What's New for BHC, 2018

Updates effective in 2018 are identified by underlined text throughout this document. Note: All content specific to Behavioral Health Home is highlighted in turquoise. In the print copy, this content will appear with a grey background.

Changes effective January 1, 2018

Orientation to the Organization – Includes additional topics for discussion related to cyber emergencies impacting patient care services, and questions about the new requirement (CTS. 03.01.09) to use a standardized tool or instrument to measure outcomes

Individual Tracer Activity – Includes additional topics for discussion with staff related to cyber emergencies and the new requirement for use of an outcome measure standardized tool

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

System Tracer - Data Management -- Includes additional topics for discussion related to the new requirement for use of an outcome measure standardized tool

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 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 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 V – Evaluating Aspects of Health Information Management Requirements – New appendix added to support BHC program surveyors in exploring organization compliance with the information management standards, with increased emphasis on the topic of cyber emergency preparedness

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

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 Directors

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.

Accreditation surveys are unannounced, unless they meet an exception rule.

Exception Rules: The following survey types are announced:

At least 30 day notice is given to:
• Early Survey Option (ESO) surveys
• Initial surveys
• Intracycle Monitoring (ICM) Option 2 and 3 surveys

7 day “short notice” is given to:
• Department of Defense facilities
• Bureau of Prisons facilities
• Foster/Therapeutic Foster Care programs
• All methadone programs, if not part of a hospital
• All in-home behavioral health, case management, or Assertive Community Treatment (ACT) programs, if not part of a hospital
• All freestanding organizations with 10 or fewer staff or a total average daily census (ADC) of less than 100
• All community-based, freestanding programs

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

Four weeks prior to the survey
• Access the following information through the Surveyor Portal:
  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 organization together unless circumstances dictate otherwise
• If this is a team survey:
  o Note the names and extensions of other surveyors
  o Coordinate travel arrangements with the team leader and other surveyors. (Note: You can make flight reservations; however, you may want to wait to hear from other surveyors to coordinate hotel and car reservations.)

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

Two weeks prior to survey:
• Access the organization’s ICM Profile
  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.

- Find the historical SAFER™ matrix(s) by selecting the quick link in WST.

- 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.

- Copy Appendix F: Handout for the BHC Organization to provide the organization upon arrival

Any time prior to survey
- Discuss questions regarding the organization or survey logistics with the Account Executive or your Field Director
- Call your Field Director with any survey process questions.
- For organizations providing Foster Care and Therapeutic Foster Care, determine if the Account Executive has:
- Emphasized with the organization that you will be making foster home visits
- Requested the organization to identify clients who live 30 minutes or less in travel time from each foster care office/site
- Instructed the organization to identify a 10% sample of foster homes for visits ensuring that the sample includes homes represented by all offices
- Asked the organization to inform foster parents about the accreditation survey and the home visit activity
- Reminded the organization that written permission is needed from the foster parents before you can conduct the visit
- Reminded the organization that there needs to be a meeting with foster parents
### Surveyor Arrival & Preliminary Planning Session

**Applies to:** All accreditation programs, except Laboratory.

<table>
<thead>
<tr>
<th>Duration</th>
<th>30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participants</strong></td>
<td>All surveyors on site</td>
</tr>
<tr>
<td><strong>Organization:</strong></td>
<td>Survey Coordinator, Senior leadership</td>
</tr>
</tbody>
</table>

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

**Objectives**

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

**Beginning**

- 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.
- 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:
  - 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.01.03.01 and 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 states: The organization notifies the public it serves about how to contact its management or The Joint Commission to report concerns about the safety and quality of care, treatment or services for individuals served. 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. (There is no requirement for posting when surveys are occurring.)
Opening Conference
Applies to: All accreditation programs.

**Duration**
15 minutes

**Participants**
All surveyors on site

Organization: Senior leadership (representing all programs and services 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/services. (e.g., CEO, COO, CFO, CIO, Administrator, Program Directors, etc.)

Note: Participation of senior leadership in all programs/services in a complex organization that independently would be eligible for an accreditation survey should participate.

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

**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 behavioral health care
- Explain that the purpose of survey is to provide an external validation of compliance with accreditation requirements and provide education/consultation. For BHH Surveys: Explain that the survey will include an evaluation of compliance with BHH-specific requirements.
- Ask organization attendees to introduce themselves and make a note of peoples’ names and title/functional responsibilities
- 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.
- 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 served.
- Emphasize with the organization that it is important for surveyors to interact with the direct care givers. Remind leaders that staff members can often become uncomfortable with large numbers of observers.
- Give an example of an Individual Tracer, if the organization is unfamiliar with the on-site survey process.
- Describe the Systems Tracer(s) or other activity you will conduct, if the organization is unfamiliar with the on-site survey process.
- For Housing Support Services: Ask the organization if it could arrange a meeting for you with an individual receiving these services. Also, ask if you could visit one of the
housing locations where individuals have been placed as part of the individual tracer.

- For Foster/Therapeutic Foster care:
  - Remind the organization that the agenda can be flexible to some extent to allow for your attendance at a regularly scheduled meeting that may occur during the survey.
  - Remind the organization that you can be present for a meeting that is scheduled in the late afternoon or early evening on any survey day except the last.
  - Ask the organization to try and have participants at the meeting who represent all types of Foster/Therapeutic Foster care services they provide.
  - Determine from the organization what information they shared with the foster parents about The Joint Commission, the onsite survey, and Foster Parents Group Meeting. This will help guide the content of your introductory comments when you meet with the foster parents.

- 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 Meeting/Surveyor planning time
  - Report Preparation Time
  - Other times pre-arranged with the surveyor(s)

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
  o All ESCs will be due 60 days after the final survey report is received (there is no longer a 45 day ESC)
  o A SAFER™ matrix generates for each accreditation program if this is a tailored survey
• Explain changes to the Clarification Process as follows:
  o Documents not available at the time of Review: Required documents that are not available at the time of review will no longer be eligible for the Clarification Process. These Requirements for Improvement (RFIs) will become action items in the post-review ESC process.
  o Clerical Errors: During the certification review, reviewers and the organization work together to identify and correct any clerical errors in the report. If clerical errors are identified post-review, The Joint Commission will work with the customer to make the corrections. The organization should submit a Clarification Request for the clerical error(s) to be resolved. The correction will be made as part of the Clarification Process. The corrected RFI will remain in the report and become an action item for the ESC process.
  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.
• 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 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**
All surveyors on site

Organization:
- At least one member of the governance or an organization trustee (in single owner organizations, this individual may also be the CEO)
- Senior organization leaders (for example, CEO, COO, CFO, CIO, Administrator, Program Directors)

**Objective**
- Learn more about the organization to help focus survey activities
- 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 or 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 the leader indicates 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 BHH Surveys:** Ask about the scope of services provided and the types of services available
  - **For BHH Surveys:** Determine how the organization uses health information technology (HIT) to support continuity of care, and to support the coordination and integration of behavioral and physical health care, treatment, or services.
  - For Housing Support Services: Determine whether the organization provides services based on a "housing first" model or a "rapid rehousing" model. While the objective of housing the individual will be the same for both, timeframes for doing so and housing options may vary.
  - Operational management structure
  - Planning, resource allocation, and decision-making processes
  - Information management, especially the format and maintenance of care, treatment or service records in use, that is, paper or electronic
  - Contracted services and monitoring performance
  - Health care errors reduction and/or safety initiatives
  - Organization performance in 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 clinical equipment and care, treatment or devices that connect to the internet.
- Descriptions of any vendor agreements or contracted services that support internet access for transmitting clinical information or connecting clinical equipment and devices.
- How IT leadership participates in identifying potential risks to care, treatment or services related to IT systems (critical data and applications, servers, computers, and digitally connected infrastructure).
- Any IT security mechanisms or vendor agreements in place to help during an emergency, for example, Application Support, Forensic Specialists.
- Strategies or resources in place to help facilitate recovery and offset liability following cyber attacks (such as a cybersecurity insurance policy).

- Ask leaders what they are doing to assess the organization's culture and attention to safety.
- Ask leaders performance improvement questions to help you better understand:
  - How the organization is addressing the requirement (CTS.03.01.09) to use a standardized tool or instrument to measure outcomes:
    - Leadership’s role in choosing the instrument
    - How leadership supports implementation and ongoing use of the tool or instrument
    - The approach that was used to choose the tool or instrument; who was involved in the decision
    - Leadership’s ability to explain how and why the tool or instrument is used
    - Education or training that was provided to staff in preparation for implementation; how training was provided
    - How data are used to identify performance improvement opportunities
    - Whether data are used to evaluate clinician performance; if so, how this is done in a manner that is consistent with a safety culture
    - Whether there are populations of individuals who are not expected to complete a tool or instrument, and if so, how the organization monitors the progress of these individuals
  - How they set priorities and expectations, and plan, assess and measure initiatives to improve the quality of care, treatment and services
  - Their approach to safety, including selection of proactive risk assessment topics, when required, and resulting improvements
  - Governance involvement in safety issues
  - Provision of resources including personnel, information systems, data management, and staff training
The organization's approach to the Focused Standards Assessment and methods used to address areas needing improvement

- **For BHH Surveys**: Ask leaders to describe processes and infrastructure in place to support the provision of integrated and coordinated care, including:
  - 24/7 access by individuals served to prescription renewal requests, test results, clinical advice for urgent health care needs, and appointment availability
  - Addressing individuals’ urgent health care needs 24/7
  - Identification of integrated care team members
  - The disciplines of those serving in the role of team coordinator
  - Involvement of individuals in performance improvement activities

- 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.

<table>
<thead>
<tr>
<th>Duration</th>
<th>30-60 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>All surveyors on site</td>
</tr>
<tr>
<td>Organization:</td>
<td>Organization’s Survey Coordinator (as requested)</td>
</tr>
<tr>
<td>Other organization surveyors may participate when cooperative evaluations are in place</td>
<td></td>
</tr>
</tbody>
</table>

**Surveyor Tips**
During performance review, think about the possible relationship of negative data to staffing. Select individual tracers from those areas with negative outcomes to gain a better understanding of performance.

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

**Objectives**
1. Begin the review of requested documentation, especially material that is critical to guiding subsequent onsite survey activity
2. Begin the selection of 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 lists of individuals served. Note: Some smaller organizations may not prepare a daily census or maintain a list of individuals served as a matter of routine. In those instances, surveyors should work with organization staff to identify which individuals served would be best to participate in tracer activity.

**During**

**Tracer Selection (25% of session)**
- Using the ICM Profile data (services, previous RFIs), identify initial individual served tracers for the day. Timing of this activity must be first to allow some programs to rearrange schedules and obtain permission of individuals served. If a census is not available, select a program/service. See the Survey Process Rules for Surveyor Planning in Appendix C for guidance.
- If conducting a complex organization survey, identify surveyors from each accreditation 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.
- 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.
- Note: In complex organizations, surveyors should review the data relative to their accreditation program(s) and survey activities.
- Identify which system and accreditation program-specific tracers will be conducted using the guidelines in Appendix E.
- Surveyors conducting the Data Management System Tracer should complete a review of performance improvement data including aggregation, analysis and action related reports.
- One surveyor from each accreditation program responsible for conducting the Individual-based System
Tracer for Medication Management should review the accreditation program-specific medication related performance reports, such as medication errors and adverse drug events.

- One surveyor from each accreditation program responsible for conducting the Individual-based System Tracer for Infection Control should review the accreditation-program specific infection control related performance reports.

- The surveyor responsible for the Life Safety Code (LSC) assessment, must access the organization’s Plan for Improvement (PFI) at this time through the Surveyor Portal. To do this, connect to the internet, access today’s itinerary, electronically review the organization’s PFI and ‘accept’ the open items. Close with your name and surveyor ID number.

Planning Discussion (25% of session)

- If part of a team, surveyors discuss their findings from the performance review with each other, giving each surveyor time to “report” what they found, where they would suggest focusing attention during individual tracers, and preliminary comparison of issues that cross the organization.

- Identify the focus for this organization’s Data Management system tracer. The first step in the process that is a problem becomes the focus for the organization. Identify participants who are needed at the session.

- When applicable, identify the focus of the Medication Management and Infection Control system tracers

After

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

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

**Applies to:** All accreditation programs.

**Duration**
60 – 120 minutes

**Participants**
One surveyor

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

**Other information**
There is no mandated order for visits to other programs/services. One approach to conducting the Individual Tracer is to sequentially follow the course of care, treatment, or services received by the individual served.

You may arrive in a setting 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 the program exploring such topics as data collection and use and performance improvement activities.

Meet with, ask questions of, and observe care, treatment or services provided by staff whenever possible. Be sure to include ancillary 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.

When applicable, and to the extent possible, coordinate with other surveyors to avoid selecting Individual Tracers that may overlap in terms of visiting programs/services 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.)

<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th><strong>Before</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The objective for this session is to evaluate the organization’s compliance with standards as they relate to the care, treatment and services provided.</td>
<td><strong>·</strong> Select Individual Tracer candidates based on the clinical services, ICM Profile risk areas, and information discovered during the Orientation session.</td>
</tr>
<tr>
<td><strong>·</strong> Begin planning how you will expand your tracer candidate selection as the survey progresses to include:</td>
<td><strong>·</strong> Individuals with more complex situations that will allow for greater exposure to the variety of care, treatment or services provided by the organization.</td>
</tr>
<tr>
<td></td>
<td><strong>·</strong> Individuals served that will provide opportunities to assess the organization's attention to the continuity of care, treatment and services.</td>
</tr>
<tr>
<td></td>
<td><strong>·</strong> Individuals served that will allow exploration of the organization’s infection control and medication management systems, as applicable to the care, treatment and services being provided (reference the system tracer descriptions for these specific topics later in this guide).</td>
</tr>
<tr>
<td></td>
<td><strong>·</strong> Individuals served who have experienced care, treatment or services that cut across accreditation programs (e.g. an individual served receiving ambulatory health services as well as BHC residential care).</td>
</tr>
<tr>
<td></td>
<td><strong>·</strong> Individuals served that have been admitted from or discharged to an outpatient service.</td>
</tr>
<tr>
<td></td>
<td><strong>·</strong> For BHH Surveys: Select an individual served who has been issued a facilitated referral or received care, treatment, or services for a chronic physical health condition.</td>
</tr>
<tr>
<td></td>
<td><strong>·</strong> Individuals served that cover multiple additional criteria.</td>
</tr>
<tr>
<td></td>
<td><strong>·</strong> Individuals who have not progressed as expected or who have deteriorated in order to see how data generated by the outcome measures standardized tool or instrument (CTS.03.01.09) was used in these situations.</td>
</tr>
<tr>
<td></td>
<td><strong>·</strong> 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.</td>
</tr>
<tr>
<td></td>
<td><strong>·</strong> Plan to evaluate all important aspects of care, treatment and services noted in the Individual Tracer and the Individual Tracer Addendum, and evaluate as many as possible during the time available.</td>
</tr>
</tbody>
</table>

**During**

| **During** | **·** Begin the Individual Tracer in the program/service where the individual served and the record is currently located. |
| | **·** Start the tracer by reviewing a clinical/case record with the staff person responsible for the individual's care, treatment, or services. If the staff person is not available, the discussion can |
If you obtain conflicting information about a policy or process, ask the leader accompanying you on the tracer to obtain the written policy for the next scheduled issue resolution time.

REMEMBER!
Reference the Program Specific and System Tracers matrix in Appendix E to determine which system tracers will be a part of this survey.

- In 24-hour care settings, surveyor(s) conducting the Individual-based Infection Control System Tracer must select an individual served to trace with an infection or who had an infection.

- Surveyors conducting the Medication Management System Tracer must select an individual served to trace for whom the organization has either prescribed or is administering the individual's medication(s).

be held with a clinical supervisor or other staff member. The primary purpose of using a clinical/case record is not to audit its contents, but to use it as a tool in following care, treatment, and services.

- Look in the clinical/case record for evidence of use of the outcome measures standardized tool or instrument:
  - Does the record contain evidence that the instrument was administered in a manner that is consistent with the instrument's guidelines and the organization's policies?
  - Are changes in treatment goals or objectives related to or associated with data?
  - Do progress notes indicate that instrument scores were discussed with the individual served (especially if deterioration was observed)?

- Trace the entire care, treatment or service process from present day through post-discharge/transfer, if applicable. This may involve moving from location to location (depending on the size of the organization).

Throughout the individual tracer, interview staff you encounter about:

- Compliance with applicable standards pertinent to the individual being traced
- Communication and coordination of care, treatment or services for the individual served. (Pay particular attention to hand offs – these are critical points in time when errors occur.)

- The outcome measure standardized tool or instrument used to objectively monitor the individual's progress, including:
  - How are staff trained on the use of the tool?
  - Are staff aware of the instrument’s key elements (such as when to administer, range of scores, reliable change)?
  - How often is the tool administered and re-administered?
  - Are data used to inform or trigger discussions about the level of service or changes to treatment plans and goals?
  - Can clinicians describe how they have used the data to inform or modify treatment goals and objectives?
  - How do clinicians document an individual’s progress or deterioration?
  - Can supervisors readily identify cases where data indicated that the client was not making progress?
  - Do treatment teams and/or supervisors discuss these “at-risk” cases with clinicians?

- Processes that are in place, and staff member roles in minimizing risks to individuals served

- National Patient Safety Goals (NPSGs) Reminder: All applicable NPSGs must be evaluated during the course of a survey

- Processes for educating individuals served
- Orientation, training and competency testing
- Awareness of content of APR.09.02.01 (staff are permitted to contact The Joint Commission with concerns related to the safety of individuals served without fear of recrimination)
Emergency management roles and responsibilities, including mitigation, preparedness, response and recovery/service continuity related to the following:
- How to report events that have occurred
- Communication with individuals served
- Communication with staff
- Communication with relevant external entities (such as contracted providers, public health and other public authorities, other health care organizations, alternative care sites, etc.

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 services if all of the IT systems are not available, including training in back up/alternative work procedures
- Contingency plans if the following systems are disabled by a cyber emergency:
  - Electronic health record (EHR) (acute and prolonged events)
  - Pharmacy
  - Clinical devices
  - Telemedicine care, treatment, or services

Other issues, relative to care, treatment or services

Validation of information learned during other survey activity

For BHH Surveys: Discuss with staff how they track and follow-up on test results and referrals; validate this through review of clinical/case records.

