14. Please indicate how the following services are provided: *(fill in all that apply)*

<table>
<thead>
<tr>
<th>Service</th>
<th>Contract</th>
<th>Employee</th>
<th>Other</th>
<th>If Other, Please print:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia/Analgesia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental Cleaning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilization/Reprocessing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waste Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INFECTION CONTROL PROGRAM**

15. Does the ASC have an explicit infection control program?  
- [ ] YES  
- [ ] NO  

**NOTE!** If the ASC does not have an explicit infection control program, a condition-level deficiency related to 42 CFR 416.51 must be cited.

16. Does the ASC’s infection control program follow nationally recognized infection control guidelines?  
- [ ] YES  
- [ ] NO  

**NOTE!** If the ASC does not follow nationally recognized infection control guidelines, a deficiency related to 42 CFR 416.51(b) must be cited. Depending on the scope of the lack of compliance with national guidelines, a condition-level citation may also be appropriate.

16a. Is there documentation that the ASC considered and selected nationally-recognized infection control guidelines for its program?  
- [ ] YES  
- [ ] NO  

**NOTE!** If the ASC cannot document that it considered and selected specific guidelines for use in its infection control program, a deficiency related to 42 CFR 416.51(b) must be cited. This is the case even if the ASC’s infection control practices comply with generally accepted standards of practice/national guidelines. If the ASC neither selected any nationally recognized guidelines nor complies with generally accepted infection control standards of practice, then the ASC should be cited for a condition-level deficiency related to 42 CFR 416.51.
16b. If YES to (a), which nationally-recognized infection control guidelines has the ASC selected for its program? (Select all that apply)

- CDC/HICPAC Guidelines:
  - Guideline for Isolation Precautions (CDC/HICPAC)
  - Hand hygiene (CDC/HICPAC)
  - Disinfection and Sterilization in Healthcare Facilities (CDC/HICPAC)
  - Environmental Infection Control in Healthcare Facilities (CDC/HICPAC)

- Perioperative Standards and Recommended Practices (AORN)

- Guidelines issued by a specialty surgical society / organization (List)

Please specify (please limit to the space provided):

- Others

Please specify (please limit to the space provided):

17. Does the ASC have a licensed health care professional qualified through training in infection control and designated to direct the ASC’s infection control program?  

- YES
- NO

NOTE! If the ASC cannot document that it has designated a qualified professional with training (not necessarily certification) in infection control to direct its infection control program, a deficiency related to 42 CFR 416.51(b)(1) must be cited. Lack of a designated professional responsible for infection control should be considered for citation of a condition-level deficiency related to 42 CFR 416.51.

17a. If YES, is this person an: (Select only ONE bubble)

- ASC employee
- ASC contractor

17b. Is this person certified in infection control (i.e., CIC) (Note: §416.50(b)(1) does not require that the individual be certified in infection control.)

- YES
- NO

17c. If this person is NOT certified in infection control, what type of infection control training has this person received?

17d. On average, how many hours per week does this person spend in the ASC directing the infection control program? 

- [ ] hours per week

(Note: §416.51(b)(1) does not specify the amount of time the person must spend in the ASC directing the infection control program, but it is expected that the designated individual spends sufficient time on-site directing the program, taking into consideration the size of the ASC and the volume of its surgical activity.)
18. Does the ASC have a system to actively identify infections that may have been related to procedures performed at the ASC?  

NOTE! If the ASC does not have a documented identification system, a deficiency related to 42 CFR 416.51(b)(3) must be cited.

- YES
- NO

18a. If YES, how does the ASC obtain this information? (Select ALL that apply)  

- The ASC sends e-mails to patients after discharge
- The ASC follows-up with their patients’ primary care providers after discharge
- The ASC relies on the physician performing the procedure to obtain this information at a follow-up visit after discharge, and report it to the ASC
- Other (please specify):

18b. Is there supporting documentation confirming this tracking activity?  

- YES
- NO

NOTE! If the ASC does not have supporting documentation, a deficiency related to 42 CFR 416.51(b)(3) must be cited.

18c. Does the ASC have a policy/procedure in place to comply with State notifiable disease reporting requirements?  

- YES
- NO

NOTE! If the ASC does not have a reporting system, a deficiency must be cited related to 42 CFR 416.51(b)(3). CMS does not specify the means for reporting; generally this would be done by the State health agency.

19. Do staff members receive infection control training?  

If training is completely absent, then consideration should be given to condition-level citation in relation to 42 CFR 416.51, particularly when the ASC’s practices fail to comply with infection control standards of practice.

- YES
- NO

19a. If YES, how do they receive infection control training? (Select all that apply)  

- In-service
- Computer-based training
- Other (please specify):

19b. Which staff members receive infection control training? (Select all that apply)  

- Medical staff
- Nursing staff
- Other staff providing direct patient care
- Staff responsible for on-site sterilization/high-level disinfection
- Cleaning staff
- Other (please specify):  

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19c. Is training:  
○ the same for all categories of staff  
○ different for different categories of staff

19d. Indicate frequency of staff infection control training (Select all that apply)  
○ Upon hire  
○ Annually  
○ Periodically / as needed  
○ Other (please specify): [ ]

19e. Is there documentation confirming that training is provided to all categories of staff listed above?  
○ YES  
○ NO

NOTE! If training is not provided to appropriate staff upon hire/granting of privileges, with some refresher training thereafter, a deficiency must be cited in relation to 42 CFR 416.51(b) and (b)(3).

