Home Care Accreditation

Surveyor Survey Activity Guide

January, 2018
What’s New for Home Care 2018

Updates effective in 2018 are identified by underlined text throughout this document. All content specific to the optional Community Based Palliative Care (CBPC) Certification for Home Care has been incorporated into existing survey activities, and can be easily identified by text with green highlighting.

Changes effective January 1, 2018

**ONE DAY -- Arrival, Opening and Orientation to the Organization** – Updated regarding the new Medication Compounding standards for pharmacy organizations

**Orientation to the Organization** – Updated regarding the new Medication Compounding standards for pharmacy organizations

**Surveyor Planning Session** – Updated regarding the new Medication Compounding standards for pharmacy organizations

**Individual Tracer Activity** – Updated to reflect the new Medication Compounding standards and types of tracers to select

**Competence Assessment Session** – Updated to reflect the new Medication Compounding standards for pharmacy organizations

**California Home Health Agency Survey Addendum** – New content reflecting additional requirements of California law that must be assessed during the Joint Commission’s on-site survey of Home Health Agencies providing skilled nursing services

**Appendix F** – Handout for the Home Care Organization – Updated to reflect the documents needed by the surveyor for pharmacy surveys

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

**Appendix AA** – Focused Evaluation Topic Screening Tool: Sterile Compounding Pharmacies -- Title and contents changed to the Medication Compounding Tracer Reviewer Tool, for use as a guide on Pharmacy surveys

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

**Appendix DD** – Medication Compounding Competency Checklist -- New tool for use on Pharmacy surveys

Changes effective November 15, 2017

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

**Individual Tracer Activity** – Includes additional topics for discussion with staff related to cyber emergencies
**Environment of Care and Emergency Management** – Includes additional content related to cyber emergencies, and the revised emergency management requirements necessary to align with the final rule from CMS for deemed status

**Report Preparation** – Corrected contents to reflect current procedures

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

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

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

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

**Important Phone Numbers** – Updated SIG and SIG-Engineering phone numbers
# Table of Contents

Pre-survey Preparation for all Survey Types .................................................. 7  
ONE DAY – Arrival, Opening and Orientation to the Organization .................. 9  
Surveyor Arrival & Preliminary Planning Session ......................................... 13  
Opening Conference ....................................................................................... 17  
Orientation to the Organization ..................................................................... 21  
Surveyor Planning Session – Initial ............................................................... 25  
Equipment Categories Prioritization – Listed in order of risk/priority ............. 29  
Individual Tracer ........................................................................................... 31  
Individual Tracer – Addendum ...................................................................... 37  
DMEPOS – CMS Multi-Site Survey Criteria ................................................. 43  
Individual Tracer – Mail-Order Business ....................................................... 45  
Individual Tracer – Walk-in Business (Patient pick-up, Retail) ....................... 49  
Program Specific Tracer – Fall Reduction .................................................... 51  
Program Specific Tracer – Community Based Palliative Care (CBPC) ......... 53  
Program Specific Tracer – Hospital Readmission ......................................... 55  
Special Issue Resolution ............................................................................. 57  
Team Meeting / Surveyor Planning – End of Day ....................................... 59  
Daily Briefing ............................................................................................... 61  
Competence Assessment Session .............................................................. 63  
Environment of Care and Emergency Management – OME .......................... 66  
Life Safety Code® Building Assessment – Home Care ................................. 79  
System Tracer – Data Management ............................................................. 83  
General Tips for Conducting the Data Management Session ....................... 85  
System Tracer – Infection Control ............................................................... 91  
System Tracer – Medication Management ................................................... 95  
Medication Management – Work Tool (for Ambulatory Infusion and Inpatient Hospice use) ................................................................. 97  
Leadership Session .................................................................................... 99  
Tips for Conducting the Leadership Session ............................................... 101  
Regulatory Review Session ........................................................................ 103  
Program Specific Tracer – Equipment/Supply Management Tracer ............ 105  
Report Preparation ...................................................................................... 107  
Exit Briefing ............................................................................................... 111  
Organization Exit Conference ..................................................................... 113  
Evaluation Guide for Optional Community based Palliative Care Certification .......................................................... 115  
Sample Agenda for Home Care Accreditation with CBPC Survey ............... 119  
Sample Agenda for CBPC Certification Extension Survey .......................... 121  
State Survey Addendums (AHC, BHC, HAP, OBS, OME) .............................. 123  
New Jersey Audit for Medicaid Waiver Programs ....................................... 127  
California Home Health Agency Survey Addendum ..................................... 133  
Appendix A – Potential Threat to Health or Safety ....................................... 139  
Appendix B - Surveyor Documentation Guidelines ....................................... 143  
Appendix C – Surveyor Worksheet ............................................................... 153  
Appendix D – Team Leader Responsibilities ................................................ 155  
Appendix E – OME Applicability Grid for Program-specific and System Tracers .......................................................... 161  
Appendix F – Handout for the Home Care Organization ............................. 163  
Appendix G – Home Care Accreditation Survey Activity List ...................... 167  
Appendix H – Accreditation with Follow-up Survey ...................................... 169  
Appendix I – Random Unannounced Validation Survey (RUV) .................... 173  
Appendix J - Extension Survey (HME Only) ............................................... 175  
Appendix K – Agenda Templates (HME Only) .............................................. 177  
Appendix L – Addendum for Home Health Deemed Status Surveys .......... 179  
Appendix L (continued) - Home Health Deemed Status – Interim Survey Process .......................................................... 190  
Form CMS 1572 -- Home Health Agency Survey & Deficiencies Report & FAQs .......................................................... 193
<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deemed Surveys – Brief Description and Survey Process</td>
<td>195</td>
<td></td>
</tr>
<tr>
<td>Appendix M</td>
<td>Addendum for Hospice Deemed Status (HDS) Surveys</td>
<td>197</td>
</tr>
<tr>
<td>Appendix N</td>
<td>CMS Required Product Specific Service Standards</td>
<td>211</td>
</tr>
<tr>
<td>Appendix O</td>
<td>Medicare Condition-Level Deficiency Follow-up Survey</td>
<td>215</td>
</tr>
<tr>
<td>Appendix P</td>
<td>Onsite Evidence of Standards Compliance (ESC), Preliminary Denial of Accreditation-Evidence of Standards Compliance (PDA–ESC) Survey</td>
<td>219</td>
</tr>
<tr>
<td>Appendix Q</td>
<td>Extension Surveys</td>
<td>223</td>
</tr>
<tr>
<td>Appendix R</td>
<td>Early Survey Policy – Survey Event Guide</td>
<td>225</td>
</tr>
<tr>
<td>Appendix S</td>
<td>Intracycle Monitoring (ICM) Option 2 &amp; 3 Surveys &amp; Focused Standards Assessment (FSA) Tool</td>
<td>229</td>
</tr>
<tr>
<td>Appendix T</td>
<td>Focused Evaluation Screening Tool and Evaluation Activities</td>
<td>233</td>
</tr>
<tr>
<td>Appendix U</td>
<td>Evaluating Contracted Services in Home Care Organizations</td>
<td>235</td>
</tr>
<tr>
<td>Appendix V</td>
<td>Evaluating Aspects of Health Information Management Requirements</td>
<td>239</td>
</tr>
<tr>
<td>Appendix W</td>
<td>Medicare Survey Mid-Cycle – Survey Event Guide</td>
<td>243</td>
</tr>
<tr>
<td>Appendix Z</td>
<td>Office of Quality and Patient Safety Survey Activity</td>
<td>245</td>
</tr>
<tr>
<td>Appendix AA</td>
<td>Attachment: Scripts for OQPS Survey Activity</td>
<td>250</td>
</tr>
<tr>
<td>Appendix CC</td>
<td>Immediate Threat To Health or Safety Abatement Survey</td>
<td>257</td>
</tr>
<tr>
<td>Appendix DD</td>
<td>Medication Compounding Competency Checklist</td>
<td>261</td>
</tr>
<tr>
<td>Important Telephone Numbers</td>
<td>263</td>
<td></td>
</tr>
</tbody>
</table>
## Pre-survey Preparation for all Survey Types

**Applies to:** All accreditation programs

**Participants**
- Account Executive
- Surveyors

**Organization:**
- HCO survey coordinator, when applicable

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

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

**Exceptions:** The following survey types are announced.

- Initial HCO surveys (unless the organization is seeking CMS recognition for DMEPOS, Hospice or Home Health Medicare certification)
- Early Survey Option (ESO) surveys

**7 day “short notice” is given to:**
- Intracycle Monitoring (ICM) Option 2 and 3 surveys
- Department of Defense facilities
- A health care organization that has only one of the following services:
  - Home health/personal care/support w/ ADC, 1 to 30
  - Hospice w/ ADC, 1 to 10
  - Pharmacy w/ ADC 1 to 50
  - Home medical equipment services, 1 to 50

### Before

- Review itinerary and confirm type of survey (unannounced or announced) and whether it is a solo or team survey
- Note the Account Executive name and extension
- **DO NOT CONTACT THE ORGANIZATION**

**Four weeks prior to the survey**

- Access the following information:
  - Survey agenda
  - E-application data
  - 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:
  - Review and follow the Team Leader Responsibilities document in Appendix D of this guide or that is posted on the Surveyor Portal
  - Coordinate travel arrangements with team members
- **Access the agenda and edit as necessary for the services and team members.** If this organization is pursuing CBPC Certification, access the sample template agenda for HC accreditation and CBPC Certification in the SAG (Appendix DD) for information to use when modifying the agenda in WST.
- Determine a team meeting place and arrival time for survey day one. **All team members should arrive at the HCO together** unless circumstances dictate otherwise.
- If this is a team survey:
  - Note the team leader’s name and extension
  - Coordinate travel arrangements with the team leader. (Note: You can make your flight reservations; however, you may want to wait to hear from the team leader to coordinate hotel and car reservations.)
- Check the internet for an HCO web site. Often these sites provide driving directions and other useful information for surveyors.
- Make travel arrangements
- **Two weeks prior to survey:**
  - Access the organization’s ICM Profile
  - View the program-specific general risk areas
  - View the organization-specific risk areas, if available
  - View available report(s) from the previous full accreditation cycle
• Note the previous accreditation events/activity

• Review the organization’s historical SAFER™ matrix(s). The purpose of the review is to determine if there are high risk findings that you may want to discuss or touch upon with the organization during the survey:
  o Find the historical SAFER™ matrix(s) by selecting the quick link in WST.
  o You will be taken to a page on the organization’s Extranet site with all SAFER™ matrix(s) for that particular organization from historical onsite survey events.
  o Review the SAFER™ matrix(s) associated with surveys that have occurred since the organization’s last triennial (or initial if applicable) survey.
  o Focus the review on the findings placed in the dark orange or red areas of the SAFER™ matrix (these areas represent higher risk findings) and the Evidence of Standards Compliance corrective action submitted by the organization.
  o Identify the higher risk findings that you would like to include or discuss with the organization during the survey to ensure sustainment has been maintained.
  o Incorporation of the identified findings to review during survey will entail the following:
    ▪ Discuss the finding with the organization
    ▪ Ask if they are still utilizing the corrective action plan outlined within the previously submitted ESC
    ▪ Determine if compliance still remains.
    ▪ If compliance has been sustained, no further action is needed.
    ▪ If compliance has not been sustained, score the same standard and determine if scoring LD.04.01.01 EP 3 is also appropriate.

• 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.

• Access the organization’s OASIS data
• Print a copy of Appendix F: Handout for the Home Care Organization for Preliminary Planning Session
• For organizations pursuing CBPC Certification: Review the Evaluation Guide for Optional CBPC Certification, found in Appendix EE.

Any time prior to survey
• Address questions regarding the organization or survey logistics to the Account Executive or your Field Director
• Call your Field Director with any survey process questions
### ONE DAY -- Arrival, Opening and Orientation to the Organization

**Applies to:** One Day Home Care Surveys Only – Any service

<table>
<thead>
<tr>
<th>Duration</th>
<th>Before</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Approximately 60 minutes</strong></td>
<td><strong>Review the e-app for the:</strong></td>
</tr>
</tbody>
</table>
| **Participants** | o Hours of operation  
Joint Commission: Surveyor  
Organization: Survey Coordinator, Owner |
| **What should you do if the organization is not open when you arrive?** | o Contact person’s name and alternate name  
o Phone number  
o Directions  
o Equipment categories provided  
o Services offered, volume and ADC  
o Account Executive name and contact number should questions arise  
Before  
Afternoon prior to survey, drive by the organization to verify location and travel time  
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  
Check the e-app data for hours of operation and the survey coordinator’s name and phone number |

Organizations have been asked to have the following documents available.

- Performance Improvement / Measurement Summary Reports
- Infection Control Summary Reports
- Infection Control Plan
- Emergency Operations Plan and evaluations of exercises and responses to actual emergencies
- Name and phone number of key contact person who can assist surveyors in patient visits or observation of service delivery
- A copy of the organizational chart, and a list of personnel and their roles (including contract staff)
- List of all sites, branches and services if applicable
- List of scheduled home visits for the duration of the survey including type of service, disciplines, diagnosis, date of

**Beginning**

- Arrive at the organization 10 minutes prior to the start of the survey. Survey start times are determined by the organization’s hours of business.  
  o Introduce yourself to the organization’s greeter and display your Joint Commission identification badge  
  o Ask to speak with the contact person or the organization’s owner/leader  
  o Verify that you are able to access the internet using the organization’s wireless service or their broadband connection |

- Direct the organization to their Joint Commission extranet site accessible through [www.jointcommission.org](http://www.jointcommission.org) to verify the survey and print the agenda.

**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 and 2) You should call the Field Director on call with the information

- Note that 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.  
  They should click on the “Joint Commission Connect” logo to access their survey information. They will be instructed to enter their login information. The following survey information is available on the morning of your arrival by 7:30 a.m. local time:  
  o Notification of scheduled Joint Commission event authorizing your presence  
  o Surveyor name, picture and biographical sketches  
  o Scheduled survey dates  
  o The survey agenda that you prepared and posted |

- Once the organization validates the authenticity of the survey:
Other information
In complex organizations, all services should be addressed in this session.

NOTE:
Look for licenses, certificates, and permits to operate that are on display throughout the organization; verify they are current

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

During
Review the proposed, published template agenda
- Make modifications to the agenda, as needed. Note: Modifications in time slots may be required based upon patient/ client schedules. Agenda changes should be consistent with guidance provided by the Joint Commission central office.
- Explain the individual tracer concept, including:
  - Defined as a survey method used to evaluate the organization’s compliance with standards as it relates to the care and services provided to an individual
  - The fact that a majority of the survey is spent evaluating the organization’s processes and compliance with standards, (and CMS regulations for deemed surveys) at the level of the patient through individual tracers
  - Give an example of an individual tracer
- Describe the System Tracer(s) you will conduct, if the organization is unfamiliar with the on-site survey process.
- Describe the regulatory and systems session, if the organization is unfamiliar with the on-site survey process.
- Inform the organization that there will be one final onsite opportunity for leaders and staff to clarify and clear observations and findings before they are committed to the Summary of Survey Findings report. This time will be at the start of the Report Preparation session. All outstanding surveyor requests for information must be fulfilled and any additional staff discussion will need to occur at this time if it is to impact report content.
- 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
Objective

Learn more about all services in the organization

During

- Use this time to discuss the organization’s structure, services, management and important processes and functions
- Ask oversight and operations-related questions that help you to better understand:
  - The organization mission, vision, goals, and strategic initiatives
  - Organization structure
  - Operational management structure – relate the leadership terms used in the manual to their structure – who are the leaders? Leadership components? Board of Directors?
  - Planning, resource allocation, and decision-making processes
  - Contract management arrangements, if any
  - Health care errors reduction and/or Patient safety initiatives
  - Adherence to National Patient Safety Goals
  - Role in emergency management planning
  - Governing body oversight (HHA deemed)
- Engage the owner in discussion about:
  - What percentage (approximately) of their business is attributed to each service and/or equipment category
  - How they view their strengths, opportunities for improvement and plans for the future
  - Oversight process for their operations
- Ask leaders performance improvement questions to help you better understand:
  - How they set expectations, plan, assess and measure initiatives to improve the quality of services
  - Their approach to safety, including selection of risk assessment topics, resulting improvements, and Board member involvement in safety issues
  - How they avoid fraudulent and unethical processes and situations
  - Provision of resources including personnel, information systems, data management, and staff training
  - Their approach to the Focused Standards Assessment and methods used to address areas needing improvement
  - Discuss what they view as their priority performance activity for the year
- Conclude the session by thanking attendees for their participation in the discussion. Reiterate the agenda activities for the day.
### Surveyor Arrival & Preliminary Planning Session

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

**Duration**

- 30 - 60 minutes

**Participants**

- All surveyors on site

**Organization:**

- Survey Coordinator
- Senior leadership

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

---

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

---

**Beginning**

- Review the hours of business on the e-app and plan to arrive no earlier than 10 minutes before the organization opens; survey start times are determined by the organization’s hours of business.