For BHH Surveys: Determine if recommendations or results from referrals are available to the integrated care team.

For BHH Surveys: Ask staff to identify the members of the individual’s integrated care team.

For BHH Surveys: Ask staff to describe, perhaps through examples, how the integrated care team works to provide coordinated and integrated care, treatment, or services to the individual.
• **For BHH Surveys:** Ask staff to describe how the individual’s self-management goals are incorporated into the plan for care, treatment, or services; ask to see examples in the clinical/case record.

• For Housing Support Services: If the organization directly provides both housing support services and behavioral or physical health care, treatment, or services, determine whether a multidisciplinary care, treatment, or services team coordinates the provision of care, treatment, or services.

• For Housing Support Services: Determine that staff use evidence-based or accepted case management practices, are trained in communication and advocacy skills, and are knowledgeable about Fair Housing rules and regulations.

• For Housing Support Services: Determine whether the organization consistently offers individuals access to housing without any requirements to participate in social, behavioral, or physical care, treatment, or services.

• For Housing Support Services: Ask staff to describe the organization’s process for determining that the housing options it offers meet all applicable safety regulations.

• For Eating Disorders Programs: Determine that all required tests, screens, assessments, and procedures are regularly completed.

• For Eating Disorders Programs: Determine that all required data are collected and analyzed.

• For Eating Disorders Programs: Determine that there is a multidisciplinary care, treatment, or services team and that the appropriate staff and others are on the team.

• For Eating Disorders Programs: Determine that the organization is able to supply individuals with information on insurance coverage accepted by the organization, whether the facility is in network for the individual’s insurance company, and the availability of financial assistance.

• For Eating Disorders Programs: Determine whether the plan of care, treatment, or services specifies a diagnosis based on the current Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the current edition of the International Classification of Diseases (ICD).

• For Eating Disorders Programs: Ask staff whether they are knowledgeable about evidence-based guidelines for treatment of individuals with eating disorders.

• For Eating Disorders Programs: Determine that the program is staffed appropriately.

Interview individuals served and when appropriate, family members about:

• Coordination of care, treatment or services including timeliness

• Their experience with the outcome measure standardized tool or instrument:
  - Do they understand how it is used to monitor their progress?
  - Does anyone on the clinical team discuss the data with them?
- Education and information provided
- Perception of care, treatment or services
- Understanding of discharge/transfer instructions, if applicable
- Staff compliance with NPSGs
- Other issues, relative to care, treatment or services
- Validation of information learned during other survey activity

**For BHH Surveys:**
- Information provided to individuals served about how the organization functions and the available services
- Directions provided to individuals served about obtaining urgent care after the office/clinic is closed and if they have ever needed such care

**Observe:**
- Administration of the organization’s outcome measure standardized tool or instrument to an individual served
- Potential environmental issues that might impact individual safety
- Care, treatment or services planning (e.g. timing of assessments). If possible, observe discharge/transfer planning or care coordination meetings
- Observe direct care practitioners working with individuals, when possible and appropriate
- Medication processes (e.g., administration of medications, and storage of medications)
- Infection control processes (e.g. techniques for hand hygiene, 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 BHH Surveys:** Ask staff how they assess the health literacy of individuals served.

**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 observations and concerns with other surveyors, if applicable, so they can be further explored in subsequent survey activity
Individual Tracer – Addendum
Individual Tracers - Important Components

The following represent areas that are important based upon current literature and Joint Commission standards. They may be applicable to the program or services you are surveying and are called to your attention for when they are applicable. These suggestions are not all inclusive of the issues and topics that can or should be covered in a tracer.

Let the tracers guide you to the following 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/case records:
  - Review the timing of screenings and assessments for individuals served
  - Verify individualization and appropriateness of the plan of care, treatment, and services
  - Determine if a standardized tool or instrument is being used to objectively monitor the individual’s progress and at what frequency
- Review and discuss the use of verbal orders (e.g., who can accept and transcribe the order, read back process and authentication), if applicable

Contracted Services
Note: In many BHC organizations contracted services are provided off-site in the community and contracted staff may not be available for interview.
- When available, interview contracted practitioners and staff about the scope and nature of care, treatment and services they provide and how they were oriented to the organization’s processes
- Interview organizational leaders about their oversight process for contracted care, treatment and services and contracted staff. Monitoring of contracted care, treatment and services and practitioners and staff is required.
- Review performance improvement plans and data for inclusion of contracted care, treatment and services and practitioners and staff
- Review contracts

Discharge/Transfer Planning
Active Review
- Ask for a list of individuals served who have recently been or soon will be discharged/transferred
- Review the clinical/case record for discharge/transfer orders
- Request that the organization obtain permission for observation from the individual served
- Observe the staff providing discharge/transfer instructions. Components of the discharge/transfer instructions include:
  - Activity
  - Diet
  - Medications (post discharge/transfer), if applicable
  - Plans for follow-up
  - Signs and symptoms to be aware of (i.e., medication side effects, etc.)
  - Practitioner’s name and telephone number to call should a problem or questions arise following discharge/transfer
  - Staff has the individual served repeat back information to confirm understanding
- Review written discharge/transfer instructions given to the individual served. Determine if discharge/transfer instructions are written in a language the individual served can read and understand
- Interview the individual served to determine their level of understanding of discharge/transfer instructions
- When discharge/transfer is from 24-hour care settings and only if the organization prescribes medication, determine the level of understanding of the individual served of the following related to medications:
  - The purpose for taking any new medication
  - How to take the medication including dose and frequency
  - Possible side effects of medication, and signs and symptoms or problems and who to call with questions and concerns
The medication regimen including continuation or discontinuation of those medications taken prior to admission
- Contraindications between prescribed medications and over the counter medications and herbal remedies
- Changes in diet and dietary restrictions or supplements
- Information regarding continued self-care
- Interview staff to ascertain the origination of discharge/transfer information
- Hand off communication
- Medication reconciliation

**Environment of Care**
- Observe the condition of the facility areas used by individuals served (e.g., safe, clean, functional, and comfortable)
- Discuss:
  - The process for conducting environmental tours to identify environmental deficiencies, hazards, and unsafe practices
    - Management of hazardous materials and waste, if any

**Emergency Management**
- Ask various staff members to explain their role and responsibilities during an emergency,
- Ask various staff members to explain their role in emergency management, including:
  - Information, education, or training they've received
  - Resources or tools needed for their role
  - 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

**Food and Dietetic Services, if provided**
- Identify the national standards used for recommended dietary allowances
- Observe hygiene practices and kitchen sanitation
- Discuss:
  - Safety practices for handling food
  - Assessment process to determine dietary needs of individuals served
  - Process for accommodating special and altered diet schedules
  - Follow-up process when the individual served refuses food served

**Hand Hygiene** - Observe practitioners and staff, specifically look for all opportunities for hand-washing (for example, prior to meals).

**Infection Control**
- Observe staff for compliance with hand hygiene techniques
- Ask about, and observe, as appropriate, disinfection, employee health, food sanitation, housekeeping cleaning processes, and other means for limiting the spread of infection
- Inquire about employee health screening and health requirements (e.g., vaccinations, immunizations); ask to see a sample of employee health files to verify compliance through documentation in these records

**Laboratory Services (if applicable)**
- Discuss:
  - Identification of individuals served and protocols being followed for gathering specimens for clinical testing
  - Waived testing, if performed,
  - Specimen collection and transportation process
  - Confidentiality of information
  - Process for communicating critical values
Clinical/Case Record Content

- Verify that:
  - Information (e.g., consultations, assessments, etc.) is filed in the clinical/case record in a timely manner
  - Clinical/case record entries are dated and authenticated (as required by law)
  - A complete informed consent is obtained, when applicable

- Review clinical/case records for:
  - The presence of sufficient information to identify the individual served, support the diagnosis, describe the individual’s progress, and response to care, treatment, or services

Medication Management

- Determine which medication management processes are within the organization's scope of care, treatment or services: Planning, selection and procurement, storage, ordering/prescribing, preparing/dispensing, administration, monitoring, or evaluation. Based on this determination review the following as appropriate
- Review and discuss how medications are prepared, when applicable
- 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 the individual’s own medications
  - Control and transportation process for unused, expired, or returned drugs are controlled by the pharmacy (24-hour care settings)

- Review medication orders for:
  - Clarity and completeness
  - Adherence to safety standards (e.g., no blanket reinstatement of previous orders).

Rights of Individuals Served

- Discuss with staff and observe, when possible:
  - Communication between staff
  - Education within the confines of the needs, physical and cognitive challenges, culture and language diversity of the individuals served
  - Restraint and seclusion, if used, including physical holding of children/youth
  - Processes followed when an individual served refuses care, treatment or services
- Individual served and family understanding of:
  - Rights
  - Process to register a complaint
  - Safety issues
  - Confidentiality of personal/health information

Performance Improvement

- Discuss:
  - Data collection process and responsibilities (e.g., medication management, restraints and seclusion, individualized behavioral contingencies)
  - Any undesirable patterns or trends in performance that are being aggregated and analyzed
  - Use of data analysis in the identification and implementation of process improvements
  - Process for identifying and implementing changes to reduce the risk of sentinel events
Evaluation of performance improvement changes are made to ensure that they achieve the expected results.

- Process for taking appropriate actions when planned improvements are not achieved or sustained.
- Inclusion of data from external sources to determine if there is excessive variability or unacceptable levels of performance.
- Changes in PI activities to accommodate urgent events such as behavioral 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 individuals served are being performed.

**Waived lab testing tracer (when applicable)**

During an individual tracer, identify an individual served who is undergoing waived lab testing by the organization’s staff. (Note: Individuals who are self testing are exempt from CLIA regulations.)

Trace the organization’s process by:

- Reviewing documentation elements in the clinical/case record (quantitative result and acceptable range).
- Interviewing staff about testing procedures, including:
  - Orientation and training about equipment use and testing process.
  - Identification of tests completed by staff in the specified location.
  - Implementation of a waived testing quality control plan, including responsibilities.
  - Validation that the organization completed quality control testing for the waived tests you are tracing.
    - Organizations are no longer required to perform quality control checks on each day of testing. Organizations are now required to perform quality control checks per manufacturers’ instructions.
  - Follow-up process when results are obtained.
- Drilling down as indicated by:
  - Identifying and interviewing the waived testing director and / or supervisor – director name found on the CLIA waiver.
  - Reviewing quality control plan and other planning documents, e.g. policies and protocols (reference standard for detailed needs).
  - Evaluating personnel files for the presence of staff education and competency for test being traced.
  - Review additional data and trace where the data flows and its use in organizational performance improvement.
  - Instrument maintenance.
Special Issue Resolution
Applies to: All accreditation programs where the survey lasts more than one day.

<table>
<thead>
<tr>
<th>Duration</th>
<th>30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>All surveyors on site available to participate</td>
</tr>
<tr>
<td>Organization:</td>
<td>As requested by the surveyor(s) depending on the issue(s) to be discussed</td>
</tr>
</tbody>
</table>

**Objective**

1. 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 individuals served to confirm an Individual Tracer finding.
  - Personnel or credentials files
  - Measures of Success or implementation status of improvements shared with surveyor(s) about plans of action
  - Review of data, such as performance improvement results
  - Review of contracts, as applicable, for performance expectations and information on how performance monitoring will be conducted
Team Meeting/Surveyor Planning – End of Day
Applies to: All accreditation programs

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

During
Surveyor(s) should:

- Review, and discuss with other surveyors when applicable, their observations
- Think about, and discuss with other surveyors when applicable, connections between observations and systems. Review your planned approach to survey activities for the next day
- Establish areas of focus for subsequent tracer activity based on observations and performance patterns
- 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 on 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
• Identify topics for upcoming system level tracers, if applicable
• Review and verify the status of any outstanding requests for information
• Prepare for the Daily Briefing discussion with the organization, including sharing where observations of non-compliance have the potential to appear on the SAFER™ matrix

After
Return documents directly to the organization contact /liaison
Daily Briefing
Applies to: All accreditation programs where the survey lasts more than one day.

<table>
<thead>
<tr>
<th>Duration</th>
<th>30 minutes per survey day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidelines</td>
<td>The briefing is not required on the first day of multi-day surveys; however, it is left to surveyor discretion to determine the need for a briefing at the conclusion of the first day</td>
</tr>
<tr>
<td>Participants</td>
<td>All surveyors on site available to participate</td>
</tr>
<tr>
<td>Organization: Governance, CEO/Administrator and other leaders or staff invited to participate</td>
<td></td>
</tr>
<tr>
<td>Session Guidelines</td>
<td>This session is intended as a briefing, not a detailed report out.</td>
</tr>
</tbody>
</table>

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

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

Objectives
- Provide organization representatives with a brief summary of survey activities of the previous day
- Relay observations according to standards areas, and note observations related to general program or organization-specific risk areas.

During
- Briefly summarize survey activities completed on the previous day. Make general comments regarding significant issues.
- Do not repeat observations made at a previous daily briefing unless it is in the context of identifying systemic performance.
- Discuss what occurred to substantiate a finding as needed for organization understanding of the issue. Do not discuss in detail each survey activity, specific records, and discussions held 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 when requested.
- Review the agenda for the day. Make necessary adjustments to plans based on organization needs or the need for more intensive assessment of a topic.
- 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. Be considerate of staff time. **Do not** make all organization representatives stay for a discussion that is specific to a small group of individuals.

• At the last day Daily Briefing the organization may provide additional documents for review or individuals to interview to clarify surveyor reported observations. Remind the organization to provide you with access to documents or individuals in sufficient time before the start of the Report Preparation session.
Competence Assessment Session
Applies to: All accreditation programs.

Duration
60 minutes

Participants
One surveyor

Organization:
Staff responsible for:
- Aspects of the organization’s human resources processes
- Establishment of qualifications
- Orientation and education of staff
- Assessing staff competency

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

Objectives
1. Learn more about the organization’s competence assessment process for staff
2. Learn more about the organization’s establishment of qualifications, orientation, education, and training processes as they relate to staff working at the organization (employees or under contract)
3. Identify competence assessment process-related strengths and potential risk points

Personnel File Selection
- Select files from staff you encountered while conducting individual tracers
- Target “well meaning and/or well educated staff” who may have expressed concerns about their level of competency or who you may have intuitively identified concerns about their level of competency

Points of Focus
Competency pertains to all types of staff: Clinical social workers, clinical psychologist, primary care provider, professional counselors, addictions counselors, case managers, music therapists, behavioral health nurses and psychiatrists.

Remember to…
- Inquire about how the organization determined hiring qualifications
- Determine if staff competencies align with job descriptions

During
- Using data gathered during Individual Tracer activity, conduct a facilitated discussion of the following topics:
  - Internal processes for establishing qualifications for positions and scope of clinical practices, e.g. facilitating groups, diagnosing
  - Internal processes and state specific laws governing the scope of clinical practice
  - Internal processes for determining compliance with policies and procedures, applicable law and regulation, and Joint Commission standards
  - Methods used to determine staffing adequacy; frequency of measurement; what is being done with the results
  - Performance improvement initiatives related to competency assessment for staff
  - Orientation of staff to the organization, job responsibilities, and/or clinical responsibilities
  - Experience, education, and abilities assessments
  - Ongoing education and training
  - Competency assessment, maintenance, and improvement
  - Competency assessment process for contracted staff; focus contract review on contractors that are not Joint Commission accredited
  - Inquire about employee health screening and health requirements (e.g., vaccinations, immunizations) for

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.

- Working in the organization; ask about the process for monitoring compliance with such requirements
  - Other issues discovered during Individual Tracers

- Summarize strengths and potential risk points in the organization’s competence assessment process

After

- Verify through review of a sample of employee health files any documentation that staff has undergone required health screenings
- Consider the relationship of your observations to system level issues
- Share with other team members issues that need to be further explored in subsequent survey activity

For BHH Surveys:

- Review the personnel file of staff serving in the role of team coordinator to gain an understanding of what types of skill and experience the organization has identified as important to this role.
Environment of Care and Emergency Management Session - BHC

Applies to: BHC accreditation program

FOR BHC - Reference Applicability Grid in matrix below – Applicability is based on the organization type, services and population(s) served.

**Duration - Variable**
30-60 minutes

**Participants**
One surveyor

Organization:
Individuals able to address issues related to the Environment of Care and Emergency Management in all areas within the organization's facilities including:
- Safety
- Security
- Emergency management activities
- Building utility systems
- IT Representative, if available
- Organization leadership

**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

**Before**
Review the following documents.
- Annual evaluations of the Environment of Care (EC) management plans (EC.04.01.03) *Not applicable to initial surveys*
- Review the organization’s performance from fire drills and fire response activity
- 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 exercises.
- Review EC-related issues observed in previous survey activities (including those made by other survey team members, when applicable). Analyze the data collected on survey up to this point and identify patterns of weakness and strengths in management processes related to EC-risks to review with the organization.
  - Management process 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 activity

- Review the organization’s performance in addressing the requirements of the Emergency Management standards including:
  - Identifying potential 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 sites, closing and reopening after emergency);
  - Identifying its role in relation to the community’s, county’s or region’s emergency response plan;
  - 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.
  - Making any necessary improvements to its emergency management 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 care and support of the individual.

- How clinical devices, care, treatment and service equipment, and care-related utilities (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.

**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 process for maintenance of safe grounds and equipment; trace the organization’s process for environmental tours using their tools, if created.

  - Security – trace the organization’s process for ensuring the security of individuals (Note: This was covered if a Program Specific Tracer was completed for Violence, Elopement or Suicide Prevention); trace how organizations prevent contraband.

  - Hazardous Materials – trace the process for the management of sharps, chemicals or other hazardous materials

  - Fire Safety –, use the outcomes of the organizations fire drills to trace identified problematic issues; trace a fire response plan in a high risk area

  - Utilities – trace the planned actions for a communication failure or electrical failure.