20. How many procedures were observed during the site visit?  
○ 1  
○ 2  
○ 3  
○ 4  
○ Other

If other, please specify the number: [ ] [ ] procedures
## PART 2 – INFECTION CONTROL & RELATED PRACTICES

### INSTRUCTIONS:
- Please select ONE bubble for each “Was Practice Performed?” question, unless otherwise noted.
- If N/A or unable to observe is selected as the response, please explain why there is no associated observation, or why the question is not applicable, in the surveyor notes box. **Surveyors should attempt to assess the practice by interview or document review if unable to observe the actual practice during survey.**
- During the survey, observations or concerns may prompt the surveyor to request and review specific policies and procedures. Surveyors are expected to use their judgment and review only those documents necessary to investigate their concern(s) or to validate their observations.

### I. Hand Hygiene

Observations are to focus on staff directly involved in patient care (e.g., physicians, nurses, CRNAs, etc.). Hand hygiene should be observed not only during the case being followed, but also while making other observations in the ASC throughout the survey.

Unless otherwise indicated, a “No” response to any question below **must** be cited as a deficient practice in relation to 42 CFR 416.51(a).

<table>
<thead>
<tr>
<th>Practices to be Assessed</th>
<th>Was Practice Performed?</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. All patient care areas have readily accessible, in appropriate locations:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Soap and water</td>
<td>○ Yes&lt;br&gt;○ No</td>
<td></td>
</tr>
<tr>
<td>b. Alcohol-based hand rubs</td>
<td>○ Yes&lt;br&gt;○ No</td>
<td></td>
</tr>
<tr>
<td>l. If alcohol-based hand rub is available in patient care areas, it is installed as required. (There are LSC requirements at 42 CFR 416.44(b)(5) for installation of alcohol-based hand rubs)</td>
<td>○ Yes&lt;br&gt;○ No</td>
<td></td>
</tr>
<tr>
<td>B. Staff perform hand hygiene:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. After removing gloves</td>
<td>○ Yes&lt;br&gt;○ No</td>
<td></td>
</tr>
<tr>
<td>b. Before direct patient contact</td>
<td>○ Yes&lt;br&gt;○ No</td>
<td></td>
</tr>
<tr>
<td>c. After direct patient contact</td>
<td>○ Yes&lt;br&gt;○ No</td>
<td></td>
</tr>
<tr>
<td>d. Before performing invasive procedures (e.g. placing an IV)</td>
<td>○ Yes&lt;br&gt;○ No&lt;br&gt;○ Unable to observe</td>
<td></td>
</tr>
</tbody>
</table>
e. After contact with blood, body fluids, or contaminated surfaces (even if gloves are worn)  
   - Yes
   - No
   - Unable to observe

C. Regarding gloves, staff:
   a. Wear gloves for procedures that might involve contact with blood or body fluids  
      - Yes
      - No
      - Unable to observe
   b. Wear gloves when handling potentially contaminated patient equipment  
      - Yes
      - No
      - Unable to observe
   c. Remove gloves before moving to the next tasks and/or patient  
      - Yes
      - No
      - Unable to observe

D. Personnel providing direct patient care do not wear artificial fingernails and/or extenders when having direct contact with patients.
   - Yes
   - No

II. Injection Practices (injectable medications, saline, other infusates)
   Observations are to be made of staff preparing and administering medications and performing injections (e.g., anesthesiologists, certified registered nurse anesthetists, nurses).
   Unless otherwise indicated, a “No” response to any question below must be cited as a deficient practice in relation to 42 CFR 416.51(a).
   If unable to observe is selected, please clarify in the surveyor notes box why it was not observed and attempt to assess by means of interview or documentation review.

   NOTE: Some types of infection control breaches, including some specific to medication administration practices, pose a risk of bloodborne pathogen transmission that warrant engagement of public health authorities. When management review confirms that a survey has identified evidence of one or more of the breaches described in S&C: 14-36-All, in addition to taking appropriate enforcement action to ensure the deficient Medicare practices are corrected, the SA should also make the responsible State public health authority aware of the identified breach.