- If the organization is not open when you arrive:
  - Check the e-app for hours of operation and the survey coordinator’s name and phone number
  - Try calling the organization to see if there is any message indicating a change in hours of operation, reason for closure, or emergency contact number
  - If the above does not produce results, call the Account Executive or the Field Director on-call for assistance and further direction.

- If more than one surveyor is conducting the survey, enter the organization as a team unless circumstances dictate otherwise, such as multiple sites being surveyed at the same time

- Report to the reception area, security officer, information desk, or administrative office upon arrival and indicate your name and 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 event.

- 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, 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 and 2) You should call the Field Director on call with the information.

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. (Note: The OME Document List and template agenda was provided to the organization with the OME Survey Activity List on their Joint Commission Connect extranet site. This list also appears in the Organization Survey Activity Guide.)
  - Ask to be taken to a location where you can work and secure your belongings.
    - If the organization does not have documents immediately ready for review, ask to begin with an individual tracer. Select this tracer based on the clinical services and 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 EP 1 states: The organization informs the public it serves about how to contact its management to report concerns about patient safety and quality of care. Note: Methods of notice may include, but are not limited to, distribution of information about The Joint Commission, including contact information in published materials such as brochures and/or posting this information on the [organization]'s Web site.
Opening Conference
Applies to: All accreditation programs

**Duration**
30 - 60 minutes

**Participants**
Joint Commission: All surveyors on site.
Organization: Senior leadership (representing all programs/settings where The Joint Commission has a defined accreditation manual in a complex organization).
- Attendees should be able to address leadership’s responsibilities for strategic planning and resource allocation, management, oversight, performance improvement (how expectations are established, planned, prioritized and managed), and support in carrying out the organization’s mission and strategic objectives. (Same attendees as for the Orientation to the Organization session.)

Attendees may include:
- At least one member of the governing body, or organization trustee. (In single owner organizations, this individual may also be the CEO, Executive Director or Owner)
- Senior organization leaders from all programs/ settings. (e.g., CEO, COO, CFO, CIO, VP for clinical services, nurse executive, laboratory medical director, director of patient services or branch manager, chief administrator/director of each program.)

Note: Senior leadership from all programs in a complex organization that independently would be eligible for an accreditation survey should try to participate. Department director-level participation is invited but not required.

**Objectives**
1. Describe the structure of the survey
2. Describe CBPC certification if organization has elected this option.
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 health care
- IF CBPC option is elected, thank the organization for pursuing this optional certification.
- Explain that the purpose of survey is to provide an external validation of compliance with standards and provide education/consultation.
- Ask organization attendees to introduce themselves and make a note of names and title/functional responsibility.
- Describe each component of the survey agenda, including staff that should attend when possible; make any necessary changes.
- For organizations pursuing CBPC Certification: Describe how the agenda is designed to incorporate CBPC evaluation in the various sessions, and patient tracers will be selected for CBPC as well as other services (HH, Hospice, etc.)
- Remind the organization that the agenda is a template to guide the on-site survey; occasional modifications may be necessary. Agenda changes should be considerate of organization operations and scheduling needs and consistent with guidance provided by The Joint Commission central office.
- Identify the specific data (previous reports, data about their services, risk areas noted in the ICM Profile) that you are using to guide your initial on-site activity, such as locations to visit, people to interview, and documentation that will be reviewed.
- Confirm with the organization what care treatment and services they are providing and the locations as reported in their e-application.
- Explain that the majority of survey activity occurs at the point where care, treatment and services are provided. The term “Individual Tracer” denotes the survey method used to evaluate the organization’s compliance with standards as it relates to the care and services provided to an individual patient.
- Emphasize with the organization that it is important for surveyors to interact with the direct care givers. Remind leaders that staff...
Other information
The survey team leader serves as the facilitator for this session.

Suggestions for use of RPI tools*
- PAGER
- Ice Breakers
- WWW
- Parking Lot
- More Of / Less Of

*You can find more information in the Robust Process Improvement (RPI) Tip Cards for Field Staff

members can often become uncomfortable with large numbers of observers.

- Give an example of an Individual Tracer, if the organization is unfamiliar with the on-site survey process.
- Describe the Systems Tracer(s) you will conduct, if the organization is unfamiliar with the on-site survey process.
- Acknowledge that surveyors, like the organization, are interested in preparing a report that accurately reflects the organization’s compliance with standards. Remind the organization representatives that throughout the survey there are multiple opportunities to present documentation and evidence of standards compliance in order to clarify and clear observations before they are committed to the Summary of Survey Findings report. Opportunities include:
  - Daily Briefings
  - Special Issue Resolution
  - Team Meetings
  - Report Preparation Time
  - Other times pre-arranged with the surveyors

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

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

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

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

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

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

- Ask if there are any questions about the survey; answer 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:
Same attendees as for the Opening Conference

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

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

**For organizations pursuing CBPC Certification:**
1. Learn about the program philosophy and approach to providing community based palliative care, treatment and services
2. Identify the community based palliative care program structure and the scope of care and services being provided
3. Determine how well integrated the CBPC program is within the Home Care organization and its other services

## During
- If an organization leader wants to provide a formal presentation, ask how long the presentation will be and if they would be open to your asking questions throughout as they pertain to topics being discussed. If they indicate a preference for questions at the end, ask if the presentation can be limited to 15 minutes so that you have sufficient time to ask follow-up questions. **For organizations pursuing CBPC Certification:** The leaders may request to provide a formal overview of their program. If this is the case, the total presentation time will likely be 30-45 minutes.
- This session addresses all programs and services and, as applicable, the team leader or his/her designee serves as facilitator.
- Surveyors should have a clear understanding of the following:
  - Services provided
  - Locations/branches included under the organization ID
  - ADC at each location
  - Specific care provided at each location, that is, wound care, blood draws, telehealth, TPN, skilled nursing, various therapies, type of equipment, Clinical Respiratory Services, patient population (pediatric, adult, diagnosis-specific, etc.)
  - Contracted staff and or services provided to patients on behalf of the organization through contract.
  - Clinical record – paper or electronic and how surveyor will access records
  - Location of HR/personnel files, especially if multiple locations are being surveyed
  - Location where billing is performed
• Coordination for home visits (determine if surveyor will drive self or will staff be available to drive surveyor)

• Special concerns or time constraints of the organization

• Suggested discussion topics are governance and operations-related that help you to better understand:
  o The organization mission, vision, goals, and strategic initiatives
  o Organization structure
  o Operational management structure
  o Planning, resource allocation, and decision-making processes, including staffing effectiveness
  o Contracted services and monitoring performance
  o Organization efforts to reduce health care errors and other safety initiatives
  o Organization performance adhering to National Patient Safety Goals
  o Community involvement initiatives
  o Leaders’ roles in emergency management planning
  o Review with the organization any activities related to risk awareness, detection and response as it relates to cyber emergencies. Suggested discussion topics include:
    • Identification of any medical equipment and care, treatment, or service devices that connect to the internet.
    • Descriptions of any vendor agreements or contracted services that support internet access for transmitting clinical information or connecting medical equipment and devices.
    • How IT leadership participates in identifying potential risks to care, treatment, or 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)
  o Governing body oversight (HHA deemed)

• Ask leaders performance improvement questions to help you better understand:
  o How they set expectations, plan, assess and measure initiatives to improve the quality of services.
  o Their approach to safety, including selection of proactive risk assessment topics, resulting improvements, and Board member involvement in safety issues.
  o Provision of resources including personnel, information systems, data management, and staff training.
Their approach to the Intracycle Monitoring (ICM) and the Focused Standards Assessment (FSA) Tool, when it was completed and the methods used to address areas needing improvement.

If multiple sites are being surveyed, discuss how system tracers will be facilitated.

- **For pharmacy organizations:**
  - Scope of sterile compounding services that are carried on throughout the organization
  - Types of medication compounding performed (sterile, nonsterile, hazardous, immediate use)
  - Inquire about the medication compounding services structure, workflows, and technology in use
  - Medication compounding staff and pharmacist in charge
  - Routine cleaning requirements and procedures (including who is responsible)
  - Beyond Use Dating assignment
  - Managing medication shortages
  - Medication compounding educational offerings for organization compounding staff
  - Identification of areas outside the main pharmacy where medication compounding is being performed (such as patient homes), and by whom.
  - Access to medication compounding services

For organizations pursuing CBPC Certification:

- **Profile of CBPC Services:**
  - Overview of the CBPC program, including target population, design, relationship to the other program(s) in the organization (PC.01.01.01, EP49)
  - Types of CBPC services provided
  - Process for identifying patients (new referrals and current patients) appropriate for CBPC services (PC.01.01.01, EP49)
  - Referral process: how patients are referred from outside sources for CBPC program services
  - Interdisciplinary team composition and roles of each member; team communication (HR.01.02.07, EPs 10-12) Clinical practice guidelines used by the program (LD.04.04.09, EP7)

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

**After**

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

Duration
30-60 minutes

Participants
All surveyors on site

Organization:
Organization’s Survey Coordinator
(at your request)

Other organization surveyors may participate when cooperative evaluations are in place.

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

Before
- Explain to the organization the purpose of this session and the need for as few interruptions as possible
- Make sure all necessary documents are available, including patient lists

During
Tracer Selection (25% of session)
- Using the ICM Profile data (services, previous RFIs), as well as high-risk services, identify client/patient tracers for the day. Timing of this activity must be first to allow the organization time to rearrange schedules and obtain patient permission.
- If this is a Complex Organization survey, identify surveyors from each program to conduct the system tracers.
- For organizations pursuing the CBPC Certification: Select patients receiving palliative care services. Three tracers should be selected, with a minimum of two home visits.

For DMEPOS Organizations
- Select equipment/supplies from each of the categories of equipment in the Individual tracer addendum
- Select from equipment categories that the organization will be providing to Medicare beneficiaries through the CMS Competitive Bidding process.
- Selection considerations should include:
  - List of all sites, branches and services, if applicable
  - List of scheduled deliveries, mail orders or planned walk in business for the day.
  - List of deliveries, mail orders or walk in business from specific points in time as delineated by the surveyor.

  (*Lists should include the type of DMEPOS, date of first encounter/admission, and address if delivery is part of the service)

- Timing of this activity must be first to allow the organization time to obtain patient permission and rearrange their schedules.

For Pharmacy Organizations
- A list of current patients with start of care date and the type of compounded medication being provided. If there are a limited number of active patients receiving compounded medication,
provide a list of discharged patients who received compounded medications representative of those provided by the organization. If the organization does high risk medication compounding, at least one of the individual tracers should involve a patient that is receiving a high risk compounded medication such as a non-sterile bulk powder that becomes sterile through the compounding process. If no high risk compounding is done at the organization, then medium risk compounded medications should be selected.

- Documents that will be needed for review during the survey include:
  1. Pharmacy organizational chart
  2. List of staff involved in medication compounding, including the pharmacist in charge
  3. Job descriptions for each category of pharmacy staff involved in medication compounding
  4. Beyond Use Dating assignment policy
  5. List of all Primary Engineering Controls (PECs) and Secondary Engineering Controls (SECs)
  6. Clean room monitoring and certification records for all PECs and SECs (certification records for the last year will be needed)
  7. All pharmacy facility licenses
  8. Most recent State Board of Pharmacy reports
  9. Policy, procedures, and software supporting medication recall and compounded medication returns
  10. Submitted DEA Form 222 and associated powers of attorney
  11. Competency assessments and performance evaluations for staff involved in medication compounding
  12. Remedial follow-up on failed competency reviews
  13. Pharmacy quality control checks and performance improvement data
  14. Performance improvement action plans that demonstrate how data have been used to improve care and services, when available
  15. All medication compounding related policies and procedures

Performance Review (50% of session)

- Complete the review of materials listed in the Surveyor Arrival and Preliminary Planning Session. Note: Evaluate all quality management activities (the organization may have different terminology, such as quality control, quality assurance, quality improvement, performance management, etc.)

  Note: In complex organizations, surveyors should review the data relative to their program(s) and survey activities.

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

- Surveyors conducting the Data Management System Tracer should complete a review of performance improvement data including aggregation, analysis and action related reports.
For organizations pursuing the CBPC Certification: Review the 4 required performance measures, data collection and analysis for the CBPC program.

Identify which system/program specific tracers will be conducted using the guidelines in Appendix E.

- If this is a Complex Organization survey, one surveyor from each program responsible for conducting the System Tracer for Medication Management should review the program specific medication related performance reports, such as medication errors and adverse drug events.

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

- If you are conducting a system tracer for multiple programs, you must review the necessary information for all programs.

Surveyors responsible for the LSC assessment must access the organization Plan for Improvement (PFI) at this time through Surveyor Portal. 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.

For organizations pursuing CBPC Certification: Inquire about the program’s schedule for interdisciplinary team meetings and if it would be possible to observe. If there is not a team meeting scheduled, ask when you can set up a time to talk to the team members about their roles in the program.

Planning Discussion (25% of session)

- 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.

- Communicate information to the organization about subsequent tracer activity, for example:
  - 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. Discuss active participants that are needed at the session.

- Identify the focus for this organization’s Data Management system tracer based on the review of OASIS data and other performance improvement data. The focus is the first step in the process that is a problem for the organization. If nothing appears to be a problem, focus on how the organization is using data to improve. Identify participants who are needed at the session.

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

After

- Communicate information to the organization about subsequent tracer activity.
Equipment Categories Prioritization – Listed in order of risk/priority

Attempt to choose one patient tracer from each category of services provided by the organization, when possible.

<table>
<thead>
<tr>
<th>Category A: Respiratory Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Invasive Mechanical Ventilators</td>
</tr>
<tr>
<td>Oxygen concentrators, reservoirs, high-pressure cylinders, oxygen accessories and supplies and oxygen conserving devices</td>
</tr>
<tr>
<td>Continuous Positive Airway Pressure (CPAP) Devices</td>
</tr>
<tr>
<td>Respiratory Suction Systems</td>
</tr>
<tr>
<td>Respiratory Assist Devices (RAD)</td>
</tr>
<tr>
<td>Intermittent Positive Pressure Breathing Devices</td>
</tr>
<tr>
<td>Nebulizers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category B: Manual Wheelchairs and Power Mobility Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power Mobility Devices (power wheelchairs, power operated vehicles, accessories)</td>
</tr>
<tr>
<td>Manual wheelchairs including standard recliners, heavy-duty wheelchairs, standard lightweight wheelchairs, hemi wheelchairs, armrests, leg rests/footplates, anti-tipping devices, other Medicare-approved accessories</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category C: Orthotics/Prosthetics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Custom Fabricated, custom fitted, custom-made orthotics</td>
</tr>
<tr>
<td>Prosthetic devices</td>
</tr>
<tr>
<td>Somatic, Ocular and Facial Prosthetics</td>
</tr>
<tr>
<td>Therapeutic Shoes and Inserts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category D: Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemodialysis Equipment and Supplies</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
</tr>
<tr>
<td>Enteral Products and Supplies</td>
</tr>
<tr>
<td>Negative Wound Pressure Therapy</td>
</tr>
<tr>
<td>Pneumatic Compression Devices</td>
</tr>
<tr>
<td>TENS Units</td>
</tr>
<tr>
<td>Traction Equipment</td>
</tr>
<tr>
<td>Pumps (Infusion, Suction)</td>
</tr>
<tr>
<td>Hospital Beds (electric and Manual), Support Surfaces, Lifts, Bedpans and Urinals, Commodes, Crutches, canes and walkers</td>
</tr>
<tr>
<td>CPM (Continuous Positive Motion)</td>
</tr>
<tr>
<td>Speech Generating Devices</td>
</tr>
<tr>
<td>Surgical Dressings</td>
</tr>
<tr>
<td>Modalities (Heat and Cold Applications)</td>
</tr>
</tbody>
</table>
**Individual Tracer**

 Applies to: All accreditation programs.

---

### Objective

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

### Before

- Select Individual Tracer candidates based on the organization’s clinical services, ICM Profile risk areas, and information discovered during the Orientation session. As the survey progresses, you may select
  - Patients with more complex situations and more contact with various parts of the organizations to assess continuity of care issues.
  - Patients related to Systems Tracer topics. Refer to the planned system tracers and select at least one individual tracer that pertains to the system. See Appendix E.
  - Patients that cross services (e.g. a patient who receives DME and home health services).
  - Patients that have been admitted from or discharged to an outpatient service.
  - Patients that cover multiple additional criteria.
- Document the manufacturer, model and serial numbers for all medical equipment provided by the organization.
- Evaluate delivery vehicle set up for compliance with law and regulation as well as compliance with the standards that require equipment delivery in a safe, clean and sanitary manner.
- For pharmacy organizations: Compounded Medication Tracer Selection
  - Describe to the representatives the types of medications you want to trace and request assistance in identifying these medications.
  - Select a minimum of three (3) compounding activities per risk level (low, medium, and high). These must:
    - Be representative of the target therapies compounded in the organization
    - Include hazardous medications and radiopharmaceuticals, if they are being compounded in the organization
    - NOTE: If the organization receives compounded radiopharmaceuticals from an outside source, the reviewer will visit the area and speak to the staff that receives these medications.
  - Prioritize the review of medium and high risk. For example, compounding of TPN, compounding of chemotherapy, compounding of product from non-sterile powder such as narcotic infusions.
REMEMBER!