- Conclude the session by summarizing strengths and risk

**After**

- Consider the relationship of your observations to system level issues

- Share with other team members, if applicable, any issues that have been uncovered so they can be further explored in subsequent survey activities
## Emergency Management Lessons Learned

### Tips and Examples

### Communication

<table>
<thead>
<tr>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication with providers</strong></td>
</tr>
<tr>
<td>Prepare for proactive communication with providers at the start of an emergency response. Providers sometimes spontaneously report to a scene or multiple scenes, which can result in too many or too few, or a mismatch of specialties to immediate needs of the individuals served.</td>
</tr>
<tr>
<td><strong>Communication via social media</strong></td>
</tr>
<tr>
<td>Informally, many staff became aware of incidents in the organization via social media before receiving official notification from their organization. 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, individuals served, the community, and traditional media. In one emergency where there was an explosion in the community, an organization developed a 'disaster blog' to keep internal staff apprised of information from the command center.</td>
</tr>
<tr>
<td><strong>Communication via Media - national and international</strong></td>
</tr>
<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 individuals served for interviews with patient consent; organization can then aid individuals served or family members in the interaction with local, national, or international media.</td>
</tr>
<tr>
<td><strong>Communication Systems</strong></td>
</tr>
<tr>
<td>Organizations have found it useful in planning and response to:</td>
</tr>
<tr>
<td>• establish a line of communication solely for command/control and a separate channel for communication with staff</td>
</tr>
<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>
</tr>
<tr>
<td>• contact government agencies in their area to request access to backup telecommunications towers.</td>
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</tbody>
</table>

### Response

<table>
<thead>
<tr>
<th>Topics</th>
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<tbody>
<tr>
<td><strong>Volunteers</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
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</table>

### Security

<table>
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<tr>
<th>Topics</th>
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<tbody>
<tr>
<td><strong>Security during Community Threat/Attack/Unrest</strong></td>
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</table>
Health care organizations can work in advance with public safety providers when there are known or perceived safety risks. During a bomb attack in one community that resulted in 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 providers 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 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 locations had additional off duty employees report for work unsolicited when the explosion was reported through the media; many were sent home.

**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 – infectious disease outbreak**
When implementing screening questions and other infectious disease precautions in the organization, provider offices and other satellite facilities should be included to help mitigate risk in all potential patient care locations.

**Health care partners – mass casualty event**
Organizations can consider how to partner with other settings to support response. Following an explosion in which local hospitals received individuals served from the community and a nursing home fire, hospitals required the support of in-house and external behavioral health providers, pastoral services and grief counselors to support individuals served, first responders, staff and community.

**EVACUATION**

**Evacuation**
Where the need to evacuate is identified as a potential risk, the organization can rehearse evacuations during drills. It’s important to consider in advance how to help evacuate individuals served who may have mobility challenges and to practice that strategy to identify weaknesses and make adjustments.

**RECOVERY**

**Recovery**
Recovery from a disaster can take 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
Duration
45-90 minutes

Participants
One surveyor

Organization:
• Person who manages the organization’s 24 hour care buildings
• 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.

Objectives
1. Evaluate the effectiveness of the organization’s processes for designing and maintaining buildings to LSC requirements.
2. Evaluate the effectiveness of the organization’s processes for identifying and resolving LSC problems.
3. Determine the organization’s degree of compliance with relevant LSC requirements.
4. Educate attendees on potential actions to take to address any identified LSC vulnerabilities.

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 Tour
• Complete the following activities to evaluate organizational compliance with the LSC, based upon occupancy requirements:
  o Assess hazardous areas, such as trash collection rooms, kitchens, special use areas such as swimming pools or barns
  o Assess required fire separations
  o Assess at least two required smoke separations
  o 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
  o Assess the main fire alarm panel to verify that it is functional
  o Assess the automatic sprinkler pump (if any) to verify that it is functional
• 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 observations with other survey team members, as applicable, so they can be further explored during 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. 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 SIG for further guidance.

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

- Gap in ceiling tile that is repositioned
- Partially burned out exit light that is corrected on discovery.
- Storage issues

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
# Program Specific Tracer - Continuity of Foster Care/Therapeutic Foster Care

**Applies to:** BHC Applicability – Foster/Therapeutic Foster Care services (when children/youth with multiple placements are identified).

## Duration
Variable – approximately 60 minutes.

## Participants
Surveyor

Organization:
- Case Manager
- Child/youth
- Foster parents / family members

## Rationale:
A frequent problem in Foster/Therapeutic Foster Care is the issue of multiple placements of a single foster child/youth. This leads to disconnects in the continuity of the foster child/youth’s care, a sense of alienation and isolation for the child/youth, potential for foster care agency/organization missing serious problems with the child/youth and more.

## Reminder
Make sure that the agency has obtained written permission for your home visits.

## Objectives
1. To evaluate the effectiveness of the Foster/Therapeutic Foster care agency’s processes surrounding placement of children/youth
2. To identify process and possibly system level issues contributing to multiple placements
3. Identify what foster care functions are within the scope of the agency (removal of child/youth from home, placement decision-making, working with family of origin, licensing foster family, recruitment, training and supervision of foster parents, case management and permanency planning)

## Before
Select a foster child/youth with multiple placements within the Foster/Therapeutic Foster Care agency being surveyed

Review the child/youth’s record to ascertain:
- Placement history – verify that the child/youth had multiple placements within this Foster/Therapeutic Foster care agency.
- Involvement of child/youth protective services, voluntary placement, and court orders

## During
- Conduct a home visit at the child/youth’s current foster home. Interview the child/youth about:
  - Their experiences with foster care homes over the past year
  - Their perceptions of
    - issues that lead to multiple placements.
    - causative factors leading to multiple placements
  - Their involvement in the process including communications from their case worker
- Interview foster parents, when possible (may be telephonic) about:
  - The placement process including
    - information they received about the child/youth – timing, content and accuracy
    - knowledge of issues that the child/youth had in other homes
  - How they were assessed for fostering (e.g. physical health, emotional capacity, interpersonal relationships, knowledge of developmental needs, financial stability, cultural and linguistic evaluations, willingness to be trained, criminal background checks, including background checks on any adult living in the home, as appropriate)
  - Support provided
- Interview the case manager about:
  - Assessment processes including:
• The timely implementation of the assessment process of this foster child/youth
• inclusion of the family of origin in the placement process
• consideration of extended family for emergency placement
• Content and use of information communicated from a state or county agency.
• Process and content of basic assessment to ensure the safety of the foster child/youth and foster family, when emergency placement is made.
• Compliance with the triage process for initial placement including removal from the family of origin and process for contacting extended family resources.
• The impact between the assessment issues, e.g. physical, developmental, educational, emotional, behavioral, social, spiritual, cultural and linguistic, and selection/placement with an acceptable foster care home
• The use of guiding criteria for appropriate placement of a foster child/youth, based upon needs, and foster family, based upon ability to meet those needs.
• The ongoing evaluation of the foster family.

After
• Discuss organization performance with survey team members during the next surveyor planning session, if applicable
• Consider the pervasiveness of identified issues. Evaluate possible systems issues.
• Seek additional information, if necessary, through other tracer activity or during an Issue resolution session
• Discuss findings with the organization at the conclusion of the tracer activity and/or at the next daily briefing
# Program Specific Tracer - Elopement

**Applies to:** BHC Applicability – Children and Youth, Addictions, Residential Treatment, Group Homes, Developmental Disabilities, Foster/Therapeutic Foster Care, Mental Health (in the presence of multiple episodes of elopement).

<table>
<thead>
<tr>
<th><strong>Duration</strong></th>
<th><strong>Objectives</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable – approximately 60 minutes.</td>
<td>1. To evaluate the effectiveness of the organization’s processes to prevent elopement therefore enhancing safety</td>
</tr>
<tr>
<td></td>
<td>2. To identify process and possibly system level issues contributing to successful elopements</td>
</tr>
</tbody>
</table>

**Participants**

**Surveyor**

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

**Rationale:** In many different types of residential programs, a major concern is the issue of residents eloping from the program.

<table>
<thead>
<tr>
<th><strong>Before</strong></th>
<th><strong>During</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Select a resident who eloped (select one who eloped multiple times, if available)</td>
<td>Review clinical/case record, including:</td>
</tr>
<tr>
<td></td>
<td>• Behavioral assessment – initial, documentation of events leading up to the elopement</td>
</tr>
<tr>
<td></td>
<td>• Plan of care, treatment or services – development, revisions and inclusion of information from assessments, revision of the plan post elopement</td>
</tr>
</tbody>
</table>

Evaluate the:

- Physical environment – look for elements that would make elopement possible and/or harmful
- Risk assessment – with respect to any issues you may have uncovered.
- Security systems and processes
  - Explore the measures taken by the organization to ensure security for residents

Interview the resident, if available, and family, if applicable, about:

- Their perception of:
  - the care, treatment or services
  - the episodes of elopement
  - causation and treatment
  - use of restraints, including physical holding
- inclusion in the risk assessment relative to their desire to elope
- elopement prevention activities for which they are aware
- guidance provided from staff to prevent escalation in the future, e.g. coping skill development, etc.

Interview the staff about:

- The episode(s) of elopement
- Information communicated to other caregivers
- Inclusion of the resident and family in identifying the risk for and prevention of elopement.
- Risk assessment process
- Use of restraint/physical holding – decision making, application, process to ensure safety, etc.
- Orientation and training of staff about elopement risks, assessment and prevention
- Other, as applicable

**After**

- When reviewing personnel files, consider the:
  - depth and breadth of orientation and training relative to elopement risks
- Impact of diagnosis/condition and environmental factors
- Staff training and competency

- Consider the relationship of your observations to system level issues
- Share performance observations with other team members, if applicable, so they can be further explored in subsequent Individual Tracers
- Discuss observations with the organization at the conclusion of the tracer activity and/or at the next daily briefing
Program Specific Tracer - Suicide Prevention

Applies to: BHC

Duration
Variable – approximately 60 minutes.

Participants
Joint Commission: Surveyor.

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

Rationale: Suicide ranks as the eleventh most frequent cause of death (third most frequent in young people) in the United States, with one person dying from suicide every 16.6 minutes. Suicide of a care recipient while in a staffed, round-the-clock care setting has been the #1 most frequently reported type of sentinel event since the inception of the Joint Commission’s Sentinel Event Policy in 1996. Identification of individuals at risk for suicide while under the care of or following discharge from a behavioral health care organization is an important first step in protecting and planning the care of these at-risk individuals.

Objectives
1. To evaluate the effectiveness of the organization’s suicide prevention strategy
2. To identify process and possibly system level issues contributing to suicide attempts

Before
Select an individual served who is a high risk for suicide:
- Currently receiving services AND
- Has a diagnosis of depression with or without suicide ideation OR who
- Is identified as a high risk for suicide OR
- Had a failed attempt at suicide.

During
- Review the clinical/case record to attain an understanding of care, treatment or services provided and issues specific to the individual served
- Interview the staff working with the individual served and explore the following issues:
  - Initial Assessment process – comprehensively trace from the initial risk screening/assessment through to treatment planning with a focus on suicide risk and prevention (Reference PC.12.40)
  - Reassessment process – trace the triggers for and frequency of reassessment of the risk for suicide and implementation of same
  - Care, treatment or services planning process – trace from the assessment through to the individualization of planning relative to suicide risk and preventive care. Evaluate the environment for risks.
  - Continuum of care – evaluate the communication and coordination process with other staff, family and significant others involved with the care relative to suicide risk
  - Education - evaluate education provided to the patient and family about ongoing care, treatment or services with respect to the suicide risk, including information for crisis situations (reference NPSG.15.01.01)
  - Human Resource components – evaluate orientation, training and competency of clinicians relative to evaluating the potential for risk including self-inflicted harm or suicide, and coexisting behavioral health problems

What does the org mean by suicide precautions?
### NPSG.15.01.01, EPs

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

2. The organization addresses the immediate safety needs of the individual served and the most appropriate setting for treatment.

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

### Sentinel Event Statistics: Most common root causes of 24 hour care setting suicides are:

- Assessment
- Environmental Security/Safety
- Communication
- Orientation and training

- Staffing – trace from staffing levels through to implementation of the organization’s safety checks, evaluate training and competency
- Information management – evaluate access to information in a timely manner by staff with a need to know

- Interview other staff, e.g. security, counselors, and ask about their training and processes relative to caring for individuals served at risk of suicide
- Assess the environment for the presence or absence of items that would prevent suicide, e.g. break away bars, no locks on doors etc. Trace their presence back through the organization’s environmental safety assessment
- Trace the care, treatment or services process from entry

**After**

- Discuss issues with surveyor team during the next surveyor planning session, if applicable
- Consider the pervasiveness of identified issues. Evaluate possible systems issues
- Seek additional information, such as assessments of other high risk individuals served, if necessary, during an issue resolution session
- Discuss findings with the organization at the conclusion of the tracer activity and/or at the next daily briefing
Program Specific Tracer - Violence
Applies to: BHC – all settings when surveyors identify concerns relative to violence.

Duration
Variable – approximately 60 minutes.

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

Rationale: Uncontrolled behavior can lead to injuries for staff and individuals served. Trained BHC staff use de-escalation techniques to control violent behavior. As a result, restraint use drops dramatically. An unintended consequence of uncontrolled behavior is injury to staff and other individuals served.

IMPORTANT TO NOTE: The process used by BHC staff in the completion of assessments is sometimes overlooked. While trying to “get through the assessment quickly” staff may focus more on their assessment tool than the individual served. Assessment is about the individual served – the tool is a guide and method for documenting information gleaned from the observations and interactions with the individual served.

Objectives
1. To evaluate the effectiveness of the organization’s processes to control violence and ensure the safety of others
2. To identify process and possibly system level issues contributing to violent behavior

Before
Select an individual served who had repetitive episodes of violent behavior with or without injury to self, staff or others

During
Review clinical/case record, including:
- Behavioral assessment – initial, documentation of events leading up to the violence
- Plan of care, treatment or services – development, revisions and inclusion of information from assessments, revision of the plan post violent episode

Evaluate the:
- Physical environment – look for elements that would make violent behavior possible, such as: Crowding, bedroom assignments, security of possessions, lack of respect for privacy, lack of physical activities/exercise
- Risk assessment – with respect to any issues you may have uncovered.
- Security systems and processes
  o Explore the measures taken by the organization to ensure security for individuals served.
  o Discuss the organization’s planning and placement of security cameras and alarm mechanisms, when present

Interview the individual served, if available, and family, if applicable, about:
- Their perception of:
  o the care, treatment or services
  o the episodes of violent behavior
  o causation and treatment
  o use of restraints, including physical holding.
- Inclusion in the risk assessment relative to their desire to elope
- Violent behavior prevention activities for which they are aware
- Guidance provided from staff to prevent escalation in the future, e.g. coping skill development, etc.

Interview the staff about:
- The episode(s) of violent behavior
- Information communicated to other caregivers
- Inclusion of the individual served and family in identifying the risk for and prevention of violent behavior.
- Risk assessment process
- Restraint use, including physical holding – decision making, application, process to ensure safety, etc.
- Orientation and training of staff about violent behavior risks, assessment and prevention
- Other, as applicable
After

- When reviewing personnel files, consider the:
  - Depth and breadth of orientation and training relative to violent behavior risks
  - Impact of diagnosis/condition and environmental factors
  - Staff training and competency

- 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

- 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

<table>
<thead>
<tr>
<th>Duration</th>
<th>60 minutes</th>
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</thead>
<tbody>
<tr>
<td>Participants</td>
<td>One surveyor (at minimum) All surveyors available to participate should do so</td>
</tr>
<tr>
<td>Organization:</td>
<td>Participants vary depending on the focus of the tracer. Discuss with the organization after the Planning Session</td>
</tr>
</tbody>
</table>

**Objectives**

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

**Before**

- Discuss and confirm the planned focus for this System Tracer with survey team members and obtain additional input for use at the session
- Review performance improvement data and construct system-level questions as appropriate
- 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 the identified area of focus. These are located at the end of this survey process.

- Additional performance improvement related topics to explore include:
  - Safety of individuals served and staff, and incident tracking/ follow-up
  - Medication management— if medication processes are within the scope of the organization’s care, treatment or services

- Use of standardized tool or instrument for outcome measurement (CTS.03.01.09)
  - Ask why the organization chose the standardized tool(s) or instrument(s) that it did
  - Data used at Individual Level:
    - Ask organization to explain its expectations for how clinicians use the data to monitor and inform treatment with individuals served
Look for evidence that data are used to inform or trigger discussions about the level of care, treatment, or services or changes to treatment goals and objectives.

Ask clinicians to describe how they have used data to inform or modify the plan of care or treatment goals and objectives.

- **Data used at Clinician Level:**
  - Ask organization to describe how the data are used to support treatment team or supervision discussions.
  - Ask if the organization uses the data to evaluate clinician performance, and if so describe how they do this.
  - If clinician performance is evaluated and compared, how does the organization do this in a way that supports organizational safety culture? How would clinicians describe how the data are used?

- **Data used at Organization Level:**
  - Ask if data from the instruments are aggregated to evaluate organization performance (overall or by subsets such as departments, clinician groups, etc.).
  - Ask if the data are used to identify performance improvement opportunities or priorities. If so, how is this done?
  - Ask if the data are used to evaluate performance improvement efforts. Do they have examples they can share like pre-post intervention comparisons?
  - Ask if aggregate data from the instruments have been used to support the organization in other ways (e.g., demonstrate value to payers, community stakeholders, etc.).

- **Other Issues for Discussion**
  - Infection Prevention and Control
  - Monitoring staff compliance with employee health screening requirements
  - Pro-active risk assessment (may be known as Failure Mode and Effects Analysis)
  - National Patient Safety Goals

**For BHH Surveys:**

- Verify that the organization is collecting the following data:
  - The individual’s experience and satisfaction related to access to care, treatment, or services
  - The individual’s perception of the comprehensiveness, coordination, and continuity of care, treatment, or services
  - Management outcomes related to chronic physical health conditions
  - The individual’s access to care, treatment, or services within timeframes established by the organization

- Ask leaders how they are using data collected to improve performance.
**Staff Influenza Vaccination**

- 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 (remember to mention the subsequent parts of the process, e.g. if the focus is data collection, without data collection, analysis, and use are impacted and should be cited)

**After**

- 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 team members, if applicable
General and Focus Specific 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, and
   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. 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.
- Planning, tracking, trending and analyzing data about critical processes and outcomes, guides organizations in 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 programs/services and population served in order that they can identify suitable measures. For example:
  - Quality issues for a community mental health center will be different than an opioid treatment program.
  - Interventions for an adult with alcohol/drug issues will be different than permanency placement planning for a foster child/youth.
  - 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 individual served actually receiving the incorrect medication, dosage, or at the wrong time” versus “a deviation from the norm during administration that results in the individual served actually receiving or the potential to have received the incorrect medication, dosage, or at the wrong time.”