<table>
<thead>
<tr>
<th>Practices to be Assessed</th>
<th>Was Practice Performed?</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Needles are used for only one patient.</td>
<td>- Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Unable to observe</td>
<td></td>
</tr>
</tbody>
</table>

9 of 18
<table>
<thead>
<tr>
<th>Practices to be Assessed</th>
<th>Was Practice Performed?</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Syringes are used for only one patient <em>(this includes manufactured prefilled syringes).</em></td>
<td>○ Yes</td>
<td>○ No</td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>C. The rubber septum on a medication, <em>whether unopened or previously accessed</em>, vial is disinfected with alcohol prior to piercing.</td>
<td>○ Yes</td>
<td>○ No</td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>D. Medication vials are always entered with a new needle</td>
<td>○ Yes</td>
<td>○ No</td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>E. Medication vials are always entered with a new syringe</td>
<td>○ Yes</td>
<td>○ No</td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>F. Medications that are pre-drawn are labeled with the date and time of draw, initials of the person drawing, medication name, strength and beyond-use date and time</td>
<td>○ Yes</td>
<td>○ No</td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>Note: A “No” answer should result in citation as a deficient practice in relation to 42 CFR 416.48(a), Administration of Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. a. Single dose (single-use) medication vials are used for only one patient</td>
<td>○ Yes</td>
<td>○ No</td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>b. Bags of IV solutions are used for only one patient <em>(and not as a source of flush solution for multiple patients).</em></td>
<td>○ Yes</td>
<td>○ No</td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>c. Medication administration tubing and connectors are used for only one patient</td>
<td>○ Yes</td>
<td>○ No</td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
</tbody>
</table>
### Practices to be Assessed

<table>
<thead>
<tr>
<th></th>
<th>Was Practice Performed?</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.  <em>The ASC has voluntarily adopted a policy that medications labeled for multi-dose use for multiple patients are nevertheless only used for one patient.</em></td>
<td>☐ Yes  ☐ No  ❋ N/A</td>
<td></td>
</tr>
</tbody>
</table>

(Fill in N/A if no multi-dose medications/infusates are used).

(Note: a “No” answer to question H. does not indicate a breach in infection control practices and does not result in a citation. **However**, a “No” response to either or both of the related questions I and J should be cited).

**If YES, please skip to “K”**

**If NO, you must also assess the practices at questions “I and J”:**

<table>
<thead>
<tr>
<th></th>
<th>Was Practice Performed?</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Multi-dose vials are dated when they are first opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. Note: This is different from the expiration date for the vial. The multi-dose vial can be dated with either the date opened or the beyond-use date as per ASC policies and procedures, so long as it is clear what the date represents and the same policy is used consistently throughout the ASC.</td>
<td>☐ Yes  ☐ No  ❋ Unable to observe</td>
<td></td>
</tr>
</tbody>
</table>

| J. Multi-dose medication vials used for more than one patient are stored appropriately and do not enter the immediate patient care area (e.g., operating room, anesthesia carts).  | ☐ Yes  ☐ No  ❋ Unable to observe |  |

*NOTE: If multi-dose vials enter the immediate patient care area, they must be dedicated for single patient use and discarded immediately after use.*

| K. All sharps are disposed of in a puncture-resistant sharps container | ☐ Yes  ☐ No |  |
| L. Sharps containers are replaced when the fill line is reached | ☐ Yes  ☐ No |  |
III. Single Use Devices, Sterilization, and High Level Disinfection

Pre-cleaning must always be performed prior to sterilization and high-level disinfection

Sterilization must be performed for critical equipment (i.e., instruments and equipment that enter normally sterile tissue or the vascular system, such as surgical instruments)

High-level disinfection must be performed for semi-critical equipment (i.e., items that come into contact with non-intact skin or mucous membranes such as reusable flexible endoscopes, laryngoscope blades)

Observations are to be made of staff performing equipment reprocessing (e.g., surgical techs), unless these activities are performed under contract or arrangement off-site from the ASC.

Unless otherwise indicated, a “No” response to any question below must be cited as a deficient practice in relation to 42 CFR 416.51(a).

<table>
<thead>
<tr>
<th>Practices to be Assessed</th>
<th>Was Practice Performed?</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. a. If single-use devices are reprocessed, they are devices that are approved by the FDA for reprocessing</td>
<td>☐ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ N/A</td>
<td></td>
</tr>
<tr>
<td>b. If single-use devices are reprocessed, they are reprocessed by an FDA-approved reprocessor.</td>
<td>☐ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ N/A</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STERILIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Critical equipment is sterilized</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Are sterilization procedures performed on-site? (If NO, skip to “F”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

(A “No” answer does not result in a citation, since ASCs are permitted to provide for sterilization off-site, under a contractual arrangement.)

(Surveyor to confirm there is a contract or other documentation of an arrangement for off-site sterilization by viewing it)

<table>
<thead>
<tr>
<th>a. If YES to B, please indicate method of sterilization:</th>
<th>Steam autoclave</th>
<th>Peracetic acid</th>
<th>Other (please specify):</th>
</tr>
</thead>
</table>