Reference the Program-specific and System Tracers matrix in the Appendix to determine which system tracers will be a part of this survey.

- Surveyors conducting the Individual Infection Control Tracer must select to trace a patient with an infection.
- Surveyors conducting the Individual Tracer for Medication Management must select to trace a patient taking a high-risk medication.

- If the organization does not do any high risk compounding, then select 3 medium and 3 low risk medications to review.
  - If there are a limited number of active infusion patients at the time of the onsite review, or the active patients do not meet all your therapy selection criteria, review compounding processes in the clean room area with compounding staff representing the key elements in preparing the targeted compounds.

During

- Start the tracer by reviewing a clinical record with the staff person responsible for the individual’s care, treatment, or testing. If the staff person is not available, hold the discussion with a clinical supervisor or other staff member. The primary purpose of using a clinical record is not to audit its contents, but to use it as a tool in following care, treatment, and services.
- Trace the entire care or service process from preadmission through post-discharge. This will involve moving from location to location (depending on the size of the organization).

Interview staff about the following, as applicable:

- Compliance with other applicable standards pertinent to the individual being traced
- Intra-departmental and inter-departmental communication for coordination of patient care. (Pay particular attention to handoffs – these are critical points in time when errors occur.)
- Processes and role to minimize risk

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

- Patient education processes
- Orientation, training and competency testing
- Awareness of content of APR.09.02.01 (staff are permitted to contact The Joint Commission with concerns of patient safety without fear of recrimination)
- Delivery and set up of equipment, including timing, operational checks, electrical safety requirements, adaptation of equipment/supplies
- Evaluation of patient home utilities, as applicable to equipment needs, e.g. electrical outlets, cords, etc.
- Fall reduction education, when applicable
- Storage
- Emergency management roles and responsibilities, including mitigation, preparedness, response and recovery/business continuity related to the following:
  - Communication with patients
  - Communication with field staff
  - Communication with relevant external entities (such as vendors, contracted providers, parent company, public health or other public authorities, other health care organizations, alternative care sites, etc.)
The IM systems they use for care, treatment and services (paper, fully electronic or a combination of the two) and about any procedures they must take to protect the confidentiality and integrity of the health information they collect.

Ask staff about any back up procedures they’ve been instructed to use if the primary system is unavailable.

If internet-connected health information, equipment, or devices are used in care, treatment, or service, ask staff to describe their access procedures (passwords, authentication, etc), confidentiality measures, and instructions on down-time procedures.

Address with staff during different tracer discussions how they approach risk awareness, detection and/or response as it relates to potential cyber emergencies. Suggested discussion topics include:

- How would they detect a cyber problem, for example, login issues, missing/modified data; strange message on screen.
- What do they do if they detect a cyber problem - who do they call?
- The plan(s) in place to continue care, treatment, and services if all of the IT systems are not available, including training in back up/alternative work procedures.
- Contingency plans if the following systems are disabled by a cyber emergency:
  - Electronic health record (EHR) (acute and prolonged events)
  - Radiology
  - Laboratory
  - Pharmacy
  - Medical devices
  - Telemedicine care, treatment, or services

Other issues, relative to care, treatment or services

Validation of information learned during other survey activity

For pharmacy organizations:

- Length of service in the pharmacy
- Orientation to compounding responsibilities
- Types of compounded medications being prepared
- Supervisor and performance reviews of compounding technique
- Gloved fingertip test and performance of a media fill; last time occurred; results
- Accessing Safety Data Sheets
- If pharmacy prepares hazardous medications, discuss staff safety and protection
- Types of monitoring; any documentation
- Cleaning hoods or isolators—when, how, with what, and documentation of cleaning
- Process for checking compounding work
- Beyond Use Dating (BUD) and product expiration dates
- Delivery and retrieval of products to patient units; explore how compounded medication is handled when returned to the pharmacy; focus on compliance with BUD for redispensing
- Discuss compounded medication storage in patient homes and maintaining stability and integrity of products.

Conducting the Patient Visit

- Introduce yourself and briefly explain the purpose of your visit.
- Provide the patient with the TJC Home Care flyer (English or Spanish version).
- Interview patients and when appropriate, family members about the following, as applicable:
  - Coordination of services including timeliness
  - Education provided
  - Response time when calls are made after hours
  - Perception of services
  - Understanding of discharge instructions
  - Staff compliance with NPSGs
  - Were they provided with information about how to access the supplier for needs – access must be consistent with the types of equipment, items and services provided and recommendations from the prescribing physician or healthcare team members.
  - Equipment operational checks, failures, troubleshooting, delivery of supplies, etc.
  - Education provided about equipment including ongoing care and maintenance
  - Supply delivery and storage issues
  - Adaptability of prosthetics
  - Response time when call made to supplier
  - Contact information for 24/7 service, when needed
  - If the patient obtained Rehabilitation Technology services, ask the patient and/or caregiver to describe their face-to-face evaluation with the supplier, including:
    - The setting – was it adequate for their needs
    - How the physician prescribing the services and other healthcare team members, such as therapists, communicated with the supplier about the patient’s needs
  - Other issues, relative to care, treatment or services
  - Validation of information learned during other survey activity
- Observe, when applicable:
  - Potential environmental issues that might impact individual safety.
  - Care planning processes (e.g. timing of patient assessments). If possible, observe discharge planning or care coordination meetings.
  - Clinicians, including physicians, providing direct patient care.
  - Medication processes (e.g. preparation and administration of medications, storage, and control of medications).
• Infection control processes (e.g., techniques for hand hygiene, sterilization of equipment, disinfection, food sanitation, and housekeeping.

• Identify and evaluate the effectiveness of the organization’s standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.

• Equipment and supplies – determine that:
  - they are consistent with the physician order
  - DMEPOS suppliers have identification stickers on rental equipment showing the company’s name, address, and telephone number

• Customization of orthotics and prosthetics

• Staff interaction with patient and caregivers relative to patient rights

• Coordination and service delivery

• Education

• In Rehabilitation Technology Service settings:
  - visit the setting where face-to-face evaluations occur – evaluate privacy, cleanliness and safety
  - ensure that the supplier maintains:
    - a repair shop in the facility or in close proximity or easily accessible from another location of the supplier
    - An area appropriate for assembly and modification of products

• Evaluate the processes around medical equipment, such as:
  - Delivery and set up
    - timeliness
    - operational checks
    - electrical safety requirements
    - adaptation of equipment/supplies
    - in home storage processes
  - Patient education
  - Troubleshooting
  - Care and use
  - Storage of supplies
  - Back up equipment, including oxygen supply
  - Other, as applicable

• Evaluate the processes around supplies, such as:
  - Delivery process
    - timeliness
    - in home storage to ensure cleanliness or asepsis as applicable to DMEPOS
  - Patient education
    - Use, if applicable
    - Care and maintenance
    - Storage of supplies
  - Re-ordering process
Inventory of unused and potential overstock in the patient’s residence

- For pharmacy organizations, for home visits and/or patient calls, evaluate:
  - Length of time patient has been receiving the infusion
  - Infusion being provided and frequency delivered to the patient.
  - Condition of the product on arrival (e.g., if the drug requires refrigeration, does it arrive cold or has the patient ever noted a “floater” in the product).
  - Signature required by the patient or caregiver upon delivery
  - Ever run out of medication
  - Educated on proper storage of the medication
  - Educated on proper disposal of the medication if no longer needed
  - Label clear on instructions for administering the medication; contains an expiration date
  - Any need to call the organization with an issue regarding the compounded medication

After

- Review pertinent meeting minutes and procedures if needed.
- As necessary, pull additional records to verify standards compliance.
- Consider the relationship of your observations to system level performance.
- Share performance observations with other team members, if applicable, so they can be further explored in subsequent Individual Tracers.
- Interview additional patients and families to validate performance and standards compliance.
- Enter tracer information into WST.
Individual Tracer – Addendum

Individual Tracers - Important Components

The following represent areas that are important based upon current literature and Joint Commission standards. These suggestions are not all inclusive of the issues and topics that can or should be covered in a tracer.

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

Clinical services
- Discuss and review clinical/medical records:
  - Review the timing of patient care assessments in relation to organization's policies and patient needs
  - Verify individualization and appropriateness of the plan of care, treatment, and services
- Review and discuss the use of verbal orders (e.g., who can accept and transcribe the order, read back process and authentication)

Clinical Record Content
- Verify that:
  - Information (e.g., advance directives laboratory reports, test results, consultations, assessments, etc.) is filed in the patient's medical record in a timely manner
  - Medical record entries are dated and authenticated (as required by law)
  - A complete informed consent is obtained, when applicable
- Review medical records for:
  - The presence of sufficient information to identify the patient, support the diagnosis, justify continued need for home care, describe the patient's progress, and respond to care, treatment, and services
  - Authentication of the history and physical exam, operative report, consultation, and discharge summary

Contract Services
- Interview contracted staff about their scope and nature of services they provide and how they were oriented to the organization's processes
- Interview organizational leaders about their oversight process for contracted services and contracted individuals. Monitoring of contracted services and individuals is required.
- Review PI for inclusion of contracted services and individuals
- Review contracts, performance expectations and data from monitoring of performance expectations

Discharge Planning
Active Review
- Ask for a list of patients who are going to be discharged during the survey.
- Review the patient's clinical record for discharge orders.
- Observe the clinician providing discharge instructions. Components of the discharge instructions include:
  - Activity
  - Diet
  - Medications (post discharge)
  - Plans for physician follow-up
  - Wound care (if applicable)
  - Signs and symptoms to be aware of (i.e. elevated temperature, medication side effects, etc.)
  - Name and telephone of a physician to call should a problem or questions arise following discharge.
  - The nurse has the patient repeat back information to confirm the patient's understanding.
- The surveyor reviews written discharge instructions given to the patient. The discharge instructions are written in a language the patient can read and understand.
- Interview the patient to determine the patient's level of understanding of discharge instructions. The patient's level of understanding should include the following:
  - The purpose for taking any new medication
  - How to take the medication including dose and frequency
  - Possible side effects of medication
o The medication regimen including continuation or discontinuation of those medications taken prior to admission to the home care setting
o Contraindications between prescribed medications and over the counter medications and herbal remedies
o The importance of maintaining a current medication list and how to use it after discharge
o Changes in diet and dietary restrictions or supplements
o Signs and symptoms of problems and who to call with questions and concerns.
o Information regarding continued self-care (wound care, activity, etc.)
o Follow-up process with physician(s)
  o Arrangements made for home health needs (i.e. oxygen therapy, physician therapy)
• Interview the nurse/clinician to ascertain the origination of discharge information (physician-nurse communication regarding discharge instruction).
• Hand-off communication
• Medication reconciliation

Discharge Planning – Retrospective Review
• Ask for a list of patients who were discharged over the past 48 hours.
• Review the patient’s discharge record for discharge orders.
• Request that the organization stay with you as you make follow-up phone calls. The organization should first talk with the patient to explain the purpose of your call and obtain permission for a phone interview.
• Interview the patient to determine their understanding of discharge instructions provided. The patient’s level of understanding should include the following:
  o The purpose for taking any new medication
  o How to take the medication including dose and frequency
  o Possible side effects of medication
  o The medication regimen including continuation or discontinuation of those medications taken prior to admission to the home care setting
  o Contraindications between prescribed medications and over the counter medications and herbal remedies
  o The importance of maintaining a current medication list and how to use it after discharge
  o Changes in diet and dietary restrictions or supplements
  o Signs and symptoms of problems and who to call with questions and concerns.
  o Information regarding continued self-care (wound care, activity, etc.)
  o Follow-up process with physician(s)
  o Arrangements made for home health needs (i.e. oxygen therapy, physician therapy)
• Explore the patient’s perception of their discharge instructions. Do they believe they were given all of the information needed?

Emergency Services
• Discuss:
  o The immediate availability of services, equipment, personnel and resources for providing care, treatment and services due to an emergency, equipment failure or inability to follow through independently
  o The integration and communication of emergency services with other services (e.g., home care, hospice, medical equipment, home pharmacy, etc.)

Environment of Care and Emergency Management
• Observe the condition of the facility areas used by patients (e.g., safe, clean, functional, and comfortable)
• Discuss:
  o The process for conducting environmental tours to identify environmental deficiencies, hazards, and unsafe practices
    • Management of hazardous materials and waste
  o Ask various staff members to explain their role in fire management or disaster management
    o Training on roles and responsibilities in the event of an emergency
    o Reporting emergencies or incidents
    o Supplies, communications, personal protective equipment
    o Ask leaders about chain of command and communication processes in the event of an emergency.
    o Evaluate understanding and planning for emergency incidents that go on for a week or more.
    o Ask leaders and staff about their participation in exercises of the emergency operations plan and evaluations of the exercises.
Equipment Management
- Obtain notes of equipment manufacturers, model and serial numbers.
- Trace the processes of equipment and supply management for specific categories of equipment identified in individual tracers. Trace from procurement through decommissioning. Look at the following steps in the process:
  - Safe environment and processes
  - Equipment evaluation
  - Staff education about the equipment/supplies
  - Storage
  - Obtaining physician orders – content and process
  - Selection of the most suitable equipment/supplies to meet patient needs
  - Preparation for delivery
  - Delivery and set up
  - Tracking equipment location
  - Patient education about the care and use of equipment/ supplies
  - Maintenance – routine and preventive
  - Equipment failure management / back up system
  - Recall of equipment – monitoring, backup equipment process
  - Equipment return, cleaning and inspection processes, including basic safety and operational checks, such as volumetric testing of infusion pumps between patient use
  - Equipment repair processes
  -Obsolete inventory
  - Incident management – internal processes, reporting processes
- Ask various staff members about equipment and supply management processes, including how they were oriented and trained and evaluated for competency
- Review documentation of ongoing maintenance, testing and inspection procedures for the equipment identified during the individual tracers. Springboard to other equipment.
- List of medical equipment provided to the patient – compare manufacturer, model and serial number to that in the home.
- 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.