Key Standards

- CTS.03.01.09 (outcome measures)
- CTS.05.05.19 (child/youth physical holding)
- CTS.05.06.33 (restraint and seclusion)
- PI.01.01.01 (planning for the collection and prioritization of data, patient perception of care, treatment or services, high risk processes)
- PI.02.01.01 (benchmarking Internal and External database)
- LD.04.04.01 (reprioritization of data collection)
- IM.01.01.01 (thorough analysis of data needs)
- IM.02.02.01 (uniform data definitions)
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 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 average daily census (ADC), sample 100% of clinical/case records
  • For a population size of 31 to 100 ADC, sample 30 clinical/case records
  • For a population size of 101 to 500 ADC, sample 50 clinical/case records
  • For a population size of more than 500 ADC, sample 70 clinical/case records
- Engage in a facilitated discussion centered on simple issues, such as data sources being used (e.g., billing data, satisfaction surveys, case/clinical record abstraction, observation) and whether the needed data are available.

Key Standards
- CTS.03.01.09 (outcome measures)
- CTS.05.05.19 (child/youth physical holding)
- CTS.05.06.33 (restraint and seclusion)
- 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/case record)
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 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 staff 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
- CTS.03.01.09 (outcome measures)
- CTS.05.05.19 (child/youth physical holding)
- CTS.05.06.33 (restraint and seclusion frequency of analysis)
- 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
- CTS.03.01.09 (outcome measures)
- CTS.05.05.19 (child/youth physical holding)
- CTS.05.06.33 (restraint and seclusion frequency of analysis)
- IC.01.03.01 (infection prevention and control)
- IC.01.05.01 (implementation of infection prevention and control strategies)
- PI.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:** 24-hour behavioral health care settings

<table>
<thead>
<tr>
<th>Duration</th>
<th>60 minutes</th>
</tr>
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<tbody>
<tr>
<td><strong>Participants</strong></td>
<td>One surveyor</td>
</tr>
<tr>
<td><strong>Organization</strong></td>
<td>Staff able to address issues related to infection control in all programs/services throughout the organization</td>
</tr>
<tr>
<td><strong>Note</strong></td>
<td>When a separate Infection Control System Tracer is not scheduled, surveyors should address this topic during Individual Tracer Activity and during the Data Management System Tracer.</td>
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</table>

## Potentially Problematic Areas
- Meal time/snacks
- Common room – housekeeping, availability of appropriate trash receptacles, tissues, etc.
- PPE availability/use
- Surveillance

## Objectives

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

## Before
- Identify an individual served with a respiratory illness or other communicable disease

## During

### Discussion (15-20 minutes)
- Review the infection prevention and control plan with the individual responsible for the organization’s program

### Staff Influenza Vaccination
- Determine if the 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
Tracing (40-45 minutes)

- Review the clinical/case record. Note any opportunities to trace infection prevention and control activities implemented by the organization.

- Conduct this tracer in various locations/rooms within the organization engaging direct care staff from various programs/services in a discussion of their infection control process. For example:
  - How this individual's (potential) infection was identified, e.g., part of surveillance or other
  - Staff orientation and training activities: e.g. what processes are in place to ensure the appropriate care of infected clients (includes staff behavior and attitudes ensuring compliance with rights of individuals served)
  - Reporting of infection control data – responsibility, methodology, where does it go?
  - Prevention and control activities (e.g., staff training, housekeeping procedures, organization wide hand hygiene, employee health, food sanitation, and the appropriate storage, cleaning, disinfection, and disposal of supplies)
  - Interventions for staff 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
  - 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
- Discuss issues with other surveyors, if applicable, during the next surveyor planning session
- Seek additional information, if necessary, during an Issue Resolution session
- 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 Individual Tracers
System Tracer – Medication Management
Applies to: All accreditation programs

Duration
60 minutes

Participants
All surveyors available to participate should do so

Organization:
Clinical and support staff in the programs/services visited

Planning:
1. **Planning** for this tracer begins at the surveyor planning session. Consider the organization’s programs/services.
   - Identify an individual receiving a prescribed and/or being administered medication.

Objectives
1. Learn about the organization’s medication management processes. Identify which, if any medication processes, are within the scope of this organization’s care, treatment or services.
2. For organizations that prescribe, evaluate the process to receive or share relevant information about the individual served to facilitate coordination and continuity at the time he/she is referred to other care, treatment, or service providers.

During
- Using the medication and experience of an individual served; trace the processes relative to medication management that are within the scope of the organization’s care, treatment or services.
- As part of the individual tracer, review the clinical/case record.
- Seek an understanding of the medication management subprocesses (selection/procurement, storage, ordering/transcribing, preparing/dispensing, administration, monitoring and evaluation) that are within the scope of this organization’s care, treatment or services.
- If the organization is prescribing medications:
  - Interview prescribers
  - Interview individuals served who are prescribed medications about the information they are given by the prescriber
- If the organization is administering medications:
  - Interview staff responsible for administering medications to determine:
    - Education they received about the medication
    - Where and how the medications are stored and how they access them; ask to see where the medications are kept and determine if they are being stored as indicated
    - Training they received for administering the medication
    - The potential side effects and reactions possible
    - Missed doses and consequences of not administering medications to individuals served at prescribed time
    - Who they have been instructed to call with questions about the medication or administration
- Interview individuals served about the medications they are being administered by staff. Ask about:
  - Education they received about the medication
• The potential side effects and reactions possible
• Timeliness of staff administration; instances where doses may have been missed
• Any education they received about consequences of not taking medication as prescribed
• Who they have been instructed to contact with questions about the medication

• Interview individuals served who are self-administering medications within the organization's facilities about:
  o Education they received about the medication
  o Training they received for administering the medication
  o Where and how the medications are stored and how they access them; ask to see where the medications are kept and determine if they are being stored as indicated
  o The potential side effects and reactions to the medication
  o Missed doses and consequences of not taking medication at prescribed time
  o Who they have been instructed to call with questions about the medication or administration

• **For BHH Surveys:** Ask staff whether individuals served are able to leave prescription refill requests 24/7.

Other issues which should be addressed during this or other tracer time include:
• Process for reporting of errors/system breakdowns/near misses
• Data collection, analysis, systems evaluation, and performance improvement initiatives
• Medications brought into the organization by individuals served
• Education of staff and individuals served about medication safety and security
• Information management systems related to medication management
• Involvement of individuals served in safe 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 team members, if applicable, to potential issues and problems, so they can be further explored during other survey activities
**Leadership Session**  
**Applies to:** All accreditation programs

**Duration**  
60 minutes

**Participants**  
All surveyors on site.

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

Typically participants include the following:

- At least one member of the governing body or an organization trustee (in single-owner organizations, this individual may also be the CEO)
- Senior organization leaders
- Senior leaders from all surveyed programs (Ambulatory Care, Behavioral Health, Home Care, Laboratory, and Nursing Care Center)
- Other organization leaders (Director of Human Resources and Performance Improvement)

The success of this activity is not necessarily walking away with RFIs, but rather facilitating a meeting that will result in:

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

**Objectives**  
The purpose of the Leadership Session is to explore where the organization is on the journey to high reliability. This is a facilitated discussion of the characteristics of a high reliability organization, specifically:

- Leadership commitment to improvement of quality and safety
- Creating a culture of safety
- Robust process improvement
- Survey findings that suggest underlying system issues.

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

- Review survey observations and potential requirements for improvement.
- Review the Leadership Session Tips on the subsequent pages.
- When possible, and in the case of complicated leadership structures, consider outlining the leadership session discussion using the "Organization Culture and Systems Expectations Evaluation Tool." The tool is located in the Document Library on the Surveyor Portal.
- Plan an approach that will move this discussion beyond theory to an evaluation of performance in the organization.

**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,
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

- Lack of compliance with a National Patient Safety Goal.

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

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

- Explore with leaders their efforts to achieve the characteristics of a high reliability organization—flexibility, agility, ability to sustain effective performance.

- Ask for examples of the progress being made and what characteristics they are struggling to achieve and maintain. Suggested Discussion topics are provided on the next page, Tips for Conducting the Leadership Session.

- Ask leaders about internal systems and how they do or do not support their efforts to be a high reliability organization.

- Inquire if leaders have studied the organization’s ability to sustain effective performance. Ask leaders to identify what aspect of performance they chose to study and why. Determine the approach that was taken by the organization in researching performance sustainability.

- 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 BHH Surveys: Ask how leaders evaluate the effectiveness of the integrated care team.

- Seek clarification from leaders on any open issues.

After

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

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

Success of this activity is facilitating a meeting that results in:

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

The issues below can serve as a framework for discussion with leaders on various topics such as:

- Leaders’ vision for the role and performance of important processes
- Senior leadership’s role/responsibility for design of systems/processes/ “infrastructure”
- Role of the Board in safety and quality
- Role of the Medical Staff in performance improvement
- Comprehensiveness of the system/process
- Patient-focused quality and safety criteria and expectations for the system/process
- Agility/adaptability/flexibility, and change as appropriate
- Responsibility for managing and monitoring effectiveness of implemented changes to the five systems

High reliability concepts you might consider exploring include:

Robust Process Improvement

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

Leadership Commitment

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

Safety Culture

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

Internal and external reporting

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

Physician/clinician involvement in performance improvement

- Accountability for quality and safety
- initiatives that involve changes in clinical practice to improve quality and safety
- Involvement in performance improvement priorities
- Serving as champions for performance improvement goals
- Leading performance improvement initiatives
Foster Parents Group Meeting
Applies to: All Behavioral Health Care organizations that offer Foster/Therapeutic Foster Care services

**Duration**
60 minutes

**Participants**
Surveyor(s)
Organization: Staff familiar with organization’s foster care services and program
Other: Invited Foster Parents

The organization should make all arrangements for this meeting, including securing location, notifying foster parents of the date, time and place.

**Tips:**
If the organization is looking for a sample meeting notice, one can be found in the Behavioral Health Care Survey and Accreditation Process Guide, or by calling their Account Executive.

Your colleagues have found that if the organization provides an educational session the families feel the session is more valuable. THIS IS NOT A REQUIREMENT OF The Joint Commission. (This process allows the surveyor to evaluate the education staff. The staff can ask the families to volunteer to meet with the surveyors during the education program.)

Remember that some foster parents have worked for more than one agency. When the parents are making comments about foster care, preparation, training, etc., be sure to clarify that they are talking about their current agency or making a general statement that applies to other agencies.

If participants ask you about how the organization is doing on their survey, refer them to

**Objectives**
Explain that you will use this meeting to:

1. Learn about the organization and their foster care program from the foster parents perspective
2. Answer participant questions about accreditation and the Joint Commission

**Before**
During the opening conference determine from the organization what information they shared with the foster parents about The Joint Commission, the onsite survey, and this session. This will help guide the content of your introductory comments when you meet with the parents.

**During**

**Facilitating the Group Meeting**
Ask the organization contact to:
- Welcome the participants
- Thank them for coming,
- Confirm the plan and schedule for the meeting
- Answer participants questions and
- Introduce you.

You will facilitate this informal meeting. Introduce yourself and explain that you represent the Joint Commission.

**Topics for Discussion**
- Ask participants to tell you about:
  - Recruitment, licensing, and training process,
  - Preparation of the foster parents to meet the needs of individuals in their care, in general, and
  - Organization’s continued support of the foster parents.
  - The information they received from the organization in the following areas:
    - The individual’s special physical, emotional, and social needs
    - The rights of the individual, foster family, and family of origin (children/youth only)
    - Procedures for reporting incidents and accidents
    - Support services available from the organization and the community
    - Foster care financial reimbursement issues
the Joint Commission’s website (www.jointcommission.org), and Quality Check where they can see the results in about 45 days from the survey end date.

- Respite care policies and procedures
- How to ensure a safe living environment
- Provision for the individual’s educational and health needs
- Confidentiality of information
- How the individual’s special cultural/ethnic needs are addressed
- Education and training provided by the organization
- Requirements for foster care family licensure
- Competency assessment and evaluation

- Ask the participants if they have any final comments or questions for you about the Joint Commission or accreditation
- Thank them for their time and participation

After

Consider the relationship of your observations to system level issues

Share observations and discoveries with other survey team members, if applicable, so they can be further explored in subsequent survey activity.
Foster/Foster Therapeutic Foster Family Home Visit
Applies to: Behavioral Health Care organizations that offer Foster/Foster Therapeutic Foster Care services

<table>
<thead>
<tr>
<th>Duration</th>
<th>60 – 90 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participants</strong></td>
<td></td>
</tr>
<tr>
<td>Surveyor</td>
<td>• During pre-survey call, reinforce that foster home visits will be made.</td>
</tr>
<tr>
<td>Organization: Case Manager</td>
<td>• Request the organization to identify individual homes within 30 minutes or less in travel time from each foster care office/site.</td>
</tr>
<tr>
<td>Other: Foster parent or family and children/youth</td>
<td>• Work with the organization to identify a 10% sample of foster homes for visits. The sample should include homes represented by all offices</td>
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<tr>
<td></td>
<td>• Ask the organization to inform foster parents about the accreditation survey and the home visit activity.</td>
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<tr>
<td></td>
<td>• Remind the organization that written permission is needed from the foster parents before you can conduct the visit.</td>
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**Home Visit Information**
1. Home visits last 20-30 minutes
2. The organization needs to obtain written permission for each home visit
3. Visits can occur at any time of the day into the early evening, preference would be when the individual is at home with one or more caregivers, such as after school or day programs.
4. Always have the organization confirm that the family and child or youth will be home before travel commences.

**During**

**Onsite Survey Process—Organization Office**

- Select once case manager per survey day who is responsible for two to three foster homes in the selected sample.
- Ask the case manager to confirm appointments and provide you with proof of written permission for the visit.
- Ask the case manager to accompany you on the home visit.
- Prior to each home visit, ask the case manager to acquaint you with the individual served and family with an overview of the services and care being provided to the individual, including:
  - History of the individual served
  - The individual's medical and emotional assessments
  - The case plan
  - Any special needs of the individual served
  - Plans for coordination with other service providers
  - Permanency goal for the child or youth
  - If time permits ask the case manager about organization level topics such as understanding of policies, procedures, and job responsibilities, and performance improvement.

**Onsite Survey Process -- Home Visit**

Your home environment observation should include:

- Staff/individual served/foster family interaction around such issues as the following:
  - Safety, security, and confidentiality
  - Communication in a language the individual served/foster family can understand
  - Encouragement by the case manager for the individual served/foster family to verbalize and ask questions
  - Respect for the individual's/foster family's privacy
  - Respect for their culture/religious beliefs

- Child care, including the following:
  - Provision of a nurturing, caring environment
  - Recognition of (and provision for) the child's assessed special needs
  - Opportunities for the child/youth to interact with siblings and other members of the family of origin if indicated in the case plan

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BHC SAG January 2018

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• Participation of the individual/foster family in case planning, permanency planning, and planning for independent living (when appropriate)

• Environmental safety issues, which include the following:
  o Life safety issues such as smoke detectors in or near the child’s sleeping room and a large window or other means of secondary egress from the individual’s sleeping room
  o Safe storage, handling, and administering of medications in the home
  o Sanitary living conditions

• Depending on the individual’s level of maturity, condition, and personal wishes, interview him or her (without the foster parents present) to discover the individual’s opinions about his or her placement, agency support, protection of individual rights, involvement in case plan decisions, and permanency planning.

• Interview the individual served in the presence of the case manager or other agency staff, or talk privately with him or her as long as they stay in visual contact with the foster parents and the case manager. This casual talk may include the following topics:
  o The individual's involvement in case planning, permanency planning, and preparation for independent living (if appropriate)
  o Steps taken to meet any “special needs” that may have been identified during assessment
  o How the individual’s unique cultural/ethnic/religious needs (if any) are addressed
  o How the foster parents handle the situation if the individual served doesn’t obey the house rules”
  o The individual’s understanding of his or her rights to safety and privacy (to learn how these issues are addressed by the organization and the foster family)
  o His or her contacts with organization staff and the support services received

• Ask about information the foster parents/family received from the organization in the following areas:
  o The individual’s special physical, emotional, and social needs
  o The rights of the individual served, foster family, and family of origin
  o Procedures for reporting incidents and accidents
  o Support services available from the organization and the community
  o Financial reimbursement issues
  o Respite care policies and procedures
  o How to ensure a safe living environment
  o Provision for the individual’s educational and health needs
  o Confidentiality of information
  o How the individual’s special cultural/ethnic needs are addressed
  o Education and training provided by the organization
  o Requirements for foster care family licensure
  o Competency assessment and evaluation

• Ask the foster parents/family if they have ever identified any problems with the support or services offered by the organization and, if so, how these problems were handled.

After
• Consider the relationship of your observations to system level issues
• Share observations and discoveries with other survey team members, if applicable, so they can be further explored in subsequent survey activity
# Report Preparation

**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>All surveyors on site</td>
</tr>
</tbody>
</table>

## 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).

- If the finding lends itself to the use of a numerator and denominator, choose the quantification lead-in statement available in WST. Upon selection, fill in the numeric values for the numerator and denominator and enter the finding. When using this approach, enter only one observation in WST. The numerator will account for the multiple occurrences observed and satisfy the requirement to cite every occurrence of non-compliance.

- If the finding does not lend itself to use of the quantification lead-in with a numerator and denominator, cite EVERY observation of non-compliance with that EP as a separate finding in WST.

## Objectives

1. To allow the organization one final opportunity to clarify and clear observations and findings, particularly from last day activity
2. To complete the entry of observations throughout the survey

### Before

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

### 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 or findings 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.

  - 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 safety of individuals served
    - The correction should not require any organizational planning or forethought

### How will this affect my survey?

- Accredited organizations will be notified about these changes
through various modes of communication prior to implementation.

- Surveyors should mention the changes in observation reporting during the Opening and Orientation to the Program session.

### Equivalencies

When preparing the report in WST, a question will be presented:

- Does the organization have previously granted equivalencies?

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

If the response is YES, two more questions will be presented:

- Were the conditions associated with the equivalency met?
- Was there evidence corrective actions would create a hardship for the organization?