12 of 18
<table>
<thead>
<tr>
<th>Practices to be Assessed</th>
<th>Was Practice Performed?</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. Items are pre-cleaned according to manufacturer’s instructions or, if the manufacturer does not provide instructions, evidence-based guidelines prior to sterilization</td>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Medical devices and instruments are visually inspected for residual soil and re-cleaned as needed before packaging and sterilization</td>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>b. A chemical indicator (process indicator) is placed correctly, as described in manufacturer’s instructions for use, in the instrument packs in every load.</td>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>c. A biological indicator is used at least weekly for each sterilizer and with every load containing implantable items, as evidenced by ASC documentation (i.e., log).</td>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>d. Each load is monitored with mechanical indicators (e.g. time, temperature, pressure)</td>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>e. Documentation for each piece of sterilization equipment is maintained and up to date and includes results from each load</td>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td>E. Items are appropriately contained and handled during the sterilization process to assure that sterility is not compromised prior to use</td>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>F. After sterilization, medical devices and instruments are stored in a designated clean area so that sterility is not compromised</td>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td>G. Sterile packages are inspected for integrity and compromised packages are reprocessed</td>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td>Practices to be Assessed</td>
<td>Was Practice Performed?</td>
<td>Surveyor Notes</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>H. Is immediate-use steam sterilization (IUSS) performed on-site?</td>
<td>☐ Yes</td>
<td></td>
</tr>
<tr>
<td>If NO, skip to “High Level Disinfection Section”</td>
<td>☐ No</td>
<td></td>
</tr>
<tr>
<td>If YES, you must also assess the practices at questions “I - K”:</td>
<td></td>
<td>(A “No” answer does not result in a citation)</td>
</tr>
<tr>
<td>I. If IUSS is performed, all of the following criteria are met:</td>
<td>☐ Yes</td>
<td></td>
</tr>
<tr>
<td>• Work practices ensure proper cleaning and decontamination, inspection, and arrangement of the instruments into the recommended sterilizing trays or other containment devices before sterilization.</td>
<td>☐ No</td>
<td></td>
</tr>
<tr>
<td>• Once clean, the item is placed within a container intended for immediate use. The sterilizer cycle and parameters used are selected according to the manufacturers’ instructions for use for the device, container, and sterilizer.</td>
<td>☐ Unable to observe</td>
<td></td>
</tr>
<tr>
<td>• The sterilizer function is monitored with monitors (e.g., mechanical, chemical and biologic) that are approved for the cycle being used.</td>
<td>☐ N/A</td>
<td></td>
</tr>
<tr>
<td>• The processed item must be transferred immediately, using aseptic technique, from the sterilizer to the actual point of use, the sterile field in an ongoing surgical procedure.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: “Immediate use” is defined as the shortest possible time between a sterilized item’s removal from the sterilizer and its aseptic transfer to the sterile field. A sterilized item intended for immediate use is not stored for future use, nor held from one case to another. IUSS is not equivalent to “short cycle” sterilization performed in accordance with manufacturers’ IFUs. IUSS must not be a routine or frequent practice in the ASC.
### Practices to be Assessed

<table>
<thead>
<tr>
<th>Practices to be Assessed</th>
<th>Was Practice Performed?</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>J. Immediate-use steam sterilization is NOT performed on the following devices:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Implants.</td>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td>- Post-procedure decontamination of instruments used on patients who may have Creutzfeldt-Jakob disease or similar disorders.</td>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td>- Devices that have not been validated with the specific cycle employed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Single-use devices that are sold sterile.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### K. Is IUSS performed on a routine basis?  

(A “Yes” answer must be cited as a deficient practice in relation to 42 CFR 416.51(a).)

### HIGH-LEVEL DISINFECTION

<table>
<thead>
<tr>
<th>Practices to be Assessed</th>
<th>Was Practice Performed?</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Semi-critical equipment is high-level disinfected or sterilized</strong></td>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ N/A</td>
<td></td>
</tr>
</tbody>
</table>

| B. Is high-level disinfection performed on site? (If NO, Skip to “F”)                   | ○ Yes                   |                |
|                                                                                         | ○ No                    |                |
|                                                                                         | ○ N/A                   |                |

(A “No” answer does not result in a citation, since ASCs are permitted to provide for high-level disinfection off-site, under a contractual arrangement.)

(Surveyor to confirm there is a contract or other documentation of an arrangement for off-site sterilization by viewing it)

| a. If answer to B was YES, please indicate method of high-level disinfection:          | ○ Manual                |                |
|                                                                                         | ○ Automated             |                |
|                                                                                         | ○ Other (please specify):|                |

<p>| C. Items are pre-cleaned according to manufacturer’s instructions or, if the manufacturer does not provide instructions, evidence-based guidelines prior to high-level disinfection | ○ Yes                   |                |
|                                                                                         | ○ No                    |                |
|                                                                                         | ○ Unable to observe     |                |</p>
<table>
<thead>
<tr>
<th>Practices to be Assessed</th>
<th>Was Practice Performed?</th>
<th>Surveyor Notes</th>
</tr>
</thead>
</table>
| D. a. Medical devices and instruments are visually inspected for residual soil and re-cleaned as needed before high-level disinfection | ○ Yes  
○ No  
○ Unable to observe | |
| b. High-level disinfection equipment is maintained according to manufacturer instructions | ○ Yes  
○ No  
○ Unable to observe | |
| c. Chemicals used for high-level disinfection are:   |                         |                |
| I. Prepared according to manufacturer instructions   | ○ Yes  
○ No  
○ Unable to observe | |
| II. Tested for appropriate concentration according to manufacturer’s instructions | ○ Yes  
○ No  
○ Unable to observe | |
| III. Replaced according to manufacturer’s instructions | ○ Yes  
○ No  
○ Unable to observe | |
| IV. Documented to have been prepared and replaced according to manufacturer’s instructions | ○ Yes  
○ No | |
| d. Instruments requiring high-level disinfection are: |                         |                |
| I. Disinfected for the appropriate length of time as specified by manufacturer’s instructions or, *if the manufacturer does not provide instructions*, evidence-based guidelines | ○ Yes  
○ No  
○ Unable to observe | |
| II. Disinfected at the appropriate temperature as specified by manufacturer’s instructions or, *if the manufacturer does not provide instructions*, evidence-based guidelines | ○ Yes  
○ No  
○ Unable to observe | |
| E. Items that undergo high-level disinfection are allowed to dry before use | ○ Yes  
○ No  
○ Unable to observe | |
| F. Following high-level disinfection, items are *placed* in a designated clean area in a manner to prevent contamination | ○ Yes  
○ No | |
IV. Environmental Infection Control