Food and Dietetic Services
- Identify the national standards used for recommended dietary allowances
- Observe hygiene practices and kitchen sanitation
- Discuss:
  - Safety practices for handling food
  - Assessment process to determine client/patient dietary needs
  - Process for prescribing and evaluating therapeutic diet orders
  - Process for accommodating special and altered diet schedules
  - Follow-up process when the client/patient refuses food served

Hand Hygiene - Observe clinicians (this includes physicians) as they provide care. Specifically observe all opportunities for hand-washing with antimicrobial soap or alcohol based rub as outlined in the CDC or WHO guidelines:
- Before:
  - Having direct contact with patients (e.g. medication administration, bathing, physical exam etc.)
  - Donning sterile gloves when inserting a central intra-vascular catheter
  - Inserting indwelling urinary catheters, peripheral vascular catheters or other invasive devices that do not require a surgical procedure
  - Donning non-sterile and sterile gloves
- After:
  - Contact with a patient’s intact skin, e.g. when taking a pulse or blood pressure, administering medications and lifting a patient
  - Contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings
  - Removing sterile and non-sterile gloves
  - When moving from a contaminated body site to a clean body site
Infection Control
- Observe clinicians, including physicians, for compliance with CDC or WHO hand hygiene techniques
- Interview staff about and observe, as appropriate, sterilization of equipment, disinfection, employee health, food sanitation, housekeeping cleaning processes, and other means for limiting the spread of infection
- Observe infection control techniques (e.g., aseptic or sterile techniques, cleaning between surgical cases, surgical attire, sterilization of operating room material, surgical devices and equipment)
- Inquire about employee health screening and health requirements (e.g., vaccinations, immunizations) for working on a unit; ask to see a sample of employee health files to verify compliance through documentation in these records

Laboratory Services
- Discuss:
  - Patient identification and protocols are used before administering blood products, taking blood samples and other specimens for clinical testing
  - Blood product usage
  - Waived testing, if performed,
  - Current CLIA waiver—director name found on the CLIA waiver form
  - Specimen collection and transportation process
  - Confidentiality of information
  - Blood product usage
  - Process for communicating critical values

Medication Management
- Review and discuss how medications are prepared and compounded (e.g., using clean or sterile techniques, minimizing contamination, use of laminar airflow hood or other class 100 environment while preparing IV admixture in the pharmacy, etc.)
  - Pharmacy surveyors: Use Directed Risk Assessment (DRA) tool to evaluate compounding process (see Appendix AA)
- 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 (look alike, sound alike, for example different insulins)
  - Process for clarifying unclear medication orders
  - Process for reviewing all prescriptions for the following: appropriateness of the drug, dose, frequency, and route of administration; indication for use with PRN medications; 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
  - Process for delivering medications
- Discuss:
  - Process for ensuring safety with high risk/high alert medications
  - Discuss the process for:
    - Access to medications when the pharmacy is closed
    - Control and transportation process for unused, expired, or returned drugs are controlled by the pharmacy
- Review medication orders for:
  - Clarity and completeness
  - Adherence to safety standards (e.g., no blanket reinstatement of previous orders, indication for use for PRN).
- Observe:
  - Preparation of hazardous medication, e.g., chemotherapy
  - Preparation of high risk medications, e.g., intra-thecal, TPN, intravenous

Outpatient Services
- Explore the mechanisms for communication between inpatient and outpatient services.
Patient Rights
- Staff discussion and observation:
  - Communication between shifts and departments
  - Education within the confines of patient needs, physical and cognitive challenges, culture and language diversity
  - Process when a patient refuses care
  - Patient complaints
    - Ascertain that the organization fulfills obligation that it must investigate complaints made by a patient or the patient’s family or guardian regarding
      - Treatment or care that is (or fails to be) furnished, and
      - Lack of respect for the patient’s property by anyone furnishing services on behalf of the home health agency
    - Ascertain that the organization documents both the existence of such complaints and the resolution of these complaints
- Patient and family understanding of:
  - Rights, including advanced directive and end of life decisions
  - Process to register a complaint with management or CMS, as well as, the opportunity to contact the Joint Commission
  - Patient safety and personal / health information privacy

Performance Improvement
- Discuss, as appropriate, at the unit or branch level:
  - Data collection process and responsibilities (e.g., medication management, blood and blood product use, infections, complaints, etc.)
  - Applicable undesirable patterns or trends in performance that are being aggregated and analyzed
  - Use of data analysis in the identification and implementation of process improvements
  - Process for identifying and implementing changes to reduce the risk of sentinel events
  - Evaluation of performance improvement changes are made to ensure that they achieve the expected results
  - Process for taking appropriate actions when planned improvements are not achieved or sustained
  - Inclusion of data from external sources to determine if there is excessive variability or unacceptable levels of performance
  - Changes in PI activities to accommodate urgent events such as staffing effectiveness and patient health outcomes, high-volume, high-risk, or problem prone processes, significant changes in the internal or external environment
  - Home Health Compare Outcomes implementation and process changes
  - Proactive activities for identifying and reducing unanticipated adverse events and safety risks to patients are being performed

Rehabilitation Services
- Review and discuss:
  - Documented (Medicare only) plan of treatment prior to the beginning of treatment
  - Process for developing the plan of treatment (e.g., who orders the service, the type and duration of services, the identification of measurable goals and changes in patient’s response to therapeutic intervention, input from the family)
  - Role of interdisciplinary team and method of documenting team discussions/case conferencing

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

During an individual tracer, identify a patient who is undergoing waived lab testing by the organization’s staff. (Note: patients who are self testing are exempt from CLIA regulations). There are, however, staff that use the patient’s meter to test the patient or the patient/caregiver uses the patient’s meter for testing. The results of the testing are called to the physician for orders. In this case, staff would need to know the manufacturer guidelines and check that the guidelines are followed if they are going to call the results to the physician. Trace the organization’s process by:

- Reviewing documentation elements in the patient record (quantitative result and acceptable range)
- Interviewing clinicians about testing procedures, including:
  - Orientation and training about equipment use and testing process
  - Identification of tests completed by non-laboratorians in the specified location
  - Implementation of a waived testing quality control plan, including responsibilities
  - Validation that the organization (patient/family) completed quality control testing for the patient’s waived tests you are tracing
    - Organizations are no longer required to perform quality control checks on each day of testing. Organizations are now required to perform quality control checks per manufacturer’s 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 each type of test being traced
  - Reviewing additional data and trace where the data flows and its use in organizational performance improvement
  - Instrument maintenance
## DMEPOS – CMS Multi-Site Survey Criteria

**Applies to:** Home Care Accreditation Program, specifically HME and Pharmacy services

<table>
<thead>
<tr>
<th>Duration</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>NA</td>
</tr>
<tr>
<td>Organization</td>
<td>NA</td>
</tr>
</tbody>
</table>

### Criteria to follow for 100% survey of 24 sites or less per CMS

**Requirement** (November 17, 2011)

- A full survey is conducted with all required activities but all sites will need to be incorporated into the survey process.

### Multi-site surveys with a low ADC

- Survey time may be streamlined at the various locations so the activities noted below are the minimum requirements that must be validated at each site as follows:
  - Physical location is appropriate for size and services provided (i.e., licenses posted, personnel available, etc)
  - If personnel files are maintained at the location verify license and competency
  - Licensed as appropriate (check state requirements with mail order/shipping to other states)
  - Surety Bond
  - Use of appropriate CMS forms (i.e. review current supplier standards utilized by Organizations)
  - Physical inventory:
    - Verify types of equipment provided (should match E-Application)
    - Warranties and instruction materials are available
  - Medical records if available on site:
    - Conduct brief chart audit of at least 1 record to verify minimum requirements are present.
  - Retail locations you must conduct individual patient tracer (remote or live)
  - Other locations remote tracers should be conducted (minimum 1) to verify receipt of equipment
  - Sub Contractors if utilized:
    - Verify accreditation status and presence of a contract
  - Regulatory Review
    - Site’s Complaint process and Log (validate it meets CMS requirements)
    - Financial management processes (budget, reimbursement process if the site bills, tracking billing and coding errors)

---

**TIP: Traveling between sites:**

It is acceptable to use a portion of your day to travel to the next site if needed. If a full travel day is required to get to your next site, please know that additional time has been allocated in the complement. Your itinerary however will not indicate a Travel day as you can route and manage your travel time in a way that is most efficient for you and or as the Team Leader determines.

Please contact the assigned AE or your FD if you have questions or concerns with accommodating the required travel between sites.
**Individual Tracer – Mail-Order Business**

**Applies to:** Home Care Accreditation Program, specifically HME and Pharmacy services

<table>
<thead>
<tr>
<th>Duration</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable per Individual Tracer</td>
<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>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants</th>
<th>Before</th>
</tr>
</thead>
<tbody>
<tr>
<td>One surveyor</td>
<td>Individual tracers for mail order customers/patients are conducted during individual tracer activity time.</td>
</tr>
</tbody>
</table>

**Tracer selection**

Select tracers from the prioritized list of HME / supply products and the organization's volume and expectation of walk in customers/patients.

**TIP:**

Remember to verify that education and training occurred prior to or at the time of delivery.

**Home Visits**

There is no need for a home visit when the organization does not deliver to the home.

When products are mailed to the patient home, patient interviews are conducted either in person or telephonically.

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

If you obtain conflicting information about a policy or process, ask the individual coordinating the survey to obtain it for review at the next scheduled issue resolution time.

**Objective**

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

**Before**

- Individual tracers for mail order customers/patients are conducted during individual tracer activity time.
- Select tracers based on the HME/supplies provided by the organization, as well as those provided by the organization to Medicare beneficiaries that are included in the CMS Competitive Bidding process. High priority HME/supplies are identified from the priority listing in this Survey Activity Guide. In addition to the prioritized listing, consider the organization’s volume.
- Randomly select a cross representation of equipment and supplies. When mail order equipment and supplies are limited, randomly select patient/customer characteristics, such as age, diagnosis etc.
- When the surveyor is ready, an organization representative should call the customers for permission to be interviewed by the surveyor.

**During**

**Conducting an Individual Tracer for mail order business**

Individual tracers for mail orders should be performed concurrently, whenever possible.

- Introduce yourself to the technician, clerk or other organizational representative processing mail orders.
- Observe the entire process, including:
  - Review of documentation
    - Physician order procurement
  - Selection
  - Education about the product, including:
    - Storage
    - Use, including the verification process of patient’s ability to use the equipment
    - Operational checks, if applicable
    - Troubleshooting, if applicable
    - Ongoing maintenance / care needs
    - Re-ordering process, if applicable
  - Access information for the organization
- Interview the technician, clerk or other involved employee about:
  - Questions you have based on the transaction
  - Their knowledge about the product and how that knowledge was obtained
Conducting an Individual Tracer for mail order business - retrospective

- If the organization does not have any or has only a few mail orders to process, surveyors will conduct a retrospective review of mail orders processed within the past week. If there are too few mail orders from the past week, the surveyors will select mail orders from two or more weeks prior to the survey.

- Review documentation. **Look for documentation indicating that the organization validated that supplies were received.**

- Interview the technician, clerk or other involved employee about:
  - the organization’s processes for filling the requested need
  - assessment information obtained
  - selection process to ensure that the right supply or equipment is provided to meet the customer's/patient’s need
  - their knowledge about the products and how that knowledge was obtained
  - education provided to the customer/patient
  - the verification process of patient’s ability to use the equipment
  - verification of delivery process
  - process for re-orders, when applicable
  - follow up, if applicable

- Call the customer/patient to interview them about their experience. Ask questions about their interactions with the organization. Elicit feedback about:
  - Introduce self and briefly describe why you are calling
  - Coordination with the customer/patient for the education and delivery of supplies
  - Training and instructions provided by the organization – **note, these must be provided at the time of the initial mail order delivery or items!**
  - the verification process of patient’s ability to use the equipment
  - Storage of their equipment or supplies
  - Use of their equipment or supplies, including relevant infection control issues
  - Operational checks, if applicable
  - Troubleshooting, if applicable
    - Ongoing maintenance / care needs
    - Re-ordering process
  - Access information for the organization
• Re-ordering process
• Other, as applicable

After
• As necessary, review additional records to verify standards compliance issues identified during the Individual Tracer for walk in business.
• As necessary, Interview other customers/patients and families to validate the presence of problem issues found during the tracer
• Review pertinent meeting minutes and procedures if needed.
• Share problematic issues with other team members, if applicable, so they can be further explored in subsequent Individual Tracers.
Individual Tracer – Walk-in Business (Patient pick-up, Retail)

Applies to: Home Care Accreditation Program, specifically HME and Pharmacy services

Duration
Variable per Individual Tracer

Participants
One surveyor

Organization:
Staff involved in the patient’s services.

Tracer selection
Select tracers from the prioritized list of HME / supply products and the organization’s volume and expectation of walk in customers/patients.

Other information
There is no mandated order for visits to other care/service areas. One approach to conducting the Individual Tracer is to sequentially follow the course of care/services received by the patient however this is not always practical given the need to travel to patient homes.

Home Visits
There is no need for a home visit when the organization does not deliver to the home.

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

If you obtain conflicting information about a policy or process, ask the individual coordinating the survey to obtain it for review at the next scheduled issue resolution time.

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

Before
- Individual tracers for walk-in customers/patients are conducted during individual tracer activity time.
- Discuss the need for flexibility with the organization. Walk-in business cannot always be predicted.
- Plan to conduct individual tracers for walk-in business around other survey activities that can be interrupted. For example, surveyors can be interrupted from a planning session or issues resolution time.
- When a customer walks-in, the surveyor should stop the current activity to trace the walk-in process.
- Select tracers from the prioritized list of HME / supply products and the organization’s volume and expectation of walk-in customers/patients. Seize the opportunities as they present since the organization’s walk-in customer/patient needs may be unpredictable and varied.
- Ask the organization to explain the role of the surveyor and request permission for observation of the interaction.

During
Conducting an Individual Tracer for walk-in business - concurrent
- If the customer/patient has a scheduled arrival time, review documentation the organization may have on file prior to arrival
- Introduce yourself to the customer/patient.
- Provide the customer with a Joint Commission HME brochure.
- Observe the entire process, including:
  - Assessment
  - Selection
  - Education about the product, including:
    - Storage
    - Use
    - Operational checks, if applicable
    - Troubleshooting, if applicable
    - Ongoing maintenance / care needs
    - Re-ordering process, if applicable
  - Access information for the organization
- Interview the Medical Tech, clerk or other involved employee about:
  - questions you have based on the transaction
  - their knowledge about the product and how that knowledge was obtained
  - plans for follow-up, if applicable
Conducting an Individual Tracer for walk-in business - retrospective

- If walk-in customers/patients do not arrive while the surveyor is on-site, randomly select walk in customers/patients from the past week. (If no walk-in customers/patients existed in the past week, select a customer/patient from 2 weeks ago or longer, if necessary.)
- Review documentation.
- Interview the technician, clerk or other involved employee about:
  o the organization’s processes for filling the requested need
  o assessment information obtained
  o selection process to ensure that the right supply or equipment is provided to meet the customer’s/patient’s need
  o their knowledge about the products and how that knowledge was obtained
  o education provided to the customer/patient
  o the verification process of patient’s ability to use the equipment
  o follow-up, if applicable
- Call the customer/patient to interview them about their experience. Ask questions about their interaction with the organization. Elicit feedback about:
  o Storage of their equipment or supplies
  o Their ability to use their equipment or supplies
  o Operational checks, when applicable
  o Troubleshooting, when applicable
  o Ongoing maintenance / care needs
  o Re-ordering process
  o Access information for the organization
- As necessary:
  - Review additional records to verify standards compliance issues identified during the Individual Tracer for walk-in business.
  - Interview other patients and families to validate the performance observations found during the tracer.
  - Review pertinent meeting minutes and procedures if needed.
  - Share problematic issues with other team members, if applicable, so they can be further explored in subsequent Individual Tracers.

CMS identifies pertinent beneficiary healthcare information that may have an impact on the medical use of the prescribed equipment as:
- Diagnoses;
- Prognosis;
- Mental status;
- Functional limitations;
- Types of services and equipment required;
- Amount, frequency, and duration of treatments;
- Frequency of visits;
- Rehabilitation potential;
- Activities permitted;
- Nutritional requirements;
- Medications and treatments;
- Any safety measures to protect against injury;
- Instructions for timely discharge and/or referral; and
- Any other necessary information to ensure delivery of appropriate services.
Program Specific Tracer – Fall Reduction
Applies to: OME Applicability – HH/PC, HME, HSP

| Duration |
| Variable – approximately 60 minutes. |

| Participants |
| One surveyor |

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

| Rationale |
| Falls account for a significant portion of patient injuries in home care and health care facilities. According to the CDC, the most recent statistic (1999) demonstrated that falls in the home constitute the third leading cause of injury-related deaths among Americans of all ages and were the leading cause of injury-related deaths among people ages 65 and older. |

| | More than one-third of adults ages 65 years and older fall each year (Hornbrook 1994; Hausdorff 2001).* |
| | Falls are the leading cause of injury related deaths among older adults (Murphy, 2000)* and the most common cause of nonfatal injuries and hospital admissions. |

| Objectives |
| 1. Learn how the organization evaluates the patient’s risk for falls. |
| 2. Evaluate the action taken to reduce the risk of falling in a targeted tracer for a patient at high risk for falling. |
| 3. Understand the organization’s plan for reducing the risk of injury, should a fall occur. |
| 4. To identify processes and possibly system issues contributing to a high re-hospitalization rate. |
| 5. Evaluate the organization’s compliance with NPSG.09.02.01 (Reduce the risk of falls). |

| Before |
| Targeted Tracer Selection: |
| • Select this tracer: |
| o When surveyors identify one or more patients who fell one or more times |
| o When PI data reflects no improvement to fall statistics |
| • HH/PC/Hospice: Select a patient who fell at home while receiving home care services or a patient who is at high risk for falls (neuromuscular deficits, medications that decrease sensorium or increase urgency, etc. ambulation difficulties, use of assistive devices, incontinence, medications, patient education, progress notes indicating unsteady gait or reports of falls), or a patient re-hospitalized after a fall. |
| • HME: Select a patient using ambulatory aids or oxygen in conjunction with professional services |

| Conducting the Falls Reduction Individual Tracer |
| • Review the patient’s home care record noting any relevant issues, e.g. diagnosis, home layout, and fall risk issues. |
| • Interview the direct care provider about the following issues: |
| Assessment |
| o Risk assessment process for falls |
| o Input from caregiver, when appropriate. |
| o Plan for risk reassessment of the patient. |
| o Identification of in-home environment |
| Care Planning |
| o Incorporation of fall risk status into care planning |
| o Need for and use of additional services / equipment to prevent falls |
| o Plan to reduce the risk of injury to this high risk patient should a fall occur. |
| o Medication review – interventions taken to offset fall risk relative to falls |
| o Post fall follow-up action, process and timeliness |

Complex Organization
Preparation for home safety begins prior to hospital discharge.
If patient admitted to home care from the hospital, ask hospital surveyors to review inpatient record, looking for: |
• Home safety questionnaire |
• Education |
• Risk assessment |
• Communication hand-off to home care – was there an opportunity to ask questions?
Communication process to internal and external care providers
Interdisciplinary approach to patient care
Communication of relevant information.