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

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

- The practice is correct but the policy needed amending to coincide with the practice, so the policy was amended
- Corrections to a form that was missing an element or piece of information and the change would not impact the process
- Contact the Standards Interpretation Group if you have any questions about the appropriate use of this provision.
- 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.

- Contact the Standards Interpretation Group if you have any questions about the appropriate use of this provision.
• Prepare the report
  o Read the report to ensure that it is accurate and clearly written
  o Proofread the report for typographical errors, proper placement of findings at EPs, grammar and punctuation
  o Review the SAFER™ matrix to determine that standards and EPs are appearing in the appropriate and intended cell.
  o Revise, as needed.
  o 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

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:
  o The organization (copy the number requested by the CEO)
  o Each survey team member present.
• Notify the organization when you are ready for the Exit Briefing and determine the meeting location
• Submit the report using WST within 24 hours of event completion
## Exit Briefing

Applies to: All accreditation programs

### Duration
15 minutes

### Participants
All surveyors on site

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

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

- If applicable, each survey team member can take a turn reviewing all of the Requirements for Improvement (RFIs) grouped under a particular standards chapter.
- Alternatively, surveyors can take turns by accreditation program presenting the RFIs pertinent to their program within a chapter.

### Objectives

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

### During

- Present the organization leader with the Summary of Survey Findings Report
- Review the Summary of Survey Findings Report with the organization leader
- 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/she has any other preferences regarding the sharing of findings with 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 duplication of the Summary of Survey Findings Report. Arranging for duplication of the report is the CEO’s responsibility.
Organization Exit Conference
Applies to: All accreditation programs

**Duration**
30 minutes

**Participants**
All surveyors on site

Organization:
Senior leadership and staff invited to participate

**Guidelines**
Before you present findings, remind attendees that observations of non-compliance 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
- Attendees may or may not have a copy of the Summary of Survey Findings Report; 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
- If this is a team survey, determine who will facilitate this activity 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:
  - SAFERTM Matrix display of findings – Standards and EPs that appear in the SAFERTM Matrix are based on likelihood of harm and scope of issue. The organization is not able to contest the placement of findings on the matrix
  - Requirements for Improvement – Observations in this section of the report require official follow-up by the organization with the Joint Commission through the Evidence of Standards Compliance (ESC) process, therefore you will review this section in detail.
- Present the Requirements for Improvement by standards chapter.
- Review any patterns or trends that are surfacing in standards, and existing or new risk areas; note any changes in standards or risk areas between this survey event and the information available in the ICM Profile.

**For BHH Surveys:** Identify those observations that directly relate to BHH-specific requirements.
- Explain that the SAFERTM matrix is a tool to illustrate potential risk areas in the organization. While this tool can be referenced during the decision-making process, it will not be used in isolation to drive or determine if certain decision rules will be applied.
- Explain that the accreditation decision is based on the risk level of findings. The higher level of risk associated with the findings, the more immediate the attention required.
- Note that an Evidence of Standards Compliance (ESC) submission is due from the organization to The Joint
Commission 60 days from the day the report is posted to the organization’s extranet site.

- Explain the ESC submission process.
  - All Requirements for Improvement (RFIs) due in a 60-day ESC
  - All findings will require an ESC
  - Current ESC entry fields (who, what, when, and how) required for all RFIs
  - Findings of higher risk (those appearing in red and dark orange areas on SAFER™ matrix will require completion of two additional ESC entry fields (Leadership Involvement and Preventive Analysis)

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

- 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.

- Revisit the customer’s survey expectations discussed during the Opening Conference.

- 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.

### 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

**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.
When an ITL is called, you will be directed to follow the procedures outlined below.

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

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

**IMPORTANT**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. They must determine and implement a risk mitigation strategy while the surveyor(s) is still on site.

2. A letter explaining the process will be posted to its extranet site.

3. Preliminary Denial of Accreditation (which is an accreditation decision category) will be posted on Quality Check by the next business day.

4. CMS and state authorities will be notified (if applicable).

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

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

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

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

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

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

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

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

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

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

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

Document Staff Title
Document the title of the person with whom the Surveyor(s) spoke. This ensures the staff who witnessed, or observed, the finding along with the surveyor can corroborate the finding to the organization. Also, identifying the staff title acknowledges the organization’s confirmation of the surveyor observation and strengthens the finding thereby discouraging post-survey clarification. Identifying the person by title is not intended to highlight a staff who has made a mistake or is at the root cause of a deficiency. This is particularly important if there are safety culture issues at the organization.
While documenting the title of the staff who observed the deficiency during tracer activity strengthens the finding and makes the citation difficult to refute, referencing staff names in an observation is not appropriate and should be avoided. Generic words like “leadership” or “leaders” should not be used, rather use the specific staff position title.

Example:
AHC IC.02.01.01 EP 2 The organization uses standard precautions, including the use of personal protective equipment, to reduce the risk of infection.

Weak: "Staff interviews revealed that protective eye shielding was not used when performing cleaning and brushing of contaminated dental instruments prior to steam sterilization."

Solid: "Interview with the infection control nurse revealed that protective eye shielding was not used when performing cleaning and brushing of contaminated dental instruments prior to steam sterilization."

... ... ...

Use a Statement to Identify the Evidence
Observations should contain the phrase “….as evidenced by…” or something similar. The specific fact, and not just a negative Element of Performance, is written into the observation to support the finding. To highlight how the facts were discovered, the use of a statement of evidence is required.

Example:
HAP MM.01.02.01 EP 1 The hospital develops a list of look-alike/sound-alike medications it stores, dispenses, or administers.

Weak: "The hospital did not develop a list of look-alike/sound-alike medications."

Solid: "The hospital did not develop a list of look-alike/sound-alike medications as evidenced by the Chief Nursing Officer’s inability to produce a list when requested. This was also confirmed by the Pharmacy Director."

OME PC.01.03.01 EP 30 For home health agencies that elect to use The Joint Commission deemed status option: The registered nurse, or other professional who is responsible for supervision of the home health aide, prepares written patient care instructions that specify the duties of the home health aide or homemaker.

Weak: "During review of record for home visit #2 it was noted that on the aide care plans dated 4/20/15, start of care and 6/18/15, recertification, the bath assignment was not specified."

Solid: "During review of the record for home visit #2 it was noted that on three of three aide care plans the bath assignment was not specified. For example, only "bath" was checked however the type of bath, i.e. bed, shower, chair, tub, partial/sponge was not indicated. This was confirmed by the home care aide."

If the deficiency identified is inherent in the observation statement, then a statement of evidence is not necessary because the observation contains the evidence.

For example:

Solid: "In the record reviewed in the Intensive Outpatient Program, the plan of care did not identify how the family participated in the care, treatment, or services of the client. Additionally, no refusal from the client or clinical contraindication for family involvement was noted within the record as confirmed by the primary clinician."

NOTE: In many cases there is an opportunity to use pre-populated lead-in statements in WST. The statements are recommended and may make the documentation process easier, but they are not required.

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

We are taking a strict look at all documentation in which there is a reasonable basis to believe the information could be used to identify the individual, or where the identifiers used meet the technical definition of PHI.

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

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

- the individual’s past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.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:

2. Then select Add New Record and the following window will open:
3. Back on the Itinerary Home Page, select the Standard section:

4. After entering the information regarding the observation, click on the corresponding Record Number to link the observation to the record:
Remember to attach the record, or records, reviewed during tracer activity when completing the Tracer entry:

**Validated Conversations**

Validate conversations with one member of the staff by speaking to additional staff. To solidify the finding through agreement from the org, another direct care staff (the survey coordinator, a staff supervisor, etc.) is queried to confirm what was discussed in the initial conversation. This is completed as part of the tracer process. Examples are:

**HAP MM.03.01.01 EP** 6 The organization prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation.

**Weak**: “The staff nurse said medications were kept at the patient’s bedside.”

**Solid**: “The staff nurse on the 4th floor medical/surgical unit stated that the organization’s practice was to leave medications at the patient’s bedside; making it possible to misuse, mishandle or divert the medications. This was confirmed with the unit manager who made the same statement.”

**Document the Policy Title**

If a policy is necessitated by the standard or if a policy is referenced, the detail must be included. The formal policy name must be capitalized to distinguish it from a generic description of the policy content. If a written policy is required and not produced, include that information in the observation. Examples are:

**AHC HR.01.02.05 EP** 5 Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented.

**Weak**: “It was noted during review of staff health records that a RN did not have a documented PPD since November 2011 although the organization’s policy is to have a TB test every two years.”

**Solid**: “It was noted during review of staff health records that a RN did not have a documented PPD since November 2011. The survey coordinator confirmed the organization’s policy is to have a TB test every two years (Policy: Vaccination and Testing version May 5, 2015).”

**BHC RI.01.03.01 EP** 13 Informed consent is obtained in accordance with the organization’s policy and processes.
Weak: "The medication informed consent form to administer Xanax was signed by the nurse on 3/13/15 but not signed by the patient until 3/17/15."

Solid: "In one of five medical records reviewed, the medication informed consent form to administer Xanax was signed by the nurse on 3/13/2015 but not signed by the patient until 3/17/2015. There is no evidence that the hospital's informed consent process requiring signature at the time of administration as articulated in policy "6.5 Informed Consent" (last revised in March 2013 and most recently reviewed in February 2015) was followed. This was confirmed by the quality director."

NOTE: Do not state that the HCO "...did not have a policy on xyz..." unless the standard/EP specifically requires a policy. Also, when an EP calls for 'documentation', it does not prescriptively refer to a policy. When an EP states something is documented, such as education, the HCO determines what/where and how such information is documented (e.g. a checklist, a power-point presentation, a data field on a form, etc).

Use Counts for Detail
Counts of supplies/equipment are documented when related to observed deficiencies. The actual number of deficient items is documented. This makes the finding more objective and reduces questions from the organization regarding the extent of the deficiency.
Examples are:
HAP IC.02.02.01 EP 4 The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.
Weak: "Multiple products were expired in the Radiology CT room.
Solid: "Observation of the Radiology CT room revealed the following expired products: five (5) Quick Core disposable biopsy needles, one (1) spinal needle, and one (1) BD Vacutainer which leaves patients exposed to possible infection due to out-of-date medical supplies."

Quantification
Utilize numerator and denominator information to more specifically detail the amount of review or census of items reviewed. An observation that indicates that the finding was noted in "many other records" is an example of weak documentation. Such phrases add little to no quantitative value. Words with vague qualifiers such as "numerous", "many", "some", and "several" make it impossible to determine the manner and degree of deficiencies and, therefore, the appropriate level of citation.

Changes were made to Web-based Survey Technology to prompt surveyors to capture quantification in a more thorough and consistent manner. A lead-in statement that captures the numerator and denominator can be completed in situations where a numerator/denominator exists and is pertinent to the scoring of the standard or EP. A category drop-down is also available to identify the activity or item that is being quantified.
Examples are:
HAP MS.06.01.09 EP 1 The decision to grant, limit, or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within the time frame specified in the medical staff bylaws. Requesting practitioners are notified regarding the granting decision.
Weak: "It was observed that three of three newly appointed practitioners did not receive notification of the granting decision for the privileges that they had requested. For example an emergency room physician did not receive notification that all of the privileges that they had requested were granted.
A Gastroenterologist did not receive notification that all of the privileges that they had requested were granted.
A surgeon did not receive notification that all of the privileges they had requested were granted."

Solid: "In 3 of 3 medical staff/credentialing files reviewed, it was observed that newly appointed practitioners did not receive notification of the granting decision for the privileges they had
requested. Specifically, an Emergency Room physician, a Gastroenterologist and a Surgeon did not receive notification that all of the privileges that they had requested were granted.

**Be Specific to the Standard/EP**
The observation must not contain multiple deficiencies that should be cited under other standards and/or elements of performance. Deficiencies related to different EPs must have their own cited observation. For instance:

**Weak:** “No biohazard label was placed on the container that was used to transport the dirty endoscope from the procedure room to the cleaning room. Emergency access to the eyewash station blocked. The cabinet in which the endoscopes were stored after reprocessing was not ventilated.”

In the example above, all findings were cited under the same element of performance. Cite under three separate standards and/or EPs.

Examples are:

**Solid:** "No biohazard label was placed on the container that was used to transport the dirty endoscope from the procedure room to the cleaning room as confirmed by the director of nursing.” *(HAP EC.02.02.01 EP 12)*

AND "Emergency access to the eyewash station outside the procedure room was blocked by a chair and a rolling cart.” *(HAP EC.02.02.01 EP 5)*

AND “The cabinet in which the endoscopes were stored after reprocessing was not ventilated which could pose infection risk for the endoscopy patients receiving treatment.” *(HAP IC.02.02.01 EP 4)*

**Document the Facts**
Only use facts to communicate the reasons for the standard deficiency (no embellishment, inference, opinion, or peer review should be added to the citation). Do not infer that certain facts exist if those facts were not actually observed. Similarly, do not draw conclusions about outcomes that were not actually observed. Do not include personal clinical opinion (peer review). Do not include positive comments to "soften" the impact of the observation.

Do not use statements such as:
- “The documentation suggests…”
- “The organization should have…”
- “The organization could have…”
- “The organization would have…”
- “It would be better if the hospital…”
- “The organization needs a policy on…”
- “The organization should consider…”

**HAP MM.01.02.01 EP2.** *The hospital takes action to prevent errors involving the interchange of the medications on its list of look-alike/sound-alike medications.*

**Weak:** “The medication management policies were in good order. However, the look-alike/sound-alike policy did not address labeling on medications. The label in the container should have used TALLman letters to indicate that the medication was on the look-alike/sound-alike medications list”

**Solid:** “The Look-Alike/Sound-Alike policy (04-1119) did not address labeling on medication. Lack of direction regarding medication labeling increases the risk of confusion.”

Ultimately the foundation of documentation rests on the clarity and detail of what is written. Once surveyors have completed their report documentation they can review their work to assess if the following factual components have been addressed:

- Who
• What
• When
• Where
• How

Generally speaking, documenting who was involved with the review of the finding; what was the deficiency observed; when and where did it occur and how; describing the event as related to a standard or element of performance, will ensure a solid observation. During survey, feel free to review your documentation with the Team Lead, contact the Standards Interpretation Group (SIG), or contact your Field Director to ensure a comprehensive, clear survey report.
### Appendix C – Surveyor Worksheet

#### Behavioral Health Surveyor Worksheet

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

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Individualized behavioral contingencies, if applicable</td>
</tr>
<tr>
<td>2.</td>
<td>Care, treatment or services provided to high risk populations (defined by org)</td>
</tr>
<tr>
<td>3.</td>
<td>Individual served perceptions of care, treatment or services (specific needs and expectations, how the organization meets these needs and expectations, how the organization can improve the safety of individuals served) <strong>For BHH Surveys: Note that additional data elements are required.</strong></td>
</tr>
<tr>
<td>4.</td>
<td>Infection prevention and control</td>
</tr>
<tr>
<td>5.</td>
<td>Medication Management, if applicable</td>
</tr>
<tr>
<td>6.</td>
<td>NPSG Data <strong>Reminder:</strong> All applicable NPSGs must be evaluated during the course of the survey</td>
</tr>
<tr>
<td>7.</td>
<td>Research, if applicable</td>
</tr>
<tr>
<td>8.</td>
<td>Restraint and Seclusion, including physical holding of children/youth, if applicable</td>
</tr>
<tr>
<td>9.</td>
<td>Risk Management</td>
</tr>
<tr>
<td>10.</td>
<td>Staff opinions and needs*</td>
</tr>
<tr>
<td>11.</td>
<td>Staff perceptions of risks to individuals and suggestions for improving safety of individuals served</td>
</tr>
<tr>
<td>12.</td>
<td>Staff willingness to report unanticipated adverse outcomes</td>
</tr>
<tr>
<td>13.</td>
<td>Utilization Management</td>
</tr>
<tr>
<td>14.</td>
<td>Environment of care issues, as appropriate to the setting</td>
</tr>
<tr>
<td>15.</td>
<td>Other PI activities</td>
</tr>
</tbody>
</table>

* Recommended, not required

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**BHC Survey Process Rules for Surveyor Planning**

<table>
<thead>
<tr>
<th>Did you</th>
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<tbody>
<tr>
<td>Survey all components in behavioral health care organizations that offer multiple services/programs (complex structure)?</td>
<td></td>
</tr>
<tr>
<td>Spend the amount of time on each component in multi-service/program organizations based on the:</td>
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<tr>
<td></td>
<td>Risk/Acuity of programs and services and</td>
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<td></td>
<td>Relative size (volume of visits/cases) of the component (see the e-app)</td>
</tr>
<tr>
<td>Each component does not require an equal amount of time. Risk is not limited to 24-hour settings. The distribution of time must be sufficient to adequately address all settings, especially when a substantial proportion of services are offered in non-24-hour settings.</td>
<td></td>
</tr>
<tr>
<td>Visit every site where 24-hour services are provided</td>
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<tr>
<td></td>
<td>Residential sites for children/youth/adults</td>
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<tr>
<td></td>
<td>Crisis stabilization sites for children/youth/adults</td>
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<tr>
<td></td>
<td>Group homes for children/youth/adults*</td>
</tr>
<tr>
<td></td>
<td>Community-based homes for children/youth/adults*</td>
</tr>
<tr>
<td>*If these are “cookie cutter” living units in the same complex or on the same campus the surveyor does not have to visit each home or unit. Foster care is not viewed as a 24-hour site for these purposes.</td>
<td></td>
</tr>
<tr>
<td>• Visit a foster home from each office site† if possible</td>
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</tr>
<tr>
<td>• Conduct at least one foster parent group meeting. This can include attendance at a regularly scheduled agency meeting occurring at the time of survey. If a meeting cannot be attended or arranged, a series of phone interviews with foster parents is an acceptable alternative.</td>
<td></td>
</tr>
<tr>
<td>† Select a case worker from each foster care office site to accompany on a home visit.</td>
<td></td>
</tr>
<tr>
<td>Sample partial/day treatment/intensive outpatient (IOP sites, traditional outpatient sites, in-home base operations, schools and supervised/transitional/supportive living sites* based on location and travel considerations. Please note:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MUST visit all child/youth sites that practice physical holding.</td>
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<tr>
<td></td>
<td>Sites not visited are reviewed by having staff and clinical records brought to a central location for interviews** and record review.</td>
</tr>
<tr>
<td></td>
<td>**Staff interviews can be accomplished by phone, when necessary.</td>
</tr>
<tr>
<td>Conduct Life Safety Code† building tour in the following settings:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residential occupancy, hotel and dormitory setting with 17 residents,</td>
</tr>
<tr>
<td></td>
<td>Residential occupancy, lodging and rooming setting with 4 to 16 residents.</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.
   a. If needed, place pre-survey phone call to TJC Account Exec to gather information for your program.
2. Share pre-survey information with the program survey team via e-mail.
   a. Provide additional pre-survey information provided by the Account Executive to other program team members and Primary Team Leader, as needed.
   b. Assure that all program team members have shared phone numbers, to assure effective communication.
   c. Choose the most appropriate program agenda from Survey tech and modify as needed
   d. Collaborate with the Primary Team Leader to assure activities are coordinated across all programs as needed (System tracers, Interim exits, etc.)
   e. Communicate plan with the program team members and publish agenda in survey technology
3. Inform the Primary Team Leader and program team members of your travel arrangements.
   a. Check in with the Primary Team Leader and your program survey team members the night before; and let them know you have arrived
   b. Confirm program team members’ travel plans post survey, to assure that the last day of survey is not shortened.