Observations are to be made of staff performing environmental cleaning (e.g., surgical technicians, cleaning staff, etc.)

If unable to observe is selected, please clarify in the surveyor notes box why it was not observed and attempt to assess by means of interview or documentation review.

Unless otherwise indicated, a “No” response to any question below must be cited as a deficient practice in relation to 42 CFR 416.51(a).

<table>
<thead>
<tr>
<th>Practices to be Assessed</th>
<th>Was Practice Performed?</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Operating rooms are cleaned and disinfected after each surgical or invasive procedure with an EPA-registered disinfectant</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unable to observe</td>
<td></td>
</tr>
<tr>
<td>B. Operating rooms are terminally cleaned daily</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unable to observe</td>
<td></td>
</tr>
<tr>
<td>C. Environmental surfaces in patient care areas are cleaned and disinfected, using an EPA-registered disinfectant on a regular basis (e.g., daily), when spills occur and when surfaces are visibly contaminated.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unable to observe</td>
<td></td>
</tr>
<tr>
<td>D. The ASC has a procedure in place to decontaminate gross spills of blood.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

V. Point of Care Devices (e.g., blood glucose meter)

Observations are to be made of staff performing fingerstick testing (e.g., nurses)

If unable to observe or N/A is selected, please clarify in the surveyor notes box why it was not observed or applicable and attempt to assess by means of interview or documentation review.

Unless otherwise indicated, a “No” response to any question below must be cited as a deficient practice in relation to 42 CFR 416.51(a).

<table>
<thead>
<tr>
<th>Practices to be Assessed</th>
<th>Was Practice Performed?</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the ASC use a point-of-care testing device, such as a blood glucose meter?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>If NO, STOP HERE.</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Practices to be Assessed</td>
<td>Was Practice Performed?</td>
<td>Surveyor Notes</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>A. Hand hygiene is performed before and after performing a finger stick procedure to obtain a sample of blood and using the point-of-care testing device.</strong></td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>□ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. Gloves are worn by health care personnel when performing a finger stick procedure to obtain a sample of blood, and are removed after the procedure (followed by hand hygiene).</strong></td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>□ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C. Finger stick devices are not used for more than one patient.</strong></td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>□ No</td>
<td>□ Unable to observe</td>
<td></td>
</tr>
<tr>
<td><strong>NOTE: This includes both the lancet and the lancet holding device.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>D. If used for more than one patient, the point-of-care testing device (e.g., blood glucose meter, INR monitor) is cleaned and disinfected after every use according to the manufacturer’s instructions.</strong></td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>□ No</td>
<td>□ N/A</td>
<td></td>
</tr>
<tr>
<td><strong>NOTE: if the manufacturer does not provide instructions for cleaning and disinfection, then the device should not be used for &gt;1 patient.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix M – 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 N through O – Not Applicable to Ambulatory
### Appendix P -- Onsite Evidence of Standards Compliance (ESC), Preliminary Denial of Accreditation-Evidence of Standards Compliance (PDA–ESC) Survey

**Applies to:** All accreditation programs

<table>
<thead>
<tr>
<th>Duration</th>
<th>Purpose</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 Accreditation Evidence of Standards Compliance (PDA – ESC) are conducted to validate that an organization</td>
</tr>
<tr>
<td></td>
<td>• Has implemented the corrective action documented in its ESC submission, and</td>
</tr>
<tr>
<td></td>
<td>• Is demonstrating current compliance with the elements of performance addressed in the ESC.</td>
</tr>
</tbody>
</table>

#### Participants

- Usually one surveyor
- **Organization:**
  - Survey coordinator
  - Senior leadership
  - Staff throughout the organization
  - Licensed independent practitioners

#### What triggers this type of survey?

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

1. Questions about the integrity/accuracy of an organization’s ESC submission, or
2. A concern about the significant nature of the findings from a survey.

#### Who approves the conduct of an Onsite ESC?

All Onsite ESC surveys require authorization from the ACO Chief Operating Officer.