Education
Fall reduction education provided to the patient and caregiver
Education provided to the staff about fall reduction processes
How does the organization evaluate the effectiveness of education

Conduct a home visit and interview patient/caregivers about:
- Discovered or noted unsafe environmental issues that could lead to a fall, e.g., throw rugs, cluttered paths, uneven surfaces, dim lighting, etc.
- Relevancy of patient’s medications to potential for falls – organization identification and actions.
  Note: Be alert - current literature provides a cautionary note about medication errors resulting from incorrectly pre-filled medication cassettes!
- Knowledge level about their fall risk status and preventative techniques to remain safe at home.

Interview other care providers
- Validate the timeliness and content of communications

After
- As necessary, review other fall reduction planning documents, including the organization’s evaluation of their program and follow-up on identified issues
- Verify standards compliance issues in other patient home care records
- 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.


# Program Specific Tracer – Community Based Palliative Care (CBPC)

**Applies to:** OME Applicability – HH and/or Hospice organizations that are pursuing CBPC Certification

<table>
<thead>
<tr>
<th>Duration</th>
<th>Variable – approximately 60 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>One surveyor</td>
</tr>
<tr>
<td>Organization</td>
<td>Staff and management who have been involved in the individual's care, treatment, or services</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
</tr>
<tr>
<td></td>
<td>Caregivers</td>
</tr>
</tbody>
</table>

## Objectives
- Learn how the organization provides care for patients receiving CBPC services.
- Observe the role of the IDT and the core members of the IDT in planning and providing care.
- Evaluate the organization’s compliance with standards as they relate to the care, treatment, and services provided for patients receiving CBPC services.
- Identify processes and possibly system issues that may contribute to a lack of effective community-based palliative care services.

## Targeted Tracer Selection:
- Select this tracer format for the patients selected for home visits as part of the CBPC Certification.

## Conducting the CBPC Individual Tracer
### Before:
- Compliance with the program’s admission criteria for CBPC services (PC.01.01.01, EP49)
- Review the patient’s medical record noting any relevant issues, e.g. diagnosis, services ordered and provided, plan of care

### During:
- IDT members’ interaction with patient and family
- Initial assessment and reassessment of patient and family needs (including physical, psychosocial, functional, spiritual, and psychological assessments) (PC.01.02.01, EPs 46-52)
- Assessment and reassessment of patient’s physical symptoms and action taken to decrease physical symptoms (such as pain, dyspnea, nausea, etc.) (PC.02.02.01, EPs 23-24)
- For pediatric patients: assessment of developmental stage and needs of patients and families (PC.01.02.01, EPs 28, 29)
- Development and implementation of the patient’s plan of care (PC.01.03.01, EPs 49-50)
- Process for arranging both internal and community services for CBPC patients (PC.01.03.01, EP51, PC.02.02.01, EP24)
- How the CBPC interdisciplinary team members collaborate and share information with each other and with other staff when
conducting assessments and reassessments. (PC.02.01.09, EPs 35-36; PC.02.02.01, EP26)

- Information and education that is provided to the patient and family concerning symptoms, diagnoses, community resources, etc. (PC.02.02.01, EP 24; PC.02.03.01, EP32; PC.04.02.01, EP9)

- Documentation of advance directives, treatment preferences, and advance care planning discussions (RC.02.01.01, EP 31-32; RI.01.05.01, EP23)

- Patient and/or family involvement in developing the plan of care and patient-centered goals of care (PC.01.03.01, EP49-50; PC.02.01.05, EP37)

- Interdisciplinary team and staff deliver CBPC care and services, including symptom management, according to the patient’s plan of care (PC.02.01.01, EPs 20 and 23)

- Use of current clinical practice guidelines in the provision of CBPC services (LD.04.04.09, EP7)

After

- As necessary, review patient’s medical record for documentation of services according to patient’s plan of care.

- Consider the relationship of your observations to program/organization level issues.

- Share any 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.
## Program Specific Tracer – Hospital Readmission

### Applies to:
OME Applicability – Medicare Certified Home Health Care

### Duration
Variable – approximately 60 minutes.

### Participants
One surveyor

**Organization:**
- Staff and management who have been involved in the individual’s care, treatment, or services.
- Patient
- Caregivers

### Rationale:
For the past five years, Medicare OASIS data outcomes demonstrate a high hospital readmission rate. This is one area that organizations have not been able to impact. This tracer is targeted to organization with high readmission rates and provides surveyors with an opportunity to focus on the organization’s processes that could decrease the need for re-hospitalization.

### Objectives
1. Evaluate the action taken to reduce the hospital readmission rate.
2. Evaluate the accuracy of medication reconciliation and education, a leading cause of re-hospitalization.
3. Identify processes and possibly system issues contributing to a high re-hospitalization rate.

### Before

**Targeted Tracer Selection:**
This tracer is conducted when the:
- Medicare certified HH organization has a significantly higher percentage of patients who:
  - had to be admitted to the hospital
  - need urgent, unplanned medical care

When possible, identify a patient who was recently resumed post re-hospitalization

### During

**Conducting the Hospital Readmission Individual Tracer**

- Begin the Individual Tracer where the patient’s home care record is maintained.
- Review the patient’s home care record. Considering the reason for readmission, review the patient assessment findings, care planning, problem identification, medication regime and patient education. *(Most re-hospitalizations in home care are related to the use of Coumadin and Heparin – Fazzi and Associates NAHC Report.)*
- Look for evidence of timely communication and coordination with internal and external care providers.
- Interview the case manager or direct care provider about the following issues:
  - *Entry into care*
    - Compliance with the organization’s admission criteria
  - *Assessment*
    - Relevance of information gleaned during patient assessment
  - *Care Planning*
    - Use of assessment information
    - Inclusion of the patient’s caregiver and support system
    - Reassessment of the patient.
    - Need for and use of additional services, e.g. home health, medical equipment, PT, OT, aide, assistive devices, and MSW for available resources
    - Appropriate follow-up to high risk issues, e.g. nutritional, fall, etc.
    - Medication review
Coordination

- Hand off communications with the hospital or "emergent care" setting at the time of transfer (note: this may be when the organization first realized there was a transfer) – content, timeliness, coordination with others
- Interdisciplinary approach to patient care – coordination with others about care need changes relative to re-hospitalization

Education

- Content and timelines - condition, medication side effects, symptoms to report, who to report symptoms to
- Evaluation of effectiveness of education
  - Conduct a home visit – interview patient/caregiver about:
    - Conditions leading to re-hospitalization
    - Review medications – evaluate reconciliation process Note: Be alert - current literature provides a cautionary note about medication errors resulting from incorrectly pre-filling medication cassettes
    - Knowledge about their condition and treatment. Education materials received from organization
  - Interview other care providers
    - Discuss communication and coordination issues, as applicable

After

As necessary, review:

- Other hospital readmission related planning and performance improvement documents and follow-up on identified issues
- Verify standards compliance issues in other patient home care records
- 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
Special Issue Resolution
Applies to: All accreditation programs in which the survey lasts more than one day

<table>
<thead>
<tr>
<th>Duration</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 minutes</td>
<td>Further investigate and resolve any open issues from previous survey activity</td>
</tr>
</tbody>
</table>

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

**Organization:**
As requested by the surveyor(s) depending on the performance observations identified for discussion

**Before**
- If necessary, inform your organization contact of who you would like to attend the session.
- Inform your organization contact of the documentation you would like to have for review during this session.
- Remind the organization of any promised items that you are still waiting for them to provide for your review.

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

**Duration**
30 – 60 minutes

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

**Organization:**
None

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

**During**
Surveyor(s) should:
- Review and discuss their observations with other surveyors when applicable
- Report on the National Patient Safety Goals they have evaluated
- Think about and review connections between observations and systems. Plan the approach to survey activities for the next day.
- Team leader should ensure that a process is in place for all surveyors to participate in this session.
  - Participation may be via Conference Call Bridge Lines for all surveyors to call in if surveyors are at multiple sites (phone lines are located on the Surveyor Portal).
- Establish areas of focus for subsequent tracer activity based on identified concerns.
- Discuss the observations made to date and where the EPs are likely to appear on the SAFER™ matrix as of this point in the survey; consider appropriateness of the potential EP placement on the matrix each day of a multi-day onsite event
  - Each observation entered in WST will require the surveyor to identify the likelihood for harm, as well as the scope of the issue.
  - WST will auto-populate the SAFER™ matrix with standards and EPs based on the surveyor designation of likelihood to harm and scope of the issue identified with each observation entry
    - Note: The organization will not see the identified likelihood to harm and scope of the issue at the observation level. This is only displayed at the EP level based on where it appears in the matrix.
  - Auto-population of the standards and EPs within the matrix is based on the worst-case observation in terms of likelihood to harm and scope of issue designation. For example, if there are multiple observations under one EP, by one or more surveyors, the observation with the most likelihood to harm is used, and the issue with the greatest
scope is used to determine where the standard and EP will appear in the matrix.

- Surveyors are able to override the matrix auto-population of a standard and EP if, based on their expertise, observations and judgment, they disagree with the placement. See Report Preparation section for further information on how to edit the matrix.

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

**After**

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

<table>
<thead>
<tr>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approximately 15-30 minutes per survey day</td>
</tr>
<tr>
<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 (that is, if the surveyor will be moving to a different survey site the next day.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide organization representatives with a brief summary of survey activities of the previous day</td>
</tr>
<tr>
<td>• Relay observations according to standards area and note observations related to general program or organization-specific risk areas.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>During</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Briefly and concisely summarize survey activities completed on the previous day. Do not go into depth regarding the patient or surveyor activities.</td>
</tr>
<tr>
<td>• Make general comments regarding significant issues.</td>
</tr>
<tr>
<td>• Do not repeat observations made at a previous daily briefing unless it is in the context of identifying a systemic issue.</td>
</tr>
<tr>
<td>• Do not discuss in detail each survey activity, specific records, and discussions held with individuals during Individual Tracers.</td>
</tr>
<tr>
<td>• Address requests for consultation on findings by scheduling a time for such consultation to take place.</td>
</tr>
<tr>
<td>• Emphasize significant performance patterns or trends in a given standards area that could lead to non-compliance determinations.</td>
</tr>
<tr>
<td>• Inform attendees that final findings for any given standard will be available only when all activities are complete and results are aggregated, especially if multiple surveyors are on-site.</td>
</tr>
<tr>
<td>• Answer attendees’ questions and clarify your comments where requested.</td>
</tr>
<tr>
<td>• Review the agenda for the day (including identifying Individual Tracer candidates).</td>
</tr>
<tr>
<td>• Make necessary adjustments to plans based on organization needs or the need for more intensive assessment of an issue.</td>
</tr>
<tr>
<td>• Inform the organization when a system tracer is planned for that day. Note that participants should include management and pertinent program staff.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>When multiple surveyors are on site, this session is conducted jointly. In such cases, team members may take turns presenting findings. Surveyors at distant locations can join the discussion telephonically, whenever possible.</td>
</tr>
</tbody>
</table>

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 surveyors then share this information with attendees on behalf of the absent surveyor as necessary.

Suggestions for use of RPI tools*
• WWW
• Parking Lot
• Active Listening
• Checklist

*You can find more information in the Robust Process Improvement (RPI) Tip Cards for Field Staff.

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

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

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

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

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

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

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

**At the last day Daily Briefing**

- **Remind the organization of any items they have promised and you are still awaiting**

- **Remind the organization that all items that they want you to review or people they want you to interview to clarify surveyor reported observations and findings must be accomplished at the start of the Report Preparation session**
### Competence Assessment Session

**For CBPC Certification option: Includes Credentialing of Licensed Independent Practitioners**

** Applies to:** All accreditation programs.

<table>
<thead>
<tr>
<th>Duration</th>
<th>30 - 60 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participants</strong></td>
<td>Joint Commission: One surveyor.</td>
</tr>
<tr>
<td>Organization:</td>
<td>Individuals responsible for:</td>
</tr>
<tr>
<td></td>
<td>- Aspects of the organization’s human resources processes.</td>
</tr>
<tr>
<td></td>
<td>- Orientation and education of staff.</td>
</tr>
<tr>
<td></td>
<td>- Assessing staff competency.</td>
</tr>
<tr>
<td></td>
<td>- Assessing licensed independent practitioner and other credentialed practitioner competency, when applicable.</td>
</tr>
<tr>
<td>Individual(s) with authority to access information contained in personnel and, when applicable, credentials files.</td>
<td></td>
</tr>
</tbody>
</table>

**File review**

Review files during this session or as part of Individual Tracers or during the Special Issue Resolution session.

- The organization’s process for maintaining competency records should guide your decision on the timing for file review. For example, if files are maintained by supervisors or managers in the area where an individual works, file review is perhaps most easily accommodated during Individual Tracers.

**Other information**

In multi-program surveys, one surveyor should conduct this activity for all programs.

- Each member of the survey team is responsible for supplying this surveyor with relevant topics and issues for discussion and identifying files for review, or conducting file review during Individual Tracer activity and reporting on their observations.

**Objectives**

1. Learn more about the organization’s competence assessment process for staff, licensed independent practitioners, and other credentialed practitioners including contracted personnel.
2. Learn more about the organization’s orientation, education, and training processes as it relates to staff, licensed independent practitioners, and other credentialed practitioners encountered during Individual Tracers.
3. Discuss competence assessment process-related strengths and potential risk points.
4. For organizations pursuing the CBPC Certification: Learn more about the credentialing process for licensed independent practitioners.

**Before**

- Review a sample of personnel files during tracer activity
- Review related policies and procedures, when appropriate, during tracer activity

**During**

- Using data gathered during Individual Tracer activity, engage attendees in discussion of the following topics:
  - Internal processes for determining compliance with policies and procedures, applicable law and regulation, and Joint Commission standards
  - Methods used to determine staffing adequacy; frequency of measurement; what is being done with the results
  - Performance improvement initiatives related to competency assessment for staff, licensed independent practitioners, and other credentialed practitioners
  - Orientation of staff, licensed independent practitioners, and other credentialed practitioners to the organization, job responsibilities, and/or clinical responsibilities
  - For CBPC staff: Orientation requirements for IDT members and staff providing care for patients in the CBPC program (HR.01.04.01, EPs 24-25)
  - Experience, education, and abilities assessments
  - Ongoing education and training
- For CBPC staff: Ongoing education that aligns with clinical practice guidelines and current best practices in community based palliative care (HR.01.05.03, EP27)
Suggestions for use of RPI tools*
- Threat vs. Opportunity Matrix
- WWW
- Process Map

*You can find more information in the Robust Process Improvement (RPI) Tip Cards for Field Staff.

Competency assessment, maintenance, and improvement

Competency assessment process for contracted staff, e.g., temp, agency, travelers (unless a concern is identified with a specific individual, focus contract review on contractors that are not Joint Commission accredited)

Inquire about employee health screening and health requirements (e.g., vaccinations, immunizations) for working in the organization; ask about the process for monitoring compliance with such requirements

Other issues discovered during Individual Tracers

Evaluating Compliance with Medication Compounding Competency Standards

From the list of compounding staff, review 20% of staff records (a minimum of 10 records). This review will seek documented evidence of:
- Media fills,
- Glove fingertip testing, and
- Most recent observation of compounding technique.

The files to be reviewed will include files for each of the compounding staff members that the surveyor observes during pharmacy visits and compounded medication tracer activity

A minimum of two (2) staff members who are involved in the cleanup and disposal activities associated with medication compounding

A minimum of two (2) staff members that are involved in storing, packing, and delivering compounded medications

NOTE: This review also includes 20% of the pharmacy services staff members who only compound on an occasional or part-time basis (staff that may compound, but it is not the primary duty in their job description).

Credentialing and Privileging Licensed Independent Practitioners (LIPs)

Review the personnel or credentials files of LIPs (MD, APN, PA) on the interdisciplinary team and one or more LIP that is serving in a leadership/manager role in the CBPC program for evidence of broad-based education and experience in the provision of palliative care.