On-Site Responsibilities for Program and Collaboration with the Primary Team Leader
1. Assure a thorough and professional survey is conducted.
   a. Manage the survey process as outlined in the Surveyor Activity Guide
   b. Manage the agenda in collaboration with the Primary Team Leader and customer so survey activities are implemented effectively and professionally. Publish, modify and coordinate agendas, as needed.
   c. Collaborating with the Primary Team Leader, provide leadership and facilitate conflict resolution when needed to manage the survey; including facilitating a conference call with the customer and central office.
   d. Utilize customer relationship management skills
2. Manage program team member assignments
   a. Review agenda assignments with program team members and Primary Team Leader, as needed
   b. Assign responsibilities for system tracers with input from other program team members and in collaboration with the Primary Team Leader
   c. Coordinate Survey Team Meetings and participation of the program team members with the Primary Team Leader
      i. Facilitate the sharing of information and issues found during tracers with program team members and the Primary Team Leader as needed
      ii. Review the progress being made on observing and evaluating program compliance with all applicable National Patient Safety Goals. Plan an approach for accomplishing the evaluation of any remaining NPSGs
d. Facilitate discussions with program team members to ensure EPs are scored accurately; that the language in the RFI is clear; and that documentation from all surveyors is included.

e. Coordinate program Report Preparation
   i. Assure all program team members lock their findings
   ii. Facilitate program team efforts to document observations at the most appropriate EP
   iii. Review to insure that similar observations from different surveyors within your program are scored at same standard and/or element of performance
   iv. Confirm that observations are complete and fully justified.
   v. Update survey report with any changes prior to exit conference.

f. Oversee professionalism of program survey team

3. In collaboration with the Primary Team Leader, manage relationship with the organization
   a. Coordinate communication between organization staff, program survey team and Primary Team Leader;
   b. Lead problem-solving activities, when needed, to resolve issues of compliance for your program
   c. Attend interim exit conferences for your program
   d. Confirm that all organization documents have been returned at the close of each day and at the end of the survey/review.

4. In collaboration with the Primary Team Leader, coordinate communication with central office
   a. If sites or services not identified on E-app are discovered, call Field Director On-Call.
   b. If the team identifies a serious situation, (immediate threat to life; scope of practice issues; falsification issues) notify the Primary Team Leader and determine who will contact the Field Director On-Call.
   c. Coordinate a conference call with program surveyors and SIG, to resolve compliance and documentation issues, collaborate or notify the Primary Team Leader of the situation.

Responsibilities for Corporate and System Surveys – (Central Office will determine if a corporate Secondary Team Leader will be assigned)

1. Educates program team members about the organization’s centralized and decentralized 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 – BHC Applicability Grid for Program-specific and System Tracers

<table>
<thead>
<tr>
<th>Tracer</th>
<th>1 day</th>
<th>2 day</th>
<th>3 day</th>
<th>4 day</th>
<th>5 day</th>
<th>complex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Management System Tracer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Included on all surveys regardless of the number of days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection Control System Tracer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluate this subject matter as part of your individual tracers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Management System Tracer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Specific Tracer for Continuity of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Specific Tracer for Elopement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Specific Tracer for Suicide Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Specific Tracer for Violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Select one, as applicable, using individual tracer activity time
Select two, as applicable, using system tracer time
Select two, as applicable, using system tracer time
Select an additional tracer, when applicable, and use Individual Tracer Activity time to conduct
Select an additional tracer, when applicable, and use Individual Tracer Activity time to conduct
Reference the columns to the left for the number of days that the BHC surveyor is on site to determine the tracers that may be conducted.
Appendix F – Handout for the Behavioral 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 thesurveyors for the unannounced survey
  b. Surveyor(s) name, picture and biographical sketch
  c. Scheduled survey dates

As a Behavioral Health Care organization, you will need the following information and documents available for the surveyor to review during the Preliminary Planning Session and Survey Planning Session which occurs on the first day of survey.

- Organization Chart, if available
- Contact person who will assist the surveyor(s) during survey (name, phone number, extension)
- Map of your organization, if applicable/available
- Results of data analysis
  o Performance improvement projects
  o Infection Control
  o Environment of Care (e.g., fire drill critiques, reports of injuries to individuals served, occupational illnesses and staff injuries, property damage or security incident reports, environmental monitoring for deficiencies, hazards or unsafe practices)
  o Emergency Management Plan and evaluations of exercises and responses to actual emergencies
- Lists of individuals served by program/service with diagnosis or condition
- Reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies and annual objective evaluation of organization’s financial ability to provide care, treatment or services. Regulatory body reports include, but are not limited to licensing reports and local/state fire inspections.

For Behavioral Health Home Surveys:
- Health screening policy with triggers
- Policy on performing assessments
- Treatment planning policy
- Brochure/information on BHH services for individuals served
- If EHR system in use, evidence of certification

Please note that this is not intended to be a comprehensive list of documentation that may be requested during the survey. The surveyor(s) may need to see additional documents throughout the survey to further explore or validate observations or discussions with staff.
# Appendix G – Behavioral 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>30 minutes</td>
<td>1st day, upon arrival</td>
</tr>
<tr>
<td>Opening Conference</td>
<td>15 minutes</td>
<td>1st day, as early as possible</td>
</tr>
<tr>
<td>Orientation to Organization</td>
<td>45 minutes</td>
<td>1st day, as early as possible</td>
</tr>
<tr>
<td>Surveyor Planning Initial</td>
<td>30-60 minutes</td>
<td>1st 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 served that surveyors trace varies by organization. If travel is required to perform tracer activity it will be planned into this time.</td>
</tr>
<tr>
<td>Lunch</td>
<td>30 minutes</td>
<td>At a time negotiated with the organization</td>
</tr>
<tr>
<td>Issue Resolution</td>
<td>30 minutes</td>
<td>End of each day except last; can be scheduled at other times as necessary</td>
</tr>
<tr>
<td>Team Meeting/Surveyor Planning</td>
<td>30 minutes</td>
<td>Mid-day and/or end of each day except last</td>
</tr>
<tr>
<td>Daily Briefing</td>
<td>30 minutes</td>
<td>Start of each survey day except the first day; can be scheduled at other times as necessary</td>
</tr>
<tr>
<td>Competence Assessment</td>
<td>60 minutes</td>
<td>After some individual tracer activity has occurred</td>
</tr>
<tr>
<td>Environment of Care and Emergency Management</td>
<td>60-90 minutes</td>
<td>After some individual tracer activity has occurred</td>
</tr>
<tr>
<td>System Tracer – Data Management</td>
<td>60 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 time negotiated with 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>Interim Exit</td>
<td>30 minutes</td>
<td>Last activity on last day of survey on surveys occurring simultaneously with other program surveys, e.g., hospital</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>Suggested Scheduling of Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Safety Code Building Assessment</td>
<td>60 minutes</td>
<td>Only takes place on surveys when the behavioral health care organization is subject to compliance with the Life Safety Code standards. See the Accreditation Manual for Behavioral Health Care, Life Safety chapter Overview, Applicability of the Standards section. If required, occurs at a time negotiated with organization</td>
</tr>
<tr>
<td>Foster Parents Group Meeting</td>
<td>60 minutes</td>
<td>Only applicable to organizations providing Foster Care services; At a time negotiated with the organization</td>
</tr>
</tbody>
</table>

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```
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```
<table>
<thead>
<tr>
<th>Activity Name</th>
<th>Suggested Duration of Activity</th>
<th>Suggested Scheduling of Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster/Therapeutic Foster Family Home Visit</td>
<td>60-90 minutes</td>
<td>Only applicable to organizations providing Foster Care services; At a time negotiated with the organization</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>Only occurs if the organization is responsible for any of the critical medication processes. Takes place 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>
</tbody>
</table>
## Appendix H – Accreditation with Follow-up Survey

### Applies to:  All accreditation programs

### Duration

Per itinerary; one day in most cases.

### Participants

Joint Commission: Surveyors

Organization: Survey coordinator, senior leadership, others

### What’s a Surveyor To Do If…

**Q:** What should a surveyor do if assigned to conduct an Accreditation with Follow-up Survey (AFS) and an ESC is not available?

**A:** The ESC is submitted 60 days after the final report is posted to the organization’s extranet site and is usually available to the surveyor prior to conducting the AFS survey. However, issues may have occurred that delayed the submission of the ESC or circumstances may warrant the AFS survey to be scheduled prior to the receipt of the ESC. An AFS survey can occur without an ESC; use the following guidelines in this situation:

- Review the organization’s previous survey report to verify the cited RFIs
- Pre-survey – plan what type of activity will be required to verify compliance, such as individual patient tracer activity, record review, personnel file review, PI data review, etc.
- On-Site – ask the organization how they are monitoring their corrective actions for sustained compliance with the standards.

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

### Objectives

1. To determine the organization’s compliance with standards that generated a Requirement for Improvement (RFI) through the evaluation of follow-up actions when an organization has received a decision of Accreditation with Follow-up Survey (AFS).

2. To verify that the organization has implemented plans of correction as reported in their Evidence of Standards Compliance and that compliance with the standards is being sustained.

### Before

1. Through your itinerary, locate the organization and click on the event ID. When the event is displayed, click on Quick Links to view:
   - Previous Recommendations
   - Available ESC submissions, Basic Building Information (BBI) data
   - Organization’s application

2. Through survey technology, select the appropriate survey agenda template for the length of survey, this will most often be one surveyor for one day. Based on the RFIs being followed-up, plan the activities you want to conduct and prepare a draft agenda.

3. Identify the reason for the organization’s Accreditation with Follow-up Survey by the code on your itinerary. There may be more than one reason for the AFS decision.

4. Review the application for information about the organization (e.g. days and hours of operation), travel directions, hotel accommodations, and other logistics. Document the organization’s survey coordinator name and phone number for easy reference.

5. Review the ESC, if it is available.

6. **Do not contact the organization.** This is an unannounced event. Call the Joint Commission Account Executive if you have any questions.

7. Review the SAFER™ matrix and RFIs from the past survey report.

8. Identify survey activities that would evaluate each element of performance (EP) previously found out of compliance. Remember, the focus of survey activity for this on-site event is on the EP’s that generated an RFI. For example, if the organization did not collect data about the perceptions of care, treatment and services, you would need to evaluate the effectiveness of the process they implemented in their ESC. You would not review all of their data collection.

### Conducting the Survey – Know the Event Type

1. Arrive at the organization no earlier than 10-minutes before the designated start time for an unannounced survey. If the survey includes multiple surveyors, all surveyors should enter the organization together.

2. Report to the reception area, security officer, information desk or administrative office upon arrival and:

   a. Provide your name and the purpose for your visit.

   b. Display your Joint Commission identification badge.
the Accreditation with Follow-Up Survey?  
A: The surveyor records all observations and findings related to any standard or EP found non-compliant.

**Q: What should you do if the organization is still non-compliant with originally scored standards?**  
A: Record all findings related to standards non-compliance. Trip the manual decision rule for AFS05.

3. Direct the survey coordinator or administrative contact to access the Joint Commission’s web page at www.jointcommission.org. Once there, select the link to access The Joint Commission Connect. They will need the user ID and password to sign-on. They should find the following information:
   a. Notification of scheduled Joint Commission event authorizing your presence
   b. Surveyor picture and biographical sketch

4. After the organization validates the authenticity of your visit, ask if they have a space where you can begin the survey.

5. Review the agenda for the survey and with the guidance of the organization, make adjustments as needed.

6. Begin the opening conference. If the organization requires additional time to gather or obtain coverage for those attending opening conference:
   a. Postpone the opening conference to mid-morning;
   b. Review documents or begin an individual tracer.

7. Select tracers based on the standards and elements of performance that were non-compliant. For example, proceed to a unit that was identified in a high-risk finding or other RFI, select individuals currently receiving care and services in the area, and trace a patient there focusing on the subject of the RFI.

8. Focus interviews and group discussion on the standards and EPs being evaluated. For example, if you choose to conduct a Data Management System Tracer because the organization did not collect PI data about restraint and seclusion, focus the discussion on the collection of restraint and seclusion data. As you trace a patient requiring restraints, interview staff about data collection.

9. Prepare your report using survey technology. Note: If you document findings that lead to a RFI at the same standard:
   a. Hover on the Standard tab to see the drop-down menu. Select “Manual Rules”
   b. Click on “AFS05” if the organization was Accredited with Follow-up Survey and has continued non-compliance at the same standards requiring a second Accreditation with Follow-up Survey. Document
the location of unresolved RFI’s. At the conclusion of the survey, prepare a report using WST.

10. Lock and publish a report for the organization. Ask the organization contact to access their Joint Commission Connect extranet site to locate and print the report.

11. At the conclusion of the survey, review the report as part of the exit conference. Explain that follow-up questions should be directed to the organization’s Account Executive.

12. Transmit the report to the Central Office within 24 hours of the exit following existing survey technology procedures.
Appendix I – Random Unannounced Validation 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>

<table>
<thead>
<tr>
<th>Participants</th>
<th>Pre-Survey Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Commission: Surveyor</td>
<td>1. Through your itinerary, locate the organization and click on the event ID. When the event is displayed, click on Quick Links to view:</td>
</tr>
<tr>
<td>Organization: Survey Coordinator, senior leadership, staff throughout the organization, licensed independent practitioners if part of the organization.</td>
<td>a. Previous Recommendations</td>
</tr>
<tr>
<td></td>
<td>2. The RUV template agenda is available to surveyors through WST for editing.</td>
</tr>
<tr>
<td></td>
<td>3. Review the ESC and the SAFER™ matrix.</td>
</tr>
<tr>
<td></td>
<td>4. Do not contact the organization. This is an unannounced event. Call the Joint Commission Account Executive if you have any questions.</td>
</tr>
<tr>
<td></td>
<td>5. Review the ESC. Note: this includes surveyor findings for non-compliant standards found during the last survey.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>7. Modify the template agenda for review with the organization at the Opening Conference.</td>
</tr>
</tbody>
</table>

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 entering the following comment: "This finding is a previous requirement for improvement from the organization's last full-like survey event.

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](http://www.jointcommission.org). Once there, select the link to access The Joint Commission Connect. They will need the user ID and password to sign-on. They should find the following information:
   a. Notification of scheduled Joint Commission event authorizing your presence
   b. Your picture and biographical sketch

6. Ask to meet with the CEO and others, as requested by the CEO, for a brief opening conference.

7. Provide the organization with the list of requested documents, prepared during pre-survey planning.

8. Provide the organization with the revised agenda template, prepared during pre-survey planning.

9. Evaluate the elements of performance identified in the ESC.

10. When time permits, conduct the following additional survey activity following the processes outlined in the Survey Activity Guide.
   a. BHC – assessment process for a high risk patient (reference program specific tracers in BHC SAG)
   b. HAP/CAH – hand hygiene or discharge planning (reference process in Individual Tracer Components, HAP SAG)
   c. NCC – dietary tracer for a patient with weight loss or treatment observation (reference process in Individual Tracer Components, NCC SAG)
   d. OME - contract oversight process, equipment management tracer or medication reconciliation process for patient referred from hospital (reference process in OME SAG)

11. The primary focus of this survey is to determine the organization has implemented the corrective action, documented in their ESC. However, if other non-compliant performance is identified, an observation should be entered at the appropriate standard and EP.

12. At the conclusion of the survey, prepare a report using WST.

13. Lock and publish a report for the organization. Ask the organization contact to access their Joint Commission Connect extranet site to locate and print the report.
14. At the conclusion of the survey, review the report as part of
the exit conference. Explain that follow-up questions should
be directed to the organization’s Account Executive.

15. Transmit the report to the Central Office within 24 hours of
the exit following existing survey technology procedures.
Appendix 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>

<table>
<thead>
<tr>
<th>Participants</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usually one surveyor</td>
<td>1. Review all ESC submissions for the assigned program to verify that the organization has implemented reported plans and corrected previously cited standards non-compliance.</td>
</tr>
<tr>
<td>Organization:</td>
<td>2. Determine if the organization has sustained compliance since implementing corrective action plans.</td>
</tr>
<tr>
<td>• Survey coordinator</td>
<td>3. The PDA-ESC survey will occur approximately 60 days after the last survey event. Due to the serious nature of the issues previously identified, a quick return is required to assure corrections have been successfully implemented.</td>
</tr>
<tr>
<td>• Senior leadership</td>
<td>4. Provide coaching and mentoring to the organization on sustaining and improving performance in those areas addressed in its ESC.</td>
</tr>
<tr>
<td>• Staff throughout the organization</td>
<td></td>
</tr>
<tr>
<td>• Licensed independent practitioners</td>
<td></td>
</tr>
</tbody>
</table>

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?

Pre-Survey Planning
1. Access the HCO information in the usual manner through your itinerary on the Surveyor Portal.
   • Scroll through your assignments to find the Onsite ESC or PDA–ESC event. Select the event by clicking on the Event ID.
   • 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.
   • 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. **Note:** Call the Account Executive if you are uncertain which of the previous survey events is related to the Onsite ESC that you are performing.