#### 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.

#### If there are ESCs for multiple programs, is the assigned surveyor expected to review ESCs for all programs?

<table>
<thead>
<tr>
<th>Pre-Survey Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access the HCO information in the usual manner through your itinerary on the Surveyor Portal.</td>
</tr>
<tr>
<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>• 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>• 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>
<tr>
<td>2. Review the ESC report related to the survey event for which you are performing the onsite ESC follow-up. These reports include</td>
</tr>
<tr>
<td>• Standard text,</td>
</tr>
<tr>
<td>• EP text and scoring category,</td>
</tr>
<tr>
<td>• Surveyor findings for non-compliant standards found during the last survey, and</td>
</tr>
<tr>
<td>• Organization provided narrative describing the corrective action taken to address the finding (who, what, when, and how).</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. 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.

<table>
<thead>
<tr>
<th>Duration</th>
<th>Per itinerary; one day in most cases.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unannounced Format</td>
<td>All surveyors on site.</td>
</tr>
</tbody>
</table>

Participants
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 its 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
   b. Surveyor picture, 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.

Surveys 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.

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### 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:
  - 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).

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**Note:** A Limited, Temporary Accreditation decision is not recognized by CMS for Medicare certification purposes.
• 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 identify any RFIs that require ESC 60-day submissions.

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.
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>
</table>

Participants
Joint Commission: All surveyors on-site
Organization: Per activity guides

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 a 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

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 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
ICM Option 2 or Option 3 visit to meet their needs by determining:
- 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.

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 top focus areas for the organization are Staffing 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 Competence Assessment session in order to explore these topics more fully. 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 Competence Assessment
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. See the 2013 Web-based Survey Tech TIP Cards, also repeated in the grey bar of this guide section
2. Designate 1-hour for the CEO and Organization Exit Conference.
9. The FSA tool opens and displays the Standards/EPs tab.

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 – 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><strong>Image Uniformity</strong></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><strong>Slice Thickness Accuracy</strong></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><strong>Slice position accuracy</strong></td>
<td>A test to verify that the correct scan position.</td>
</tr>
<tr>
<td><strong>Alignment Light Accuracy</strong></td>
<td>Measures the deviation between the laser alignment (positioning) beam with the actual x-ray beam.</td>
</tr>
<tr>
<td><strong>Table travel accuracy</strong></td>
<td>Tests CT table motion</td>
</tr>
<tr>
<td><strong>Radiation beam width</strong></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><strong>High Contrast Resolution</strong></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><strong>Low Contrast Resolution</strong></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><strong>Geometric or Distance Accuracy</strong></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><strong>CT Number Accuracy and Uniformity</strong></td>
<td>A phantom is used to verify the scanner’s ability to show different materials.</td>
</tr>
<tr>
<td><strong>Artifact Evaluation</strong></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><strong>Image acquisition display monitor</strong></td>
<td>Testing – 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>
</tr>
</tbody>
</table>

**Magnetic Resonance Imaging (MRI) Equipment**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Image Uniformity</strong></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).

### 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 of whether any abnormal streaks, rings, pinpoints, or other non-real 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

#### Image uniformity/ system uniformity
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.
<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 (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>
</tr>
</tbody>
</table>
Appendix U – Focused Evaluation Screening Tool & Activities

Topic Area: Cleaning, Disinfection, and Sterilization  Program: AHC

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:

bullet Additional patient tracer activity to all locations where cleaning, disinfection, and sterilization are performed

bullet Additional HR file review

bullet Interview additional staff that perform cleaning, disinfection, and sterilization

bullet 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 V – Evaluating Cleaning, Disinfection, High-level Disinfection and Sterilization Processes

Applies to: Ambulatory Health Care, Critical Access Hospitals, Hospitals, Laboratory, Nursing Care Center, and Office-Based Surgery Accreditation Programs, and any sites or services where these tasks are performed

Surveyor Tips & Tools

The activities described are to be incorporated into patient tracer activity. Use this guide to enhance your evaluation of an organization’s processes related to the cleaning, disinfection, high-level disinfection and sterilization of medical equipment, devices, and supplies. This tool will provide guidance on how to conduct a thorough review of cleaning, disinfection, high-level disinfection and sterilization processes and to evaluate the topics addressed in the standards.

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.

Patient Tracer Selection

When selecting patients to trace consider including a sample operative, surgical or procedure patients who have had procedures using non-disposable medical equipment, devices, and supplies. Examples include patients having an endoscopy and/or duodenoscopy.

Organization

Suggested individuals to speak with during patient tracer activity include:
- Organization leadership
- Individual(s) responsible for directing infection control efforts
- Sterile processing technicians and other staff who perform cleaning, disinfection, and sterilization of medical equipment, devices, and supplies.
- Staff responsible for materials management/ purchasing

Documentation

1. Review IC policies

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 Tracers
- 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).
- CMS Memorandum Summary – Duodenoscopes:
- FDA--- Duodenoscopy
  http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm434871.htm
- Multisociety Guideline:
  http://www.asge.org/uploadedFiles/Public_E-Blast_PDFs/ReprocessingEndoscopes.pdf
- CDC Interim Duodenoscope Surveillance Protocol:
- AORN - The Association of periOperative Registered Nurses
  http://www.aorn.org/
- SGNA - The Society of Gastroenterology Nurses and Associates
  http://www.sgna.org/Resources/standards.cfm