Review a sample of credentials files for LIPs (MD, APN, PA) for the following:
- state licensure, registration, or state certification as applicable
- training and pertinent experience
- scope of privileges granted (if applicable)
- evidence that they are legally and professionally qualified to exercise privileges granted
- evidence of reappraisal within the timeframe specified in the organization’s policy

Review the personnel file of the individual responsible for oversight of the CBPC program (if person is an LIP)
Review personnel files of selected practitioners and staff for qualifications and competency assessments related to assigned responsibilities

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

**After**

- Verify through review of a sample of employee health files any documentation that staff has undergone required health screenings.
- Request files based on patient care activities performed that may require special education or competency assessments.
- Competency assessment process for contracted staff, e.g. temp, agency, travelers.
- Consider the relationship of your observations to system level performance.
- Share performance observations and trends with other team members, if applicable so they can be further explored in subsequent Individual Tracers.
Environment of Care and Emergency Management – OME
Applies to: AHC, BHC, LAB, NCC, OBS, OME accreditation programs

**Duration - Variable**
Approximately 30 - 60 minutes; however varies by length of survey and services offered by the organization

**Participants**
One surveyor
Organization: Individuals able to address issues related to the management of the environment and associated risks
IT Representative, if applicable
Note: In most organizations individuals may be responsible for multiple roles.

Review the changes made to NPSG.15.02.01, effective 1/1/15.

**TIP:** Be sure to include responsible staff members during the “out and about” portion of the tracer. Give the staff responsible for managing the particular process or risk reviewed opportunity to provide information regarding their role in addressing any vulnerability you observe.

**Objectives**
- To assess the organization’s degree of compliance with relevant standards and identify vulnerabilities and strengths in the organization’s EC management processes.
- Learn how the organization processes equipment and supplies from initial receipt through decommissioning.
- Evaluate the implementation effectiveness for specific pieces of equipment.
- To identify processes and system performance contributing to failed equipment/supply management.
- Evaluate the organization’s preparedness for emergencies in the organization and disasters in the community that could affect their capability to provide care, treatment and service.
- Evaluate the organization’s compliance with NPSG.15.02.01 (Identify risks associated with home oxygen therapy such as home fires).

Note: Specific emergency management evaluation activities related to CMS Deemed Status requirements for home health agencies and hospice are indicated with appropriate headers.

**Before**
- Ask organizations to bring the following documents with them for reference:
  - Management plans, as indicated in matrix below, as required by the services provided.
  - Safety data analysis and actions taken by the organization, as per EC.04.01.03.
  - CMS Deemed Status HHA and Hospice only: Annual review and update of the Emergency Operations Plan.
  - CMS Deemed Status HHA and Hospice only: Documentation of emergency management training provided to staff, volunteers, and individuals providing on-site services under arrangement. Training is consistent with the individuals’ role in the organization and in emergency response plans, and is conducted at least annually and when these roles change.
  - Volunteers may be individuals in the organization performing non-clinical functions, or may be skilled providers who regularly volunteer or come in response to particular events or incidents. Contractors may be on-site only sporadically. Training should be consistent with their usual responsibilities and role (if any) in the emergency response plan.
  - CMS Deemed Status HHA and Hospice only: Determine if the organization participates in an integrated emergency preparedness program in its system. Note: The integrated system evaluation is important in terms of coordination of emergency preparedness efforts and plans, but most time
During this session should be devoted to evaluating the individual organization’s preparedness and response capabilities.

- Review the organization’s performance from drill activity. Drills are required for emergency management (all programs) and fire (Hospice, Ambulatory Infusion, Respiratory Therapy).
- Review any changes to the Emergency Operations Plan based on the organization’s evaluation of exercises and responses to actual events.
- Review notes from the planning session
- Annual evaluations of the EC management plans
- EC multidisciplinary team meeting minutes for the previous 12 months
  - Review EC-related issues observed in previous survey activities (including those made by other survey team members). Analyze the data collected on survey up to this point and identify strengths and opportunities for improvement in management processes related to EC risks.
  - Management processes include:
    - Plan
    - Teach
    - Implement
    - Respond
    - Monitor
    - Improve
    - EC-risks include:
      - Safety
      - Security
      - Hazardous materials and wastes
      - Emergency management
      - Fire safety
      - Medical/Laboratory equipment
      - Utilities
      - Construction

During
Environment of Care and Emergency Management Discussion

- Engage attendees in discussion about their EC practices. Focus on high-risk areas, e.g. life sustaining medical equipment, fire prevention activities, emergency management planning and outcomes of drills, outcomes of incident investigations etc.
- Review the organization’s performance in addressing the Emergency Management chapter of standards, that is, review its performance in:
  - Identifying potential risks and emergencies.
  - Determining their response strategies (e.g., maintaining or expanding services, curtailing services, working with alternative care site, closing and reopening after emergency, evacuation) and how the Emergency Operations Plan (EOP) supports these strategies.
• Identifying its role in relation to the community’s, county’s or region’s emergency management program (including relationships with other health care providers, linkage with the community’s incident command structure, etc.).

• Determining if they will shelter in place vs evacuating or closing. If sheltering in place:
  o Inquire about how they determine which staff will remain on-site
  o Inquire about how provisions for necessary space, utilities, and supplies will be made

• CMS Deemed Status Inpatient Hospice only: Identifying alternative site(s) for care, treatment, and services and developing evacuation procedures that meet the needs of its patients during emergencies:
  o Determine that the organization has a procedure for addressing 1135 waivers that, at a minimum, describes how to contact the authority responsible for 1135 waivers should such waivers be needed for the organization to provide care at an alternate care site
  o Ask the organization to describe its process for transporting patients (and required medication, support staff, supplies, equipment, etc.) to the alternate care site(s);
  o Safety procedures for patient evacuation, including decision-making regarding where patients will be evacuated to based on clinical needs, transportation arrangements, etc.

• CMS Deemed Status HHA and Hospice: Addressing patient care and clinical support activities, including
  o services for any vulnerable patients (geriatric, disabled, chronic conditions, etc) served by the organization
  o additional populations that could be cared for based on the organization’s capabilities.
  o a system of medical documentation that preserves patient information during an emergency; protects confidentiality and availability, and includes back-up systems for mitigating loss of information due to cyber failures or intrusions

• CMS Deemed Status HHA only: As part of patient assessment, an emergency plan is documented for the patient that advises the patient of steps to take if an emergency in the organization or community disrupts their care, treatment or service. Review this documentation through clinical record review, and ask the organization how the patient or patient’s family is oriented to this plan.

• Inpatient Hospice only: Preparing for how the organization will manage:
  o the personal hygiene and sanitation needs of its patients, residents, and staff during an emergency.
  o maintaining temperatures at a level that protects patient health and safety and the safe and sanitary storage of provisions.
• CMS Deemed Status HHA and Hospice only: Maintaining essential communication and location capabilities and processes:
  o Tracking the location of on-duty staff during emergencies
  o Communicating with and supporting agency staff in conducting patient visits safely during disaster response and recovery
  o Tracking the location of patients sheltered on-site
  o Incorporating volunteers and federally designated health care professionals into staffing strategy during emergencies as relevant to the emergency and organization need
  o Processes for informing state and local officials about patients they cannot contact or who may need evacuation, and on duty staff they cannot contact

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

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

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

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

• CMS Deemed Status HHA and Hospice only: Discuss with the organization the type of emergency preparedness training provided (for example, classes, webinars, self-study modules, conferences) and how they determine which groups of staff - disciplines, departments, shifts, etc – receive education and
training and why. Discuss how staff performance in emergency exercises or actual responses is used to inform additional education or training. Review attendance lists for orientation and training activities.

- **CMS Deemed Status Hospice only:** Ask leadership how they make the emergency management plan available to staff and any relevant volunteers. During tracer, ask staff if they have had the opportunity to review the plan in the past 12 months.

- Designing and performing exercises consistent with patient care and service plans defined in the EOP. Exercise design can be tabletop, functional, or some hybrid of the two, but should be demanding enough to surface weaknesses, gaps or opportunities for improvement in the organization’s response effort.

  - **CMS Deemed Status HHA and Hospice only:** Two exercises (or activations of the EOP in response to actual emergencies) are required each year. One of the exercises may be a tabletop exercise. The other must be an operations based exercise that is conducted either as part of a full scale community exercise, or as an exercise within the organization.

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

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

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

- **Discuss with leaders:**
- IT system integrity support for maintaining high reliability in care, treatment, or services.
- IT participation in system risk identification and prioritization, and planning for system emergencies that might impact care, treatment, or services.
- Updates received by leadership on cyber risk analysis or the state of cybersecurity, including who provides the updates and how frequently they are provided.
- Leadership support for IT system resilience through EM preparedness activities that mitigate risk of cyber attacks that could impact care, treatment, or services.
- **Discuss with staff involved with emergency management planning how they collaborate with other staff to address potential cyber emergencies. Suggested discussion topics include:**
- How IT is represented in or informs EM activities related to risk identification or development of the organization’s emergency management plan.
The organization’s emergency management planning related to information management, primary and back-up communications, and patient care and support.

How medical devices, care, treatment or service equipment, and care-related utilities (medical gas, electricity, water, etc) that are connected to the internet are protected from unauthorized access, catastrophic failure, or malicious attack.

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

CMS Deemed Status HHA and Hospice only: Integrated Healthcare System Member Organization

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

Review the following materials:

- Organization chart or similar document describing the system’s integrated emergency preparedness program.
- The system’s integrated emergency preparedness plan.

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

Ask the organization to describe its participation in the system’s integrated emergency preparedness planning processes, plan and preparedness activities. Query about the following:

- Ask how they were involved in developing the system’s integrated emergency preparedness program.
- Ask who has been designated to facilitate coordination with the system on integrated emergency preparedness planning.
- Ask about any unique circumstances, patient populations or services in their organization relevant to emergency preparedness, and how they informed the development of the system’s integrated program. Review supporting documentation.
- Discuss how the organization participated in risk assessment activities as part of the system’s integrated emergency preparedness program, including prioritization of risk. Review supporting documentation.
- Ask the organization to talk through the system’s integrated emergency preparedness plan. Discuss how the organization is involved in on-going preparedness activities, especially related to integration of communications, training, and exercises. Review supporting documentation.
Ask how the organization participated in the annual review of the system’s integrated emergency management program. Review supporting documentation.

Ask the organization to discuss the system’s current program status with respect to their organization’s involvement—what integration activities are currently implemented, and what activities are in planning, design, or development phases.

Environment of Care and Emergency Management Tour

CMS Deemed Status HHA and Hospice only:
Emergency Management - During tracer activity, ask staff about any orientation or training they received in emergency preparedness roles or responsibilities, and of any involvement in emergency management exercises or responses to actual emergencies. Review personnel files if necessary to support evaluation of staff involvement.

Home Based services:

- In the office -observation of office based vulnerabilities are dependent on the organization’s processes. For example:
  - Safety and security issues, relative to community location and on-call staff
  - Fire safe practices – storage of equipment
  - Acceptance, processing and discarding of hazardous waste returned from the homes
- In-home observation of high risk vulnerabilities are conducted as part of the individual tracer during home visits, e.g. trace:
  - Rx. equipment and supply delivery
  - Storage of high risk medications
  - Hazardous waste management
  - Utility failure back up plans
- In-home oxygen risks (home health, hospice, durable medical equipment, respiratory care, and clinical respiratory services). NPSG.15.02.01 has new and modified requirements.
- Frequency of Assessment - Determine that the organization conducts a risk assessment at initiation of oxygen therapy or when home care services are initiated for patients on oxygen. Inquire if the organization has a protocol, policy, or regulatory requirement that specifies timing or triggers after initial assessment, and survey the organization against these. Please note: The 2015 current EPs require reassessment at intervals set by the organization. Evidence of patient non-compliance with safety precautions may be used to establish these intervals.
- Expectations in Risk Assessment - Examples of potential fire risks the home care organizations might identify include the following:
  - cigarettes, cigars, pipes
  - matches, lighters, candles, incense
  - space heaters (especially in cluttered areas), gas fueled water heaters, gas fueled stovetops
  - fireplaces and wood stoves
  - toasters, toaster ovens, and other appliances that give off excess heat (these should not be operated by a patient while he or she is also using oxygen)
The risk assessment should be documented.

- Smoke Detectors - Determine whether the organization ascertains if a functional smoke detector is present in the home. The organization may use visual observation – the smoke detector is mounted to the wall, an indicator light shows proper color for functioning, etc – but is not required to test or inspect the smoke detectors. The organization may also use patient/caregiver interview as the source of information on whether the smoke detector is functional.

- Patient and Family/Caregiver Comprehension and Compliance - Determine that the organization assesses and documents comprehension of the individuals in the home at the time a new treatment or service is initiated, and patient compliance at initiation of treatment/service or upon next revisit.

- Strategies for non-compliant patients: When unsafe practices are observed in the home, the organization needs to address them by either notifying the physician ordering the oxygen, providing additional education, placing written reminders in the home, or exploring alternate living arrangements with the family. The organization should document that these or other strategies were used.

- Accountability when there are multiple providers serving home oxygen patient - Each provider who has contact with the patient in the home should assess risk, educate, and assess comprehension and compliance. Ascertain that the organization does so consistent with the scope of service the organization provides to the patient.

### All Facility Based Services (Inpatient hospice, facility based RT and ambulatory infusion):

- Trace high risk processes relative to the services, location and vulnerabilities. For example:

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

- Security – trace the controls established by the organization for one of its risks, identified in any risk assessment activity; trace the processes for access to the building.

- Hazardous Materials – trace the disposal of hazardous waste.

- Fire Safety – use the outcomes of the organizations fire drills to trace identified problematic issues; trace the process for reporting a fire through to a mock activation of emergency response; trace the storage of combustible materials.

- Equipment Management – trace the use of organization owned equipment for multiple patient use; trace the medical equipment maintenance (note: this is completed as part of the Equipment Supply Management Tracer in HME companies).

- Utilities – trace the performance and safety testing of important components, e.g. emergency back-up generator; alternate energy to maintain fire detection, extinguishing, and alarm systems); trace the process for ensuring that the right utility power requirements are implemented for equipment; trace the process for resupplying and maintaining piped medical gas.

- Conclude the session by summarizing strengths and risk.
After

- Consider the relationship of your observations to system level issues
- Share problematic issues with other team members, if applicable, so they can be further explored in subsequent Individual Tracers
# Emergency Management Lessons Learned

## Tips and Examples

<table>
<thead>
<tr>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planning</strong></td>
</tr>
<tr>
<td>Planning</td>
</tr>
<tr>
<td>In considering risks and planning, the organization should consider not only the emergencies that impact the immediate area, but also emergencies that might impact their suppliers in adjacent communities (for example, contamination of community’s water supply might affect cleaning or sanitizing certain durable medical equipment or off-site laundry service). Where alternate suppliers may be indicated, pre-planning with such suppliers can be initiated.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Communication</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication via social media</td>
</tr>
<tr>
<td>Informally, many staff became aware of incidents in the organization via social media before receiving official notification from their managers. Many organizations found social media to be more effective than their mass communication plans and have incorporated it in various ways to communicate with staff, patients, the community, and traditional media. In one emergency where there was an explosion in the community:</td>
</tr>
<tr>
<td>• One organization developed a ‘disaster blog’ to keep internal staff apprised of information from incident command.</td>
</tr>
<tr>
<td>• Another organization began sending out regular updates on the number of patients affected, types of health risks, etc., to their health care partners.</td>
</tr>
<tr>
<td>• Another organization requested blood donors and other volunteers on its Facebook site, and over 250 people came to provide assistance.</td>
</tr>
<tr>
<td>Communication via Media - national and international</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 organization</td>
</tr>
<tr>
<td>• Decides (in advance to the extent possible) the type of circumstances and conditions under which media can be allowed access to patients for interviews with patient consent; organization can then aid patients or family members in the interaction with local, national, or international media.</td>
</tr>
<tr>
<td>Communication Systems</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>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>STAFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Support</td>
</tr>
<tr>
<td>In planning for community disasters where staff’s homes may be compromised (such as tornados, hurricanes, wildfires), create a plan for staff sheltering, meals, and transportation. Adjust staff rotations and schedules. Provide support for longer days or transportation where possible.</td>
</tr>
<tr>
<td>Staff Planning</td>
</tr>
<tr>
<td>Communicate proactively with staff at the start of response and throughout as early each day as possible so that a sufficient number and type of staff deploy to the right location when needed for services being provided that day. In a community explosion, each of three satellite facilities had additional off duty employees report for work unsolicited when the explosion was reported through the media; many were sent home.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>EXERCISES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercises</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH CARE PARTNERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care partners - utilities</td>
</tr>
</tbody>
</table>
| Community-based providers have partnered effectively with inpatient settings to share information, maintain situational awareness, and support response. Following a contamination of the community water supply, a local ambulatory dialysis company:
| - mobilized its biomedical engineer, and maintained contact with its regional director and the command center at its affiliated hospital throughout the incident.
| - through its national contract, acquired a 6000 gallon tanker truck within 4 hours, rigged up a distribution center, and worked with hospital building engineers and local fire department to provide for proper pressurization to operate hospital equipment and services until community water services were restored.
kept in touch with the CDC and the EPA in an attempt to identify the specific contaminant. Because clear information was not available and it was difficult to measure the contaminant in the field, they worked with a competitor dialysis provider to share information, sampled water at the hospital, and contracted with an independent laboratory.