2. Review the ESC report related to the survey event for which you are performing the onsite ESC follow-up. These reports include
   • Standard text,
   • EP text and scoring category,
   • Surveyor findings for non-compliant standards found during the last survey, and
   • Organization provided narrative describing the corrective action taken to address the finding (who, what, when, and how).
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.

Duration
Per itinerary; one day in most cases.

Unannounced Format

Participants
All surveyors on site.

Organization: Survey Coordinator, Senior leadership

Reasons for Extension Surveys
An extension survey is conducted at an accredited organization or at a site that is owned and operated by the organization if the accredited organization’s current accreditation is not due to expire for at least nine months and when at least one of the following conditions is met:

- Changed ownership and has a significant number of changes in the management and clinical staff or operating policies and procedures
- Offered 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

Pre-Survey Activity

1. Review Central Office correspondence on the surveyor portal through the itinerary to identify the reason for an extension survey. Check notes to identify the site name and address for arrival as this may be different from the main site.
2. Review the e-app for information about the HCO, travel directions, hotel accommodations and other logistical information.
3. Speak with the Accreditation and Certification Operations account executive for additional details about the extension survey.
4. If this is an extension survey for expanded capacity of existing services, review the previous accreditation report.
5. If this is an extension survey due to change in ownership, check the internet for information about the previous and new owner to identify any transition challenges.

Onsite Process and Survey Conclusion

1. It is recommended that surveyors arrive no earlier than 10-minutes before the intended start time for an unannounced survey.
2. If the survey includes multiple surveyors, surveyors should enter the organization together.
3. All surveyors will report to the reception area, security officer, information desk or administrative office upon arrival and indicate your name and purpose for your visit.
4. Display your Joint Commission identification badges.
5. Have the organization’s survey coordinator name and phone number from the e-app available to give to the staff person greeting you.
6. If the organization’s survey coordinator is unavailable, ask the staff person to contact the administrative office or an organization leader to let them know of your arrival.
7. Direct the survey coordinator or administrative contact to access their Joint Commission Connect extranet site. They will need the user ID and password to sign-on. The morning of your arrival, the HCO’s extranet site will have the following information available:
   a. Notification of scheduled Joint Commission event authorizing your presence
   b. Surveyor picture and biographical sketch
   c. Extension survey agenda template
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.
• National Patient Safety Goals.

The day ends with time for issue resolution, report preparation and an Exit Conference.

Surveyors can change individual tracer time to other available survey activities. For example: A Life Safety Code building tour might be appropriate if the organization has added a new building and still has outstanding citations with local inspectors; or if the surveyor notices potential environment issues while conducting individual tracer activity.

**What's a Surveyor To Do If…**

**Q:** The extension survey cannot be completed in the scheduled time?

**A:** Discuss with the HCO at the outset that the day may go beyond the agenda end time. Provide the HCO with updates as the day progresses and you begin to determine if you will need additional time.

**Q:** The extension survey cannot be completed in a day?

**A:** Call the Field Director On-Call for instructions.

**Q:** The reason for the extension survey does not exist when the surveyor arrives on site?

**A:** Call the Account Executive and your Field Director or the Field Director On-Call for instructions.

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.

11. If the organization is requiring extra time to gather some of the initial planning information and people for the first activities, ask to begin with an individual tracer and reschedule the Planning and Opening for later in the morning.

12. Select tracers based on the reason for the extension survey. For example, select individuals accessing the new program or service, or trace an individual receiving care and services in the area with expanded capacity, trace two individuals—one receiving care and services under previous owner and another experiencing care and services under the new owner.

13. If this extension survey is due to new owner (merger, acquisition), ask to speak with members of the transition team if one was established.

14. If the extension survey is due to a new program or service or expanded volume or new location, inquire about the data that drove the decisions and ask to speak with the planning team if one was established.

15. Determine if there are any issues that require follow-up or closure and use the issue resolution time for this purpose.

16. At the conclusion of the survey prepare a report using WST.

17. Lock and publish a report for the organization. Ask the organization contact to access the Joint Commission Connect extranet site to locate and print the report.

18. At the conclusion of the survey, review the report as part of the exit conference. Explain that follow-up questions should be directed to the organization’s Account Executive.

**Post-Survey**

Transmit the report to Central Office following existing survey technology procedures.
Appendix R – Early Survey Policy – Survey Event Guide
Applies to: All accreditation programs

Duration
Per itinerary
Varies by program

Participants
One or more Joint Commission surveyors

Organization: Survey coordinator, senior leadership, staff throughout the organization, licensed independent practitioners

This is an unannounced survey event.

Why would an organization request this type of survey?
The two most common reasons organizations seek this type of survey include:

- The state requires evaluation by an approved accrediting body in order to issue a license to the organization.
- The organization holds no accreditation or had accreditation through a Joint Commission competitor or state certification, and prefers an incremental survey approach to ease the transition to compliance with new standards.

Note: A Limited, Temporary Accreditation decision is not recognized by CMS for Medicare certification purposes.

Early Survey Policy Eligibility
The Early Survey Policy is available to any organization currently NOT accredited, with the exception of an organization that has been denied accreditation.

Account Executives have checked that organizations meet the following eligibility criteria.

- The organization is licensed, provisionally licensed, or is engaged in the licensing process as required by law and regulation.
- The building in which the organization will offer services or from which services will be coordinated is identified, constructed, and equipped to support services.
- The organization has identified a CEO or administrator, a director of clinical or medical services and a nurse executive, if applicable.
- The organization has identified the date it will begin operations.

The surveyor will confirm aspects of the criteria throughout the course of the survey.

Overview of Event
- This survey uses a designated limited set of standards (See appendix in the accreditation manual.)
- Web-based Survey Technology will only present surveyors with the subset of standards that applies to this type of survey.
- During this survey event, surveyors assess the organization’s:
  - Physical facilities, as required for care provision or care coordination
  - Policies and procedures (for example, assessment and reassessment, staff orientation and education), plans (for example, infection control, emergency management, environment of care, performance improvement
  - Organizations are not required to collect or analyze data at the time of the Early survey
  - Organizational structures (for example, leadership team, mission, budget, human resources, information management)
- Limited, Temporary Accreditation is granted to organizations that demonstrate satisfactory compliance with the limited set of standards as determined by the onsite survey and submission of timely and acceptable Evidence of Standards Compliance (ESC) post survey for any Requirement for Improvement (RFI).
An initial, full accreditation survey must occur within six months of the successful achievement of Limited, Temporary Accreditation.

**Procedures**

**Before**

- Access the HCO information in the usual manner through the surveyor itinerary on the Surveyor Portal.
- Scroll through the surveyor assignments to find the Early Survey Policy (ESP) event. Select the event by clicking on the Event ID.
- Surveyors use Web-based Survey Technology (WST) to access all available TJC information related to the organization through the Quick Links option. Click on the Quick Links button in the lower right corner of the screen to view the menu of available information.
- Surveyors should review the subset of standards that applies to this type of survey to prepare for the event. This will assist surveyors in planning the agenda for the onsite visit.
- Surveyors will select a template agenda that is appropriate for the event through WST and edit accordingly.

The survey agenda will include:

- Opening Conference and Orientation to Organization
- Surveyor Planning Session
- Life Safety Code Building Tour (HAP and CAH only)
- System Tracer – Data Management that includes review of Infection Control and Medication Management structures and processes – **data collection and analysis is not required**
- Competence Assessment processes
- Credentialing and Privileging structure and processes, as applicable
- Environment of Care and Emergency Management
- Report Preparation
- Exit Conference

**NOTE:** No individual tracer activity takes place on this survey, even if the organization is already engaged in patient care.

**During**

1. Arrive at the organization approximately 10 minutes prior to the designated start time. **Note:** Most surveys begin at 8 AM unless the organization opens later as identified in the organization’s e-application data.
2. Report to the reception area, security officer, information desk or administrative office upon arrival. Surveyors should provide their name(s), and explain the purpose of the visit.

3. Each surveyor should display and show the organization’s representative their Joint Commission identification badge.

4. Ask the staff person first encountered to contact the administrative office or an organization leader to indicate that Joint Commission surveyors are onsite, unless someone is already waiting.

5. Direct the survey coordinator or administrative contact to access the Joint Commission’s web page at www.jointcommission.org. Once there, select the “Click here to access The Joint Commission Connect”. They will need the user ID and password to sign-on. Ask them to view the following information
   a. Notification of scheduled Joint Commission event
   b. Surveyor picture and biography

6. Ask to meet with the CEO or senior leader for a brief opening conference.

7. Begin the survey with the Opening Conference
   • Provide the organization with the list of documents that need to be available for review during the survey so that representatives have time, as necessary, to gather them. Remind the organization that you will review documentation wherever it is most convenient.
   • Provide the organization with the draft agenda and determine if any adjustments are needed to activity timing; make revisions as necessary.
   • Verify the date the organization plans to begin provision of care, treatment and services, or will be ready for a full, initial accreditation survey
   • Explain that on-site activity focuses on evaluating the structures and processes that the organization has put in place to support the provision of care, treatment and services. **Note: Data collection and analysis is not required for this survey.**
   • Activities are conducted similar to how they would be on a full survey, however, with no individual tracers.
   • Learning about organization structures, plans, policies and procedures will be accomplished through interview and document review. This will be as interactive as possible, with organization representatives guiding surveyors to content and providing explanation for the planned implementation,
   • Surveyors will interact with staff and focus on the design and knowledge of policies and procedures expected to support day-to-day operations.
   • Evaluating readiness of the physical facilities to support operations is a critical component of this survey. The Life Safety Code building tour and the Environment of Care activities will focus on organization preparations to
provide safe and secure facilities for staff to deliver care, treatment and services.

- Indicate that any discovery of non-compliance with standards outside the sub-set will serve as an educational opportunity.

8. Continue to implement the agenda as planned with the organization. Surveyors should refer to and follow the detailed guidance for each activity found in the SAG.

Note: Report any potential immediate threat to health or safety as early as possible to the Field Director on call.

9. Surveyors prepare a report using WST. Reminder: Only a subset of standards is applicable on this survey and WST will only present these standards for scoring and observation entry.

10. Surveyors will lock and publish a report for the organization and ask the organization contact to access the Joint Commission Connect extranet site to locate and print the report.

11. Surveyors review the report with the organization at the exit conference and 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.

### Duration
Variable

### 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 an optional scheduled phone conference with Standards Interpretation Group.

### ICM Option 3 Description
- The organization undergoes an on-site ICM survey. The survey length is determined by the organization and there is a fee to cover survey costs. Surveyors review and respond to HCO-identified risk areas and General topics for Discussion identified in the ICM Profile submission. **No written documentation or written report of the survey is provided to the organization.**
- Findings are verbally conveyed. This eliminates the availability of a survey report for possible discovery from the organization, and permits the organization, as in Option 1, to control the language and documentation of the assessment activity.

### Pre-Onsite Activity
1. Access your itinerary and then HCO information
2. Click on the Quick Links button
3. View ICM Profile data in advance of the survey
4. Use the e-app and Survey Process Rules for Surveyor Planning as well as ICM Profile data to organize the on-site visit (Note: An ICM Profile Review Form is available on the Surveyor Portal Document Library, in the ICM folder)
5. If conducting the survey with a team, communicate with other surveyors

**Reminder:** For multiple surveyor events, the ICM Profile/FSA Tool is accomplished at an organization level; the last surveyor on-site submits the acknowledgement of completion of the ICM event. Surveyors departing before the last scheduled date of the event should enter their findings and comments into the ICM Profile/FSA Tool, but should not submit.

### Onsite Survey Process

#### Opening Conference and Orientation
1. Remind the organization that you will evaluate compliance with as many standards as possible (with an emphasis on the risk-focused standards), but it is not likely that you will touch on 100% due to the reduced onsite time.
2. Remind the organization that they are responsible for compliance with all the standards.
3. Advise the organization that they need to continue to explore their own compliance with standards.
4. Remind the organization you will be following the Survey Activity Guides in conducting all onsite activities. IMPORTANT REMINDER—the organization only sees a template for a single day of survey which indicates that this agenda will be repeated each day of the on-site visit. You must review with the organization the plans for all additional survey days once these are established.
5. Depending on the option the organization has selected, advise them of what they can expect at the conclusion of the survey, and when that is expected to occur.

### ICM Template Agenda
ICM Option 2 & 3 surveys are educational in nature. The agenda is intentionally generic so that you may focus attention on the needs of the organization based on the ICM Profile, rather than on all activities. Remind the organization you will be following the Survey Activity Guides in conducting all onsite activities. The agenda template, which can be found under the FSA tab of the ICM Profile, includes the core activities of the first and last days of survey:
1. 1-hour Opening Conference and Orientation session, including a review of the ICM Profile
2. 1-hour Surveyor planning session
3. 4.5-hours of Individual Tracer Activity
4. 30-minute lunch
Other information
As organizations complete their Intracycle Monitoring (ICM) Profile, they tailor their ICM Option 2 or Option 3 visit to meet their needs by determining:
- 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.

5. 1-hour Surveyor Report Preparation
6. 1-hour CEO Exit Briefing and Organization Exit Conference

On multi-day surveys, activities 5 and 6 occur on the last day of survey.

On multi-day surveys, each day between the first and last includes:
1. 30-minute Daily Briefing,
2. 7-hours of Individual Tracer Activity
3. 30-minute lunch
4. 30-minute Surveyor Team/Planning Meeting

You have the option to convert individual tracer activity time into any of the other sessions that are available in the survey activity guide. Duration of onsite activities should not exceed the time typically allotted on a regular survey agenda.

For example, you note that two of the risk areas for the organization are assessment and infection control. You can take a block of individual tracer activity time and convert it to a 60-minute Infection Control System Tracer and a 60-minute assessments focused tracer in order to explore these topics in more depth. Thus, your agenda for a 3-day survey may look something like the following:

Day 1
1. 1-hour Opening Conference and Orientation session, including a review of the ICM Profile
2. 1-hour Surveyor planning session
3. 5.5-hours of Individual Tracer Activity
4. 30-minute lunch
5. 30-minute Surveyor Team/Planning Meeting

Day 2
1. 30-minute Daily Briefing
2. 3.5-hours Individual Tracer Activity
3. 30-minute lunch
4. 1-hour Infection Control System Tracer
5. 1.5-hour Individual Tracer Activity
6. 1-hour Assessment Focused Tracer Activity
7. 30-minute Surveyor Team/Planning Meeting

Day 3
1. 1-hour Leadership Session
2. 2-hours Individual Tracer Activity
3. 1-hour Data Use System Tracer
4. 30-minute lunch
5. 1.5-hour Environment of Care Session
6. 1.5-hour Surveyor Report Preparation
7. 1-hour CEO Exit Briefing and Organization Exit Conference

You must coordinate the agenda changes with the organization to identify the day and time for the sessions so that appropriate staff can be available for these discussions.

The last day of an ICM Option 2 survey, you will:
8. The FSA History Page displays. Under the Historical Submissions section, Option Submitted column, click on the View button next to the appropriate FSA Event.

9. The FSA tool opens and displays the Standards/EPs tab.

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.”)

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 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.

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 – Screening of Individuals Served Who May Pose a Threat to Self or Others

Applies to: All organizations surveyed under the Behavioral Accreditation Manual

Use this guide to enhance your evaluation of an organization’s processes related to the screening of risk to harming self or others. The Information in this guide is intended to be used during survey activities.

Tracer Selection
When selecting individuals served, include individuals that present with any risk factor known to be associated with suicide or violence.

Organization Participants
Suggested individuals to speak with during survey activities include:
- Leadership staff
- Staff involved in care, treatment or services.
- Family members

Documentation
1. Review screening instruments used by the organization.
2. Review the process by which the organization ensures that each and every individual served is screened.
3. Review process that the organization follows when screening data indicates that there might be a risk to self and others.
4. Review behavioral assessment
5. Review plan of care, treatment or services and revisions as appropriate to demonstration of risk to self and others.
6. Review personnel files for staff qualifications related to screening individuals for self harm or violence.
7. Review organizations performance improvement data in regards to screening/assessment and staff training.

Objectives
1. To assess if the organization is adequately screening individual’s served for the risk of suicide or physical violence towards others.
2. Increase the organization’s awareness of the importance of conducting proper screening measures with their population(s) served and taking appropriate actions as indicated by the results of the screenings.

The evaluation of these processes may be incorporated into the following existing survey activity sessions:
- Orientation to the Organization
- Surveyor Planning Session
- Individual Tracers
- Data Use Session
- Competence Assessment

Orientation to the Organization
- Listen for evidence that the organization is conducting screenings on the population(s) served and the process used. Inquire about acuity level of individuals served.

Surveyor Planning Session
- Select individuals on which to conduct tracer activity and review clinical and or case record for evidence of screening activity and follow-up when applicable. Choose tracer activity on an individual served who has a history of self violence or violence towards other or who has one or more risk factors present. Review organizational data that pertains to incidents of suicide, gestures or violent acts toward staff or other individuals served.

Individual Tracers
- Inquire about the roles and responsibilities of staff providing screening oversight.
- Ask about staff orientation and ongoing competency assessment.
- Ask staff about episodes of violence towards self and others, how information is communicated to/ among staff, and how the individual and family are included in care, treatment or services process related to violence and the communication that has occurred with law enforcement and potential target of violence, if indicated.
- Explore with individual served, and family if applicable, their awareness of screening process, their perception of care, treatment and services, preventive activities that they have discussed with staff in regards to self harm and harm to others, and guidance from staff to prevent escalation of violence to self or others.
- Review several clinical records to ensure that screenings are being conducted in the same way and within the time guidelines stipulated by the organizations policy.
- Validate that the organization has a two step process, Step 1: A risk screening for suicide and violent behavior; and Step 2: A detailed evaluation (assessment by a LIP).

Applicable Standards/EPs may include:
- CTS.01.01.01 EP 1-6
- CTS.01.03.01 EP 1-3
- CTS.02.01.01 EP 1-3
- CTS.02.02.07 EP 1

Data Use Session
- Ask what data is being collected and monitored related to screening for risk of harm to self and others.
  - Review how staff evaluates the impact of the environment and care, treatment and services on risk level of violence towards self and others. Do the organizations reviews of data reflect any change in experience or processes related to screening and assessment process?
  - Review screening and or assessment forms and documents used with individuals served.

**Competence Assessment Session**
- Ask how staff is deemed competent to evaluate screening data.
- Review overall orientation and competency of staff
- Review primary source licensure of staff as applicable

**Leadership Session**
- Discuss with the leaders how they interpret performance data related to screening and assessment for suicide and risk of violent behavior.
- Discuss how accurate communication is maintained between staff and between staff who work on different shifts.
- Discuss with leadership how family and individual licensed professionals are involved in the screening and assessment process.
Appendix V – 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

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 individuals served 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
**Documentation**

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

- Plans for managing interruptions to the information process
- Policy addressing privacy of health information
- Policy on security of health information, including access, use, and disclosure
- Policy addressing protection of health information integrity (protection against loss, damage, unauthorized alteration, unintentional change, accidental destruction)
- Policy addressing intentional destruction of health information
- Policies addressing data capture, display, transmission and retention

**Applicable Standards include:**

- EM.01.01.01, EP 6
- EM.02.01.01, EP 4
- EM.02.02.01, EP 14
- EM.02.02.11, 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.01.02.01, EP 1, 5
- RC.01.01.01
- RC.01.03.01
- RC.01.04.01
- RI.01.01.01, EP 7

**Related Systems**

- Leadership
- Emergency Management
- Rights and Responsibilities of the Patient
- Record of Care, Treatment and Services
- Performance Improvement

- Staff and practitioners knowledge and ability to access data they need to provide patient care
- Orientation and training that staff and practitioners received on accessing data needed to provide patient care
- Availability of data to staff and practitioners—timeliness of entries, accuracy of entries, access to and timeliness of data from other systems (e.g., laboratory, radiology, pharmacy)
- Troublesome features of computer systems; "work-arounds" that staff and practitioners may employ to accomplish their tasks in a more efficient manner
- Features of computer systems that allow efficiency, but that can compromise data accuracy and integrity – clinical information systems not synchronized, posing risk that current version of clinical information cannot be viewed from all systems; "cutting and pasting" of data from one part of an electronic health record to another without determining it is the latest information or if it needs editing to reflect the current patient condition
- Procedures followed by staff and practitioners when help with automated systems is needed; responsiveness of the support system
- Procedures followed by staff and practitioners when automated systems are interrupted and patient health information is not available via routine sources and means
- Security and access permissions processes that staff and practitioners must follow, including password 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 difficulty locating patient data and information
- Staff report that patient health data and information is not available in time to influence patient care, treatment and services
- Staff reports of discontent with the existing systems for contributing to and accessing patient health data and information
- Staff 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 do not have an awareness of standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.

• Observations reveal concerns for the security and integrity of 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 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 medical 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 plans 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 Z – Office of Quality Monitoring Survey Activity

**Applies to:** All accreditation programs

### Duration

Complement and survey length is determined by TJC Leaders and Field Directors based on the patient safety concern.

### Participants

**Joint Commission:** Surveyors

**Organization:** Survey coordinator, senior leadership, others

### What is an OQPS incident?

**A:** An allegation or report of patient safety or quality of care concern from members of the public or other entity or agency. TJC assigns a unique numeric identifier and conducts follow-up activity.

### What's a Surveyor To Do If…

**Q:** What should you do if you:

1. Meet with any resistance from the organization?
2. Identify a potential Immediate Threat to Life?
3. Need more time to complete the survey (or more time to finish the report and transmit)?
4. Identify that other field staff or surveyor disciplines (RN, MD, LSCS) are needed?
5. Are anticipating an early departure?
6. Need assistance in determining if HCOs actions have addressed potential compliance issues?

**A:** The following resources are available to you in the Central Office:

- Field Director on-call at 800.965.5888 option 2 then option 1.
- SIG for standards related questions at 1-800-965-5888 option 2 three times, then option specific to program.
- TJC Engineers 1-800-965-5888 option 2 twice, then option 1.

### Objectives

1. Explore the organization’s response to potential issues of patient safety in relationship to standards compliance.
2. Determine if actions have resolved the potential patient safety issues and that a mitigation strategy is in place for similar events.

### Before

1. The Office of Quality and Patient Safety (OQPS) will conduct an analysis of the incident and any related information such as prior survey reports, sentinel event and complaint profile, and other available documents. OQPS will recommend next steps in response to the patient safety issue identified in the incident.

2. TJC Leaders will determine if the OQPS incident:
   a. Warrants pulling the organization’s full survey forward,
   b. Can be assessed on an already scheduled full survey, or
   c. Needs to be a separate OQPS survey event, i.e., a For-Cause survey.

3. Leaders and Field Directors will determine the type of survey event to best evaluate the patient safety issue. Your itinerary will indicate the type of event.

4. A Field Director will be designated as your contact person for all pre-survey planning and strategizing related to the survey event. Their name will be noted on the GSAP.

5. A pre-survey conference call may be required at the directive of leadership, or at the request of the Field Director or surveyor.

6. Review the application for information about the organization (e.g. days and hours of operation), travel directions, hotel accommodations, and other logistics. Document the organization’s survey coordinator name and phone number for easy reference.

7. Review the following items in preparation for the survey. All of these items are viewable through web-based survey technology (WST) under the OQPS tab, by clicking on the Edit button.
   - OQPS incident
   - Supporting documents, when available (e.g., SIG Assessment map)
   - Gold Sheet Approval Process template (GSAP)
   - Other relevant resources that may be provided
   - Previous survey reports (use Quick Links)

8. Check for recent email from your Field Director to locate the high-risk findings report for the organization. Review the report and use the information to prioritize the issues to cover during this on-site event.

9. When reviewing allegations pre-survey, consider what standards areas may be vulnerable and what clinical settings need to be visited. Also, consider what types of patients you need to trace within the setting.

10. Be cautious and use discretion if printing any materials related to the OQPS incident. Do not leave these items visible and unattended in any location. Do not bring hard copies of any of the above noted items into the
Q: What should you do if you discover non-compliant performance while conducting the OQPS For Cause Survey?
A: The surveyor records all observations and findings related to any standard or EP found non-compliant, whether or not they are related to the incident.

The organization 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.

6. Use the OQPS incident to explore standards compliance and to evaluate processes in place to support patient safety.

7. Select tracers based on the standard areas related to the incident.
8. Review at least ten patient records, active or a combination of active and closed as applicable to the incident you are exploring.

9. You are performing an assessment of systems, looking for vulnerabilities that could contribute to incidents where patient safety has the potential to be compromised.

10. Take time to consider your progress at this point. Use discretion and reassess your plan for the remaining time. Seek guidance on whether additional time may be needed for exploration of the OQPS incident.

11. Consult with SIG or Engineers if there are any questions about whether or not to score and where to score a particular concern you observe.

12. At the close of the visit, a written survey report is not made available to the organization at the conclusion of the survey. Explain that the report will be reviewed carefully in Central Office to ensure that it is conveying accurate messaging back to you.

13. You will provide a verbal summary of the survey observing the following guidelines
   a. Focus on areas for improvement, and be direct about what has been observed.
   b. You may note standards areas explored, but do not provide specific standard numbers and EPs.
   c. Do not offer any conclusions as to the survey outcome or provide an indication of whether or not the allegation has been substantiated.

14. Score RFIs in WST, click the OQPS tab. Click Edit next to the corresponding Incident Number to enter your supporting text in the Findings drop-down field.
   a. Enter all observations made, whether or not they relate to the original OQPS incident; this will provide the organization with as accurate an assessment as possible.
   b. Check all RFIs which were cited related to the OQPS incident.
   c. Do not check any RFIs which were generated unrelated to the OQPS incident.

15. Use the OQPS notes feature to state whether the OQPS incident has been substantiated or not substantiated. Do not write any narrative notes.

16. Use the Additional Event Information box to select relevant information regarding the organization.

17. Use discretion on whether or not the Field Director on-call should be contacted given the survey conclusions.

Post Survey Process

- Lock and transmit your report as soon as possible following the conclusion of the survey via air card or internet connection. Note: This activity can be completed off-site should you require additional time to formulate and document your findings. However, this should be completed within 24 hours of the Exit Conference.
- Survey reports will be reviewed in Central Office by SIG and OQPS.

Exploring an OQPS Incident During a Full-Survey Event

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.
When TJC leadership has determined an OQPS incident will be evaluated during a full survey or other type of scheduled survey event:

- A Field Director will be designated as your contact person for all pre-survey planning and strategizing related to the survey event. Their name will be noted on the GSAP.
- The team leader and team members will have access to the OQPS incident report under the OQPS tab in WST. To view the details of the incident report you must click on the blue highlighted Gold Sheet link in the lower right corner of the OQPS Incident screen.
- The Field Director on-call will still remain your primary contact to assist with any needs or concerns during the on-site visit.

**Before**

1. Review the following items in preparation for the survey. All of these items are viewable through web-based survey technology (WST) under the OQPS tab, by clicking on the Edit button.
   - OQPS incident
   - Supporting documents, when available (e.g., SIG Assessment map)
   - Gold Sheet Approval Process template (GSAP)
   - Other relevant resources that may be provided
   - Previous survey reports (use Quick Links)

2. Check for recent email from your Field Director to locate the high-risk findings report for the organization. Review the report and use the information to prioritize the issues to cover during this on-site event.

3. Review the organization demographics data to prepare for the survey. Consider at what points throughout the agenda the incident is most likely to be explored.

4. If you have any questions after reviewing the available material, contact the designated Field Director for the incident. The name will be noted on the Gold Sheet. This is your contact for all pre-event questions or concerns related to the incident.

5. Be cautious and use discretion if printing any materials related to the OQPS incident. Do not leave these items visible and unattended in any location. Do not bring hard copies of any of the above noted items into the organization. The organization is not told the specifics of the complaint to ensure the complainant’s confidentiality.

**During**

1. At the start of the survey, it is appropriate to mention to the CEO or other designated senior leader that the full survey event will include exploration of a specific patient safety and quality issue received and reviewed by Joint Commission leaders.

2. Organizations may be surprised to see you, especially if Joint Commission leadership has decided to pull an organization’s full survey forward. This can sometimes be 12-18 months before the organization is expecting a survey. See the attachment to this section for sample scripting to assist you in discussing the purpose for your visit.
3. Survey the organization integrating OQPS incident exploration into your tracer and other on-site activities to explore standards compliance and to evaluate processes in place to support patient safety. If a particular name is noted in the incident, please include the medical record, credentials or staff personnel file in your review sample.

4. You are performing an assessment of systems, looking for vulnerabilities that could contribute to incidents where patient safety has the potential to be compromised.

5. Consult with SIG or Engineers if there are any questions about whether or not to score and where to score a particular concern you observe.

6. If you are unable to evaluate the OQPS incident, call the Field Director on-call for direction.

7. Click the OQPS tab. Click Edit next to the corresponding Incident Number to enter your supporting text in the Findings drop-down field.
   - Enter all observations made, whether or not they relate to the original complaint; this will provide the organization with as accurate an assessment as possible.
   - Check all RFIs which were cited related to the OQPS incident.
   - Do not check any RFIs which were generated unrelated to the incident.

8. Use the OQPS notes feature to state whether the OQPS incident has been substantiated or not substantiated. Do not write any narrative notes.

9. Complete the full survey report according to the routine Report Preparation activity.

10. At the conclusion of the survey you will conduct an Exit Conference with the organization according to the procedure outlined for any full survey event.

11. In relation to the OQPS incident exploration, do not offer any conclusions as to the outcome. You may note that the results of all standards compliance evaluation activity are reflected in the survey report.

12. Inform the organization that the Central Office will need to review the report and that the final report will be available on their extranet site within ten calendar days.

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**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.
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 gero-psych 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>
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<tbody>
<tr>
<td>When a surveyor identifies an Immediate Threat to Health or Safety during an on-site event, The Joint Commission conducts a follow-up survey within 23 days.</td>
<td>1. To evaluate the organization’s follow-up actions in response to an identified Immediate Threat to Health or Safety.</td>
</tr>
<tr>
<td>Duration</td>
<td>2. To evaluate current compliance with standards related to the Immediate Threat to Health or Safety.</td>
</tr>
<tr>
<td>Per itinerary. One day in most cases.</td>
<td>3. To validate that the organization implemented corrective actions to eliminate the Immediate Threat and have a documented Joint Commission record.</td>
</tr>
</tbody>
</table>

### Pre-Survey Planning

1. Through your itinerary, locate the organization and click on the event ID. When the event is displayed, click on Quick Links to view:
   a. Previous Requirements for Improvement and findings that led to the Immediate Threat to Health and Safety determination
   b. Available ESC submissions
   c. Organization’s application
2. Review the application for accreditation to locate information about the organization, travel directions, hotel accommodations, and other logistical information. Make note of the survey coordinator name and phone number.
3. **Do not contact the organization.** Call the Joint Commission Account Executive or Field Director On-Call with any questions.
4. Review the last survey report (Previous Recommendations under Quick Links).
5. Identify survey activities that would evaluate the element(s) of performance previously found out of compliance. **The primary focus of this follow-up survey is on the area(s) identified as posing a serious threat to public or patient health or safety.** However, if additional areas of non-compliance are discovered during the follow-up survey, document the additional observations in survey technology.
6. Plan for the on-site visit. While not required, consider selecting an agenda template from those available in WST that closely matches the survey length and complement for the assigned event. Revise the template to reflect activities that will allow for evaluation of the non-compliant standards related to the immediate threat. The agenda can include individual tracers, system tracers, building tours and review of documents.
7. One to two days before the scheduled survey date, access the organization’s extranet site and check the last survey report for any Central Office updates.

### Conducting the Survey

8. Arrive at the organization no earlier than 10 minutes before the designated start time for the unannounced survey. If the survey
includes multiple surveyors, all surveyors should enter the organization together.

9. Report to the reception area, security officer, information desk or administrative office upon arrival and:
   a. Provide your name and the purpose for your visit.
   b. Display your Joint Commission identification badge.
   c. Ask to speak with the survey coordinator, by name. If the coordinator is unavailable, ask to speak with an administrator or the most senior leader available.
   d. Clearly explain the purpose of the survey to the organization.

10. Direct the survey coordinator or administrative contact to access the Joint Commission’s web page at www.jointcommission.org. Once there, select the “Click here to access The Joint Commission Connect”. They will need the user ID and password to sign-on. They should find the following information:
   a. Notification of scheduled Joint Commission event authorizing your presence
   b. Your picture and biographical sketch

11. After the organization validates the authenticity of your visit, ask if they have a space where you can get settled.

12. Begin the opening conference. At a minimum, discuss the schedule for the visit (the activities you want to conduct and an approximate time for each) and work with the organization to make any necessary adjustments. The organization needs to know your plan to effectively facilitate the visit. If you have prepared an agenda, provide the organization with a copy. NOTE: If the organization requires additional time to gather staff or obtain coverage for staff attending the opening conference:
   a. Suggest postponing the opening conference to mid-morning;
   b. Proceed with an individual tracer, conduct a building tour, or request and review documents.

13. Select tracers based on the reason for the Immediate Threat to Health or Safety Abatement survey. For example, proceed to the care setting(s) that was identified in a Requirement for Improvement (RFI), select individuals currently receiving care and services in the area, and trace a patient there, focusing on the condition associated with the immediate threat RFI(s). Document all tracers in WST.

14. Focus interviews and group discussion on the conditions associated with the immediate threat to health or safety.

15. If the conditions related to the Immediate Threat to Health or Safety have not been corrected, that is, standards continue to be non-compliant, or if there are new standards identified as being non-compliant, document and flag the observations as required. Call SIG to discuss the situation and to receive further direction.

16. If activities are completed in less than 8-hours, the surveyor should enter a note in the CO Comments tab indicating their time of departure from the organization and notify the FD on Call.
17. At the conclusion of the survey, provide organization leadership with the evaluation results, focusing on the abatement of the immediate threat to health or safety.
   a. Explain that follow-up questions should be directed to the organization’s Account Executive.
   b. Indicate that you will not be posting a preliminary report to the HCO’s extranet site for this on-site survey.
   c. Indicate that Joint Commission Central Office will review the findings and will then post a final report to the organization’s extranet site indicating the results of this event.

18. If the Immediate Threat to Health or Safety is resolved, send an email to Andrea Coffaro in Central Office at the conclusion of the survey stating this conclusion. Email address: acoffaro@jointcommission.org.

19. If the condition related to the immediate threat still exists, call the central office (FD on Call or SIG) to discuss and document findings in WST.

20. Enter a note in CO Comments in WST that provides a brief overview of what was looked at and any information that would be helpful to paint a picture of this organization. The note needs to reflect an affirmative observation of each Standard/EP related to the ITL survey.

21. Your survey activity should focus on determining that the immediate threat was abated. However, if during the course of the survey you identify new instances of standards non-compliance, this should be documented in WST.

22. Lock and transmit a report for the event to Central Office within 24 hours of the exit. The event type automatically stops the report.
Important Telephone Numbers

Field Director (FD) on call
800-965-5888, then Option 2, then Option 1 (24 hours, 7 days/week)

Standards Interpretation Group (SIG) on call
HAP/CAH/AHC/OBS/DSC: 630-792-3016
OME/HOSPICE, NCC: 630-792-3013
BHC, LAB, HCSS: 630-792-3014
(On-Call Hours – M-F, 7 a.m. – 7 p.m. Central)

The Office of Quality and Patient Safety (OQPS) on call
800-965-5888, then Option 2, then Option 3

SIG Engineer on call
630-792-3002
(On-Call Hours – M-F, 7 a.m. – 7 p.m. Central)

Accounts Payable
(Expense Reporting & Reimbursement)
AP FAX: 630-792-4613 or
AP FAX: 630-792-4114
630-792-5613
(Steve Mazzone, Manager)

Help Desk
630-792-5599, 630-792-5522
Toll Free: 866-965-3977
(Open 24/7)

Survey Technology
630-669-4004
Toll Free: Dial same as for Help Desk to be routed to Survey Technology
(On-Call Hours – M-F, 7:30 a.m. – 6:00 p.m. Central)

Travel and Transport
877-668-5834
(24 hours, 7-days/week)

Surveyor Management & Development
630-792-5813
(Suzanne Boylan-Murray)

Surveyor Education
630-792-5757
(Barbara Buturusis)