- 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 related 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 EP1
- 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, 2, 3 & 4
- HR .01.05.03 EPs 1 & 4
- LD .04.01.07 EP 1 & 2
- EC.02.05.01 EP15
- LD.04.01.05 EPs 1,3,4
- LD.04.01.11 EP5

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 work flow 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 W – Evaluating Aspects of Health Information Management
Requirements

Applies to: Any of the sites or services where these systems are used in 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 staff 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 staff to speak with during 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 health data and information
- Staff supporting those throughout the organization who work with computer applications that support care, treatment, or service: 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

Documentation
Review, as necessary, the following documentation required by the standards:

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 service.
- 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
- 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
1. Plans for managing interruptions to the information process
2. Policy addressing privacy of health information
3. Policy on security of health information, including access, use, and disclosure
4. Policy addressing protection of health information integrity (protection against loss, damage, unauthorized alteration, unintentional change, accidental destruction)
5. Policy addressing intentional destruction of health information
6. 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 1
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
IM.04.01.01
RC.01.01.01
RC.01.02.01, EP 1, 5
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

- 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 protections.
- 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 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:
  - Email
  - Phone calls
  - Internet/web sites
  - Wi-fi
  - Public access spaces (meeting rooms, waiting rooms, cafeteria)
- Review organization emergency management planning to determine if and how health information management is addressed in terms of
  - potential risks to care, treatment, or service from catastrophic cyber failures or threats
  - the organization’s capability to detect, respond to and recover from cyber emergencies that could impact care, treatment, or service.
- Review with leaders the organization’s approach to risk awareness, detection and response as it relates to cyber emergencies
Appendix X – 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:
  o 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)
  o 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
  o Identify the Logistics Manager
  o Ask about ownership of the tractor/trailer. Is there a warehouse for its storage/ maintenance?
  o Explore Department of Transportation (DOT) inspections
  o Explore role and responsibilities associated with packing up the mobile unit prior to it being moved
  o Explore processes for coach Set-up: including patient lift and stair safety, and leveling of the mobile unit/coach, (a critical safety factor).
  o Disaster planning – for example, where are the mobile units moved to when a hurricane is anticipated, to minimize damage?
  o Explore the organization’s plan for routing and on-time delivery of mobile units
  o For anesthesia and sleep study services, ask about equipment maintenance activities and storage
  o 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

Individual Patient Tracer

<table>
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<tr>
<th>Areas to explore</th>
<th>Related Standards</th>
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| 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? | EC.02.01.01  
EC.02.04.01  
EC.02.04.03 |
| 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? | RC.01.01.01  
RC.02.01.01 |
| 3 How is PHI handled? What about patient personal privacy?                      | IM.02.01.03  
RI.01.01.01 |
| 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. | HR.01.04.01  
HR.01.05.03 |
<p>| 5 Describe staffing or equipment contracts that are in place. What specific expectations for services to be provided are detailed in the contract? | LD.04.03.09 |
| 6 Describe patient/staff ratio. How is it adjusted based on patient acuity?     | LD.04.01.11 |
| 7 How is security addressed, such as access to the mobile unit during and after hours? | EC.02.01.01 |</p>
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</thead>
</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 |
| 9 | Hand hygiene is performed utilizing hand sanitizer/soap and water between patient contact and after glove removal | NPSG.07.01.01 |
| 10 | Appropriate use of personal protective equipment | IC.02.01.01 |
| 11 | Medications are stored in accordance with manufacturers’ guidelines. | MM.03.01.01 |
| 12 | Medications are administered per organization’s policies and procedures. | MM.06.01.01 |
| 13 | Safe needle practices are followed. | IC.02.02.01 |
| 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>
</tr>
</thead>
</table>
| 22 | Review personnel files for documentation of staff orientation and ongoing education. | HR.01.04.01  
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>---</td>
</tr>
<tr>
<td>25</td>
<td>Equipment and beds/chairs (if applicable) are disinfected with appropriate agent, and in accordance with manufacturers' recommendations.</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 – Office of Quality and Patient Safety Survey Activity