Improved its preparedness going forward by mapping the water sources for each of its sites; and including review of the EM plan as a standing agenda item in its monthly meetings with its affiliated hospitals.

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

**Health care partners – mass casualty event**
Organizations can consider how physician practices, home care agencies, nursing homes, and behavioral health providers can partner with inpatient settings to support response. Following an explosion in which local hospitals received patients from the community and a nursing home fire:

- Local ENT specialists were mobilized for care in the community via the state’s Regional Advisory Council (RAC).
- Hospitals utilized in-house behavioral health staff, employee assistance programs, pastoral services and grief counselors to support patients, first responders, staff and community.
- Local nursing homes coordinated among themselves and contacted the hospitals to let them know how many displaced nursing home residents they could take from each hospital.
- Hospital case managers helped with patient placement for two weeks post event, including coordination with affiliated home care providers.

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

**Recovery**
Recovery
Recovery can takes months and sometimes years; long term psychological impacts on staff to consider include:
- need for ongoing empathy
- identifying and mitigating triggers of overreaction, fear, etc.
- role of leadership in seeing battle fatigue in self and others
Life Safety Code® Building Assessment – Home Care
 Applies to: Home Care accreditation program

<table>
<thead>
<tr>
<th>Duration</th>
<th>45 – 60 minutes</th>
</tr>
</thead>
</table>

**Participants**
One surveyor

**Organization:**
- Person who manages the organization’s facilities
- 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 sprinkled and the ceiling is smoke tight, the walls may terminate at the ceiling line.)
- The presence or absence of required smoke detectors or fire dampers.
- The presence or absence of required fire proofing on structural members such as columns, beams, and trusses.

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

**Home Care Applicability:** This session only applies to facilities with hospice beds that are either:
- In a freestanding, inpatient hospice facility or
- In a segregated hospice unit within a hospital or nursing home that is not accredited by The Joint Commission.

**Note:** Effective July 1, 2015, these type of hospice settings must adhere to the Life Safety Code® for Healthcare Occupancy standards LS.02.01.20 through LS.02.01.70 (based on the requirements of Chapters 18/19 of the NFPA Life Safety Code, 2012 edition (NFPA 101-2012, 1.4)).

**Objectives**
1. Evaluate the effectiveness of the organization’s processes for designing and maintaining buildings to Life Safety Code (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 organization contact that you will need the following items for this session:
  - Ladder
  - Flashlight
  - Keys or tools necessary to gain access to all locked areas and spaces above ceilings. Identify where you will meet the facility manager and other attendees to initiate this session.
- Review the report of available Basic Building Information (BBI) through the surveyor itinerary. The report contains sites/buildings information and the History Audit Trail.

**During**

**Conducting the LSC Building Tour**
- Complete the following activities to evaluate organizational compliance with the LSC, based upon occupancy requirements:
  - Assess hazardous areas, such as soiled linen rooms, trash collection rooms, oxygen storage rooms, and kitchens.
  - Assess required fire separations.
  - Assess at least two required smoke separations.
  - Pick at least two exits per building and verify that they are continuous from the highest level they serve to the outside of the building.
o Assess the integrity of access doors and discharge doors of laundry and trash chutes.
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.

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

**ILSMS: LS.01.02.01**

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

Include the following language in each finding:

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

- Verify that any granted equivalency conditions align with the information submitted by the organization as reflected in the History Audit Trail.
- 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
Note: When care is provided in rented space, the oversight and maintenance may be the obligation of the landlord contractually however the organization is ultimately responsible for providing a safe patient care environment.

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

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

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

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

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

- Unsealed penetrations in walls and smoke/fire barriers
- Door problems (e.g., improper fire rating, latching and automatic closer problems)
- Non-functioning fire alarm
- Missing smoke detector
- Missing fire damper
- Missing handrail in stairwell
- Remote shut off for generator set missing
- Missing sprinkler spares
System Tracer – Data Management
Applies to: All accreditation programs

Duration
60 minutes

Participants
• One surveyor
• Other surveyors may participate as available

Organization:
Participants vary depending on the focus of the tracer. To be discussed with the surveyor(s) after the Planning Session.

Hospice organizations that are Medicare certified: The HQRP requires all Medicare certified hospices to collect and submit data on CMS-specified measures as part of their QAPI plan. Surveyors should ask to see the data collected and submitted, and the CMS reports that correspond to the data.

For organizations pursuing CBPC Certification: During this session, a CBPC leader or member of the IDT should be present to review the program’s PI plan.

Suggestions for use of RPI tools*
• PAGER
• WWW
• Bar, Line, Histogram Graphs
• Helping / Hindering
• Cause & Effect Diagram
• Stakeholder Analysis

*You can find more information in the Robust Process Improvement (RPI) Tip Cards for Field Staff.

Objective
1. To understand and assess the organization’s performance improvement process.
2. To learn how leaders of the organization oversee the collection and use of data to evaluate the safety and quality of care being provided to patients.
3. For organizations pursuing CBPC Certification: To learn which four performance measures were selected for data collection and analysis in the CBPC program, and how the data is being used to improve care.

Before
• Discuss and confirm the planned focus for this System Tracer with team members and obtain additional input for use at the session
• Review performance improvement data and construct system-level questions as appropriate
• Inform the organization about who should attend as active participants

During
• With the organization, identify the fundamental principles of performance improvement that need strengthening and enhancement within their operations. These principles include:
  o Planning - Selection of measures: Understand the organization’s planning process for data use including how your organization identifies and prioritizes measures.
  o Data collection: Understand the organization’s methodology for ensuring that all data is collected as planned.
  o Data Aggregation and Analysis: Understand the organization’s processes for turning data into useful information.
  o Data use: Understand how the organization uses the information obtained from data analysis.
• Reference the “general tips” and “tips for focus” for recommendations on planning a discussion of the principles. These are located at the end of this section.
• Additional performance improvement related topics to explore include:
  o HH - OASIS
  o Pharmacy - Med Errors
  o PC/SS – Incidents
  o Hospice – Hospice Quality Reporting Program (HQRP) reports (QAPI data collected and submitted to CMS)

For organizations pursuing CBPC Certification, the following should be addressed:
• Selection of performance measures, both the four required for certification and any others the organization has chosen to study
  o Who is involved in the selection
  o Program’s process for prioritizing what to measure
  o Source of measures (evidence-based)

• Data collection related topics, including
  o Staff assigned to collect, compile, generate reports
  o Process followed for collecting data -- manual or automated
  o Process for evaluating validity and reliability of data
  o Guidelines for population sampling that the organization is following
  o Frequency with which data is collected

• Data analysis and interpretation
  o Who performs the analysis and interpretation
  o What types of analyses are being conducted
  o Is data being trended or compared to an expected level of performance
  o Are there any potential cause and effect relationships being explored

• Dissemination and transmission of data and information
  o Who receives the data within the organization
  o Are staff made aware of performance measurement results

• Describe any performance improvement projects underway

• Other issues for discussion or follow-up:
  o Medication Management
  o Infection Prevention and Control
  o National Patient Safety Goals— including monitoring of CDC or WHO hand hygiene compliance
  o Monitoring staff compliance with employee health screening requirements

  • 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
  • Follow-up on any identified issues or remaining topics during subsequent survey activity.
  • Consider the relationship of your observations to system level issues.
  • Share problematic issues with other team members.
General Tips for Conducting the Data Management Session

1. Success with the Data Tracer is contingent upon the availability of organization data and the surveyor’s good use of time in the surveyor planning session.

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

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

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

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

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

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

Focus: Planning – Selection of Measures

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

Key Points

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

Key Standards

- PI.01.01.01 (patient perception of care, safety and quality, adverse events, staff input and patient environment)
- PI.02.01.01 (benchmarking Internal and External databases in usable formats and frequency)
- LD.04.04.01 (re prioritization of data collection)
- IM.01.01.01 (thorough analysis of data needs)
- IM.02.02.01 (uniform data definitions and standardized data collection)
- For CBPC Certification: LD.04.04.01, EPs 27-29 (Written PI plan, priorities)
- For CBPC Certification: APR.11.02.01 (Performance measures requirement)
Data Management - Focus Specific Tips

Focus: Data Collection

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

Key Points

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

Key Standards

- PI.01.01.01 (data collection)
- IM.02.01.03 (data integrity)
- IM.04.01.01 (integrity and quality of health information)
- RC.01.02.01 (authentication of data in the clinical/medical record)
- For CBPC Certification: LD.03.02.01, EP 8 (patient satisfaction data collection)
- For CBPC Certification: PI.01.01.01, EPs 41-55 (data collection)
Focus: Data Aggregation and Analysis

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

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

Key Standards
- PI.02.01.01 (systematic aggregation and analysis)
- PI.01.01.01 (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 (ability to analyze data to support care)
- For CBPC Certification: PI.02.01.01, EPs 15-17 (Data analysis, use of tools)
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
- LD.04.04.01 (prioritize and reprioritize)
- LD.04.04.03 (new or modified processes)
- IC.01.02.01 (infection prevention and control information)
- IC.01.03.01 (infection prevention and control risks)
- IC.01.05.01 (infection prevention and control plan)
- IC.01.06.01 (Infection outbreaks)
- IC.02.01.01 (Surveillance)
- IC.03.01.01 (Evaluation of activities)
- LD.04.04.05 (information used to make changes)
- IM.02.01.03 (data security and integrity)
- IM.02.02.03 (data retention for quality control purposes / displayed for use by decision makers)
- IM.02.02.03 (data organization and availability - easily retrievable for decision making)

For CBPC Certification: PI.03.01.01, EP13 (Role of patient)
System Tracer – Infection Control

Applies to: All accreditation programs, except NCC

**Duration**
30 - 60 minutes

**Participants**
All surveyors

Organization:
- Individual staff at various locations encountered during tracer activity
- Infection control coordinator and individual staff at various locations
- Physical plant staff, if applicable
- Organization leadership

**Individual Tracer Selection Tips**
In settings where there are no patients being treated for infections, pull a discharge record of a patient with an infection, review the record and use this patient’s experience as your scenario for the individual patient tracer or IC System Tracer.

If the organization has never cared for a patient with an infection, create a realistic scenario for this session. For example:
- A home health patient is noted to be coughing excessively during a regularly scheduled visit. Two weeks later you receive a call from the Public Health Department indicating that this patient has active TB.

**Note:** When a separate Infection Control Systems Tracer is not scheduled, surveyors should address IC during Individual Tracers and during the Data Management system tracer.

**Objectives**
1. Learn about the planning, implementation and evaluation of the organization’s infection prevention and control activities.
2. Evaluate the organization’s infection prevention and control planning process, 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**
While conducting individual tracers:
- Identify a patient being treated for an infection such as a respiratory illness or a multi-drug resistant organism or other potentially communicable disease.
- Review the record. Note any opportunities to trace a related laboratory testing process through the organization.

**During**
**Discussion (15 to 20 minutes)**
- Review the documented infection prevention and control activities to minimize, reduce, or eliminate risk of infections with the individual responsible for the organization’s program

- Determine if the infection control plan includes a goal of improving influenza vaccination rates (IC.02.04.01)
  - 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

**Potentially Problematic Areas**
- Local and regional outbreaks – ask the organization, reference current literature and websites, e.g., www.cdc.gov/mmwr
- Hazard Vulnerability Analysis re: Bioterrorism or local industry
- Governing Body involvement and accountability
- Hand hygiene
• Transportation processes for medications, laboratory specimens
• Supply storage areas and conditions (trunks, storage rooms)
• Equipment – cleaning between patients, storage conditions, delivery processes
• Medication admixing and delivery processes
• Surveillance

Key Standards
IC.01.03.01 (infection risks)
IC.01.04.01 (goals to minimize spread)
IC.01.06.01 (infection outbreaks)
IC.02.01.01 (implementation)
IC.03.01.01 (evaluation)

If this is a complex organization survey: Conduct this session with representatives from all programs being surveyed. If not possible, due to distance constraints, the team has the option of conducting this discussion telephonically or delegating an individual tracer to infection control in each program. In any case, it is important for the team to discuss findings at the next planning session to look for common issues across programs.

Tracing (40 to 45 minutes)

Site locations

• OME surveyor conducts this tracer in warehouse, pharmacy, patient home, delivery vehicles
• Using the record, engage front line staff from various departments in a discussion of their infection control process. For example:
  o How this individual’s (potential) infection was identified, e.g., part of surveillance or other
  o What process exists for laboratory confirmation? Trace that process in the record and with interviews including physician request for testing, physician order, communication to lab, collection of specimen, transportation to the lab, turn-around time for results, communication of results from lab to org to physician, follow-up orders, monitoring and patient instruction
  o Staff orientation and training activities: e.g., what processes are in place to ensure the appropriate care of infected patients (includes staff behavior and attitudes ensuring compliance with patient rights)
  o Reporting of infection control data – responsibility, methodology, where does it go, what comes back to the unit, branch, or area
  o Actions taken as a result of surveillance and the outcomes of those actions

The following are to be considered when the organization provides inpatient or residential services such as hospice:
  o Prevention and control activities (e.g., staff training, housekeeping procedures, organization wide hand hygiene, employee health, food sanitation, and the appropriate storage, cleaning, disinfection, sterilization and/or other disposal of supplies and equipment)
  o Interventions for licensed independent practitioner, staff, students/trainees, independent practitioners, and volunteers that include screening for exposure and/or immunity to infectious diseases they come in contact with, the referral for assessment, potential testing, immunization and/or prophylaxis treatment and counseling to those who have potentially been identified with an infectious disease
  o Physical facility changes, either completed or in progress, that have an impact on infection control
  o Actions taken as a result of surveillance and the outcomes of those actions

• Inform organization participants about findings 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 surveyor team during the next surveyor planning session. Share problematic issues so they can be further explored in Individual Tracers.

• Seek additional information, if necessary, during an Issue Resolution session.

• Consider the relationship of your observations to system level issues.
System Tracer – Medication Management
Applies to: Modified for organizations surveyed under the CAMHC

<table>
<thead>
<tr>
<th>Duration</th>
<th>30 - 60 minutes (The data collection for this drug is conducted as part of Objectives)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Learn about the organization’s medication management processes.</td>
</tr>
<tr>
<td></td>
<td>2. Evaluate the continuity of medication management from procurement of medications through monitoring.</td>
</tr>
<tr>
<td></td>
<td>3. Evaluate the medication reconciliation process during hand offs.</td>
</tr>
</tbody>
</table>

Participants
All surveyors available to participate should do so

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

Planning:
1. Planning for this tracer begins at the surveyor planning session. Consider the organization’s programs and high risk services.
2. Identify a patient receiving a medication on the organization’s high risk medication list.
3. As part of the individual patient tracer, review the medical record.
4. Collect necessary data using the work tool. The organization can assist in this process.

For Complex Organization Surveys
1. When multiple programs are being surveyed and a medication management system tracer is selected by more than one program, select a high risk medication for a patient who moved across those programs, or has the potential of moving across those programs. (If a program is not involved in the selected high risk medication, the surveyor from that program should select a medication from that program’s high risk list.)
2. Surveyors* from each program where a medication management system tracer is being conducted, should trace the high risk medication through their program during the tracer time.
3. All surveyors should engage in the conference room “wrap-up” discussion either in person or telephonically for the last 10 minutes of the session. Surveyor team discretion can be used to move this “wrap up” to an upcoming issues resolution time.
If the agenda does not permit a medication management tracer in some programs, surveyors will cover the standards during individual tracer activity. Whenever possible though, these surveyors should engage in the “wrap-up” discussion with the team.

For Integrated Surveys:
1. Select a high risk medication for a patient who moved across all programs or has the potential of moving across all programs.
2. Trace the high risk medication through all programs. (If distance is a barrier, conduct the medication tracer as part of an individual tracer at another time.

Discussion (15 minutes) – can take place in a conference room or another location within the organization

- Inquire about:
  - Implementation of USP-NF 797 requirements related to standard requirements
  - Process for reporting of errors/system breakdowns/near misses/overrides
  - Data collection, analysis, systems evaluation, and performance improvement initiatives
  - Education, staff and patient/client
  - Information management systems related to medication management
  - Patient involvement in safe medication management.

- Ask organization participants to describe their evaluation of the medication management system.
- Summarize identified strengths and risk points or vulnerabilities.
- Ask the attendees if they have any questions.
- Ask attendees to consider how they might incorporate a similar tracer to promote continuous readiness.

After
- Review additional medication related issues during subsequent tracer activity.
- 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.

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

- Warehouse/Materials Management for review of equipment or devices, if applicable to the medication being traced
- Interview with the consultant and other pharmacists, if applicable (Ambulatory Infusion, OME)
- Other important considerations for this tracer
  - Consider several medications as you evaluate the medication management processes.
  - Talk with the organization’s prescribing physician, when applicable, about prescribing issues or talk with consulting pharmacists, when involved
  - Explore communication exchange during hand-offs from one level of care to the next
  - Explore the critical steps in medication management: selection and procurement, storage, ordering and transcribing, preparing and dispensing, administering and monitoring.
Medication Management – Work Tool (for Ambulatory Infusion and Inpatient Hospice use)

<table>
<thead>
<tr>
<th>Patient Identifier:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication Ordered</th>
<th>Date ordered</th>
<th>Time ordered</th>
<th>Amount Ordered</th>
<th>Frequency</th>
<th>Route</th>
<th>Pharmacy Review</th>
<th>Amount Administered</th>
<th>Time Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**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), if applicable
  - 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, or
- Lack of compliance with a National Patient Safety Goal.
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

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 organizations pursuing CBPC Certification: Ask leaders about:
  - CBPC service/program integration into the Home Care organization
  - Evaluating the success of the program
- 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:

<table>
<thead>
<tr>
<th>Robust Process Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluating root causes of identified problems</td>
</tr>
<tr>
<td>Systematically developed and implemented solutions</td>
</tr>
<tr>
<td>Evaluation of solutions for effectiveness</td>
</tr>
<tr>
<td>What is in place to make sure that improvement is sustained</td>
</tr>
<tr>
<td>Regular measurement and assessment of the quality and safety of patient care and important organization systems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leadership Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leader focus on quality and safety issues; involvement of Board members, senior management, and medical staff</td>
</tr>
<tr>
<td>Priorities of the organization in terms of improvement and prevention of conditions leading to adverse events</td>
</tr>
<tr>
<td>Making sure that improved performance is sustained</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Physician/clinician involvement in performance improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability for quality and safety</td>
</tr>
<tr>
<td>initiatives that involve changes in clinical practice to improve quality and safety</td>
</tr>
<tr>
<td>Involvement in performance improvement priorities</td>
</tr>
<tr>
<td>Serving as champions for performance improvement goals</td>
</tr>
<tr>
<td>Leading performance improvement initiatives</td>
</tr>
</tbody>
</table>
### Regulatory Review Session

**Applies to:** Applicable to: HME (CMS DMEPOS Providers)

#### Duration

| 30 – 60 minutes |

#### Participants

| One surveyor |

#### Organization:

- Owner, Chief Executive Officer or other individual responsible for managing services
- Billing / Finance personnel familiar with accounts payable and receivables

### Objective

1. Learn about the organization’s financial management processes relative to Medicare/Medicaid billing and receivables

### During

- Validate that the organization has implemented or plans to implement its own internal oversight and reconciliation process to ensure:
  - Medicare/Medicaid is being billed only for supplies and equipment provided to the patient/client; and
  - Medicare/Medicaid payments are being appropriately assigned to the patient/client’s account; and
  - Money is being deposited into the organization’s account.

- Learn about the organizations processes for:
  - Preparing an operating budget – ask to see the current year’s budget if one exists; if organization is just beginning operations, determine if they are thinking ahead to a time that such planning tools would be required
  - Accounting* -- ask to see their statements of revenue and expenses or samples of what these reports will look like and procedures for how they will be prepared
  - Tracking and recording Medicare/Medicaid payments for specific accounts – ask to see ledgers or whatever income recording tools that are in place or that will be available when billing is initiated
  - Determining that Medicare/Medicaid payments are being posted or reconciled to the correct patient/client account
  - Tracking and resolving complaints from patients/clients – ask to see the complaint log/file

* Different organizations will have different names for reports. Per Medicare/Medicaid regulation, the organization must use either a cash or accrual based accounting practice.

- Select patients/clients to trace the organization’s financial processes from equipment/supply order through posting of money into the account. **Note:** The number of patients to trace is left to surveyor discretion based on circumstances specific to the survey. If the organization has not yet served a patient/client, trace the process using a virtual patient.
  - Ask the organization to identify the internal processes they have in place to monitor each of the following steps:
    - Matching physician order to
    - Delivery of supplies – including documented verification that supplies were delivered, e.g. patient signature, follow up phone call when mailed, to
    - The check receipt from Medicare/Medicaid, to
• The reconciliation of the patient/customer account, to
• Depositing of the payment into the organization account.

**NOTE:** This is not an audit of what has been billed to Medicare/Medicaid or to patients/clients. This is a review of the procedures the organization has in place to monitor the quality/accuracy of each step in their own process.

**Conducting the complaint portion of the session**

- Discuss the process for complaint resolution
- Using a complaint that the organization received, trace the process from:
  - the patient’s notification of the complaint process to
  - receipt of the complaint through to
  - resolution of complaint
- Ensure that the beneficiary received:
  - A notification that the organization is investigating the complaint within 5 days. Notification can be orally or via phone, e-mail, fax or letter
  - Written notification from the organization of the results from the investigation and response. In some organizations this written notification must be completed in 14 days of receipt of the complaint.

**After**

- Consider what you have learned relative to organizational systems. Use this information for subsequent survey activity.
- Share problematic issues with other team members, if applicable, so they can be further explored in subsequent Individual Tracers.
Program Specific Tracer – Equipment/Supply Management Tracer
Applies to: OME Applicability – HME only

**Duration**
Variable – approximately 60 minutes.

**Participants**
One surveyor
Organization:
- Staff from various areas throughout the organization

**Rationale:**
HME companies are required to purchase and maintain a variety of equipment. As a follow-up to individual tracers, the surveyor is provided with time in the agenda to learn about the processes such as ordering equipment, stocking, cleaning, maintaining, and decommissioning.

**Objectives**
1. Learn how the organization processes equipment and supplies from initial receipt through decommissioning.
2. Evaluate the implementation effectiveness for specific pieces of equipment.
3. Identify processes and possibly system issues contributing to failed equipment/supply management.

**Before**

**Targeted Tracer Selection**
Select this tracer for all HME surveys. Trace high risk equipment from individual tracers and springboard to other equipment to evaluate all aspects of procurement, inventory, cleaning, maintenance and decommissioning.
- Review notes from the planning session
  - Annual evaluations of the EC management plans.
  - EC multidisciplinary team meeting minutes for the previous 12 months
- Review EC-related issues observed in previous survey activities (including those made by other survey team members). Use the following matrix to help identify patterns of management process or risk category weaknesses and strengths.
- Obtain notes of equipment manufacturers, model and serial numbers.

**During**

**Conducting the Walk-Through Tour**
- This is a walking tour through the sites responsible for the equipment management plan.
- Trace the processes of equipment and supply management for specific categories of equipment identified in individual tracers.
- Trace from procurement through decommissioning.
- Observe, when possible, and interview staff about the following steps in the process:
  - Safe environment and processes
  - Equipment evaluation
  - Staff education about the equipment/supplies
  - Storage
  - Obtaining physician orders – content and process
  - Selection of the most suitable equipment/supplies to meet patient needs
  - Preparation for delivery

Explore other types of equipment and supplies
- Delivery and set-up
- Tracking equipment location
- Patient education about the care and use of equipment/supplies
- Maintenance – routine and preventive
- Equipment failure management/back-up system
- Recall of equipment – monitoring, back-up equipment process
- Equipment return, cleaning and inspection processes, including basic safety and operational checks, such as volumetric testing of infusion pumps between patient use
- Equipment repair processes
- Obsolete inventory
- Incident management – internal processes, reporting processes
- Staff orientation, training and competency evaluation processes
- Other issues identified during other tracer activity or relative to the standards

After
- Review documentation of ongoing maintenance, testing and inspection procedures for the equipment identified during the individual tracers. Springboard to other equipment.
- Log of medical equipment provided to the patient – compare manufacturer, model and serial number to that in the home.
- 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.
Report Preparation
Applies to: All accreditation programs

Duration
90 – 120 minutes

Participants
All surveyors on site

Changes in Scoring and Reporting – Effective January 1, 2017
- Elements of performance no longer categorized as A or C
- All observations of non-compliance are documented
- Direct and indirect EP categories eliminated
- No OFIs in the accreditation report
- All observations of noncompliance require follow-up in the form of a 60-day ESC
- MOS are no longer required
- RFIs will be displayed in the SAFER™ matrix based on the surveyor determination of the likelihood the issue has to harm a patient, visitor, or staff member (low, moderate, high) in addition to the scope of the issue within the organization (limited, pattern, widespread).

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.

How will this affect my review?

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

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

During
- Document any additional observations you made. Follow the Surveyor Documentation Guidelines section of the SAG found in Appendix B.
- Remove any observations that the organization is able to clarify.
- Revise any documentation of observations that the organization has corrected during the on-site event. 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 patient safety
    - The correction should not require any organizational planning or forethought
    - The practice is correct but the policy needed amending to coincide with the practice, so the policy was amended
Accredited and certified 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.

- Corrections to a form that was missing an element or piece of information and the change would not impact the process
  - Contact the Standards Interpretation Group if you have any questions about the appropriate use of this provision with a finding.
  - WST will auto-populate the SAFERTM matrix with standards and EPs based on the surveyors’ designation of likelihood to harm (low, moderate, high) and scope of the issue (limited, pattern, widespread) identified with each observation entry.
    - Auto-population of the standards and EPs within the matrix is based on the worst-case observation in terms of likelihood to harm and scope of issue designation. For example, if there are multiple observations under one EP, by one or more surveyors, the observation with the most likelihood to harm, and the issue with the greatest scope are used independently to determine where the standard and EP will appear in the matrix.
    - Surveyors are able to override the matrix auto-population of a standard and EP if, based on their expertise, observations and judgment, they disagree with the placement.
      - Editing where a standard and EP appear on the matrix is accomplished by accessing the EP (not the individual observations) to adjust the likelihood to harm and scope of issue designations.
    - When an EP has multiple observations entered underneath, and all observations have been designated as having a “limited” scope, a warning will appear in WST for the surveyor finalizing the report (“last surveyor standing”). The warning will list the applicable standards and EPs and ask the surveyor to verify that these are appropriate to keep the ‘Limited’ column of the matrix, or should be moved to either the Pattern or Widespread column.

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

- Plan the approach for presenting the report during the Exit Briefing and Exit Conference.
- When more than one surveyor is present, determine who will facilitate and the presentation approach.
After

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

**Applies to:** All accreditation programs

### Duration

15 - 30 minutes

### Participants

All surveyors on site

**Organization:**
CEO, Executive Director, Owner (if available)

### Guidelines

The Summary of Survey Findings Report is organized by chapter.

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

### Objectives

1. Review the survey findings as represented in the Summary of Survey Findings Report.
2. Discuss any concerns that the CEO may have with the report.
3. Determine if the CEO wishes to have an Organization Exit Conference or if the CEO prefers to deliver the report privately to the organization.
4. Determine the need for any special arrangements for the Organization Exit Conference.

### During

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

**Applies to:** All accreditation programs

<table>
<thead>
<tr>
<th><strong>Duration</strong></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>Leadership and staff invited to participate by the CEO</td>
</tr>
</tbody>
</table>

## Guidelines

Before you present findings, remind attendees that observations have been communicated throughout the survey.

As you present the requirements for improvement:

- Comment, where appropriate, on areas where the organization is performing well.
- Respond to questions and comments about findings.
- Remember that attendees may or may not have a copy of the Summary of Survey Findings Report, so adjust your presentation to fit the situation.

## Equivalencies

The Joint Commission manages equivalencies, which are based on the LSC (NFPA 101-2012.1.4):

- An equivalency is when alternative methods, systems, or devices offset the risk associated with the LSC non-compliance condition.

## Objectives

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

## Before

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

## During

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

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

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

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

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

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

Ask if there are any other questions about the report.

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

After
- Submit the report using WST within 24 hours of event completion
Evaluation Guide for Optional Community based Palliative Care Certification

**Applies to:** Home Care organizations (Home Health and/or Hospice) who comply with all foundational requirements for accreditation and are seeking this optional certification.

---

**Tracer Selection**

Patients receiving community based palliative care, treatment, and services.

**Objectives**

- To assess the organization’s provision of community based palliative care services.
- To evaluate the degree of compliance with standards and elements of performance as they relate to the provision of community based palliative care services.
- To provide informational and educational opportunities to health care organizations, regarding the community based palliative care certification.

The evaluation of these processes is to be incorporated into the following survey activity sessions:

- Orientation to the Organization
- Individual Patient Tracers
- Meeting with the Interdisciplinary Team/Team members (New – see activity description later in this guide) Competence Assessment / Credentialing Session
- Environment of Care/Emergency Management Session
- Leadership Session
- Data Management System Tracer

**Orientation to the Organization** – Explore the following topics:

- Profile of Community based Palliative Care (CBPC) Services
- Overview of the CBPC program, including target population, design, relationship to the other program(s) in the organization (PC.01.01.01, EP49)
- Types of CBPC services provided
- Process for identifying patients (new referrals and current patients) appropriate for CBPC services (PC.01.01.01, EP49)
- Referral process: how patients are referred from outside sources for CBPC program services
- Interdisciplinary team composition and roles of each member; team communication (HR.01.02.07, EPs 10-12) Clinical practice guidelines used by the program (LD.04.04.09, EP7)
- Leadership:
  - CBPC leadership structure (same or different than home health/hospice leadership?)
  - How does leadership provide resources to enable the program to provide services
  - How does leadership ensure that program staff are experienced in providing palliative care? How are staff educated? (HR.01.05.03, EP27; LD.03.02.01, EP10)
Who coordinates the provision of CBPC services with staff, patients, and/or family?

**Individual Tracer Activity**

Assessment of the CBPC patient – Look at:

- Program team interaction with patient and family
- Initial assessment and reassessment of patient and family needs (including physical, psychosocial, functional, spiritual, and psychological assessments) (PC.01.02.01, EPs 46-52)
- Assessment and reassessment of patient’s physical symptoms and action taken to decrease physical symptoms (such as pain, dyspnea, nausea, etc.) (PC.02.02.01, EPs 23-24)
- For pediatric patients: assessment of developmental stage and needs of patients and families (PC.01.02.01, EPs 28, 29)
- Development and implementation of the patient’s plan of care (PC.01.03.01, EPs 49-50)
- Process for arranging both internal and community services for CBPC patients (PC.01.03.01, EP51; PC.02.02.01, EP24)
- How the CBPC interdisciplinary team members collaborate and share information with each other and with other staff when conducting assessments and reassessments. (PC.02.01.05, EPs 35-36; PC.02.02.01, EP26)
- Information and education that is provided to the patient and family concerning symptoms, diagnoses, community resources, etc. (PC.02.02.01, EP 24; PC.02.03.01, EP32; PC.04.02.01, EP9)
- Documentation of advance directives, treatment preferences, and advance care planning discussions (RC.02.01.01, EP 31-32; RL.01.05.01, EP23)

**Plan of Care**

- Patient and/or family involvement in developing the plan of care and patient-centered goals of care (PC.01.03.01, EP49-50; PC.02.01.05, EP37)
- Interdisciplinary team and staff deliver CBPC care and services, including symptom management, according to the patient’s plan of care (PC.02.01.01, EPs 20 and 23)
- Use of current clinical practice guidelines in development of the program and in the provision of CBPC services (LD.04.04.09, EP7)

**Competence Assessment/Credentialing Session** - from observations gathered during Individual Tracer activity, engage attendees in discussion of the following topics:

- Qualifications of interdisciplinary team members and clinical staff match the needs of the CBPC patients and families (HR.01.02.01, EPs 27-29)
- Members of the core interdisciplinary team include at least a physician, nurse, social worker and chaplain/spiritual care provider (see HR.01.02.07, EP 10 for specific requirements)
- The orientation for CBPC interdisciplinary team members and clinical staff includes all required elements (see HR.01.04.01, EPs 24-25)
• Competency assessment specific for staff providing CBPC services are established, assessed, and documented per organizational policy [HR.01.06.01, EPs 26-27]

Environment of Care/Emergency Management Session - Explore:
• Each patient’s home environment for safety factors, including any factors related to medical equipment, mobility devices, etc.
# Sample Agenda for Home Care Accreditation with CBPC Survey

## Day 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:30 a.m.</td>
<td>Surveyor Arrival and Preliminary Planning Session</td>
</tr>
<tr>
<td>8:30 – 9:00 a.m.</td>
<td>Opening Conference and Orientation to Organization</td>
</tr>
<tr>
<td>9:00 – 9:30 a.m.</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td>Orientation to Home Care services</td>
</tr>
<tr>
<td></td>
<td>Orientation to Community-Based Palliative Care program/services</td>
</tr>
<tr>
<td></td>
<td>- Program scope, philosophy, structure</td>
</tr>
<tr>
<td></td>
<td>- Program integration within the organization</td>
</tr>
<tr>
<td></td>
<td>- Use of clinical practice guidelines