Applies to: All accreditation programs

<table>
<thead>
<tr>
<th>Duration</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complement and survey length is determined by TJC Leaders and Field Directors based on the patient safety concern.</td>
<td>1. Explore the organization’s response to potential issues of patient safety in relationship to standards compliance</td>
</tr>
<tr>
<td></td>
<td>2. Determine if actions have resolved the potential patient safety issues and that a mitigation strategy is in place for similar events</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants</th>
<th>Before</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Commission: Surveyors</td>
<td>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.</td>
</tr>
<tr>
<td>Organization: Survey coordinator, senior leadership, others</td>
<td>2. TJC Leaders will determine if the OQPS incident:</td>
</tr>
<tr>
<td></td>
<td>a. Warrants pulling the organization’s full survey forward,</td>
</tr>
<tr>
<td></td>
<td>b. Can be assessed on an already scheduled full survey, or</td>
</tr>
<tr>
<td></td>
<td>c. Needs to be a separate OQPS survey event, i.e., a For-Cause survey.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>5. A pre-survey conference call may be required at the directive of leadership, or at the request of the Field Director or surveyor.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>• OQPS incident</td>
</tr>
<tr>
<td></td>
<td>• Supporting documents, when available (e.g., SIG Assessment map)</td>
</tr>
<tr>
<td></td>
<td>• Gold Sheet Approval Process template (GSAP)</td>
</tr>
<tr>
<td></td>
<td>• Other relevant resources that may be provided</td>
</tr>
<tr>
<td></td>
<td>• Previous survey reports (use Quick Links)</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>10. Be cautious and use discretion if printing any materials related to the OQPS incident. Do not leave these items visible and unattended in</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is an OQPS incident?</th>
<th>What’s a Surveyor To Do If...</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Q: What should you do if you:</td>
</tr>
<tr>
<td></td>
<td>1. Meet with any resistance from the organization?</td>
</tr>
<tr>
<td></td>
<td>2. Identify a potential Immediate Threat to Life?</td>
</tr>
<tr>
<td></td>
<td>3. Need more time to complete the survey (or more time to finish the report and transmit)?</td>
</tr>
<tr>
<td></td>
<td>4. Identify that other field staff or surveyor disciplines (RN, MD, LSCS) are needed?</td>
</tr>
<tr>
<td></td>
<td>5. Are anticipating an early departure?</td>
</tr>
<tr>
<td></td>
<td>6. Need assistance in determining if HCOs actions have addressed potential compliance issues?</td>
</tr>
<tr>
<td></td>
<td>A: The following resources are available to you in the Central Office:</td>
</tr>
<tr>
<td></td>
<td>• Field Director on-call at 800.965.5888 option 2 then option 1.</td>
</tr>
<tr>
<td></td>
<td>• SIG for standards related questions at 1-800-965-5888 option 2 three times, then option specific to program</td>
</tr>
<tr>
<td></td>
<td>• TJC Engineers 1-800-965-5888 Option 2 twice, then option 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
<th>What’s a Surveyor To Do If...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explore the organization’s response to potential issues of patient safety in relationship to standards compliance</td>
<td>Q: What should you do if you:</td>
</tr>
<tr>
<td>2. Determine if actions have resolved the potential patient safety issues and that a mitigation strategy is in place for similar events</td>
<td>1. Meet with any resistance from the organization?</td>
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<td></td>
<td>2. Identify a potential Immediate Threat to Life?</td>
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<td>3. Need more time to complete the survey (or more time to finish the report and transmit)?</td>
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<td></td>
<td>4. Identify that other field staff or surveyor disciplines (RN, MD, LSCS) are needed?</td>
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<td></td>
<td>5. Are anticipating an early departure?</td>
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<td></td>
<td>6. Need assistance in determining if HCOs actions have addressed potential compliance issues?</td>
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<tr>
<td></td>
<td>A: The following resources are available to you in the Central Office:</td>
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<td>• SIG for standards related questions at 1-800-965-5888 option 2 three times, then option specific to program</td>
</tr>
<tr>
<td></td>
<td>• TJC Engineers 1-800-965-5888 Option 2 twice, then option 1</td>
</tr>
</tbody>
</table>
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.

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. 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. 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.

Itinerary Identifiers for OQPS Events

<table>
<thead>
<tr>
<th>OQPS -U</th>
<th>Unannounced event</th>
</tr>
</thead>
<tbody>
<tr>
<td>OQPS -A</td>
<td>Announced event</td>
</tr>
</tbody>
</table>

Off-Shift Arrival or Alternate Site Survey Launch Locations

- Notice of the survey event appears on the HCO site prior to the survey start time, even if it is in the middle of the night.
- Central Office support team remains available to the surveyor(s), even during off hours survey events.
- If HCO staff on the alternate shift or at the alternate site does not have access to the extranet site, instruct them to notify the HCO’s Administrator On-Call, who can support proceeding with the survey.
- Questions or concerns about the start time or location should be addressed with the assigned Field Director during event planning.

Generic script for arrival

Joint Commission leadership has received and reviewed information regarding your organization and has asked that I spend time with you to assess issues related to a number of standards and potential risk areas in ____________service(s). During the visit today I would like to begin in ____________ and may visit other areas.
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.

Concurrent or Coordinated Survey Events
There can be occasions when an incident involves more than one HCO, related to each other or possibly not. The OQPS surveys of these organizations may be scheduled to occur simultaneously conducted by different teams or one after another by the same team.

A planned and collaborative effort is required in either situation. This could include mid-survey phone calls among team members to compare notes, findings, etc. These types of events typically have a pre-survey call with all surveyors, led by the field director.
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.

**Script for Introducing the Exploration of a Patient Safety and Quality Issue during a Full Survey Event**

I just want to share with you that Joint Commission leadership has received and reviewed information regarding your organization related to standards areas _____________ and ______________ service(s). Leaders have requested that I (the team) further explore these areas and clinical services as part of this scheduled evaluation of your organization’s compliance with applicable standards.

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 geropsych 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 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>

This type of survey is identified as OQM-IU (Immediate Threat Unannounced) or OQM-IA (Immediate Threat Announced) on the surveyor itinerary.

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.
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 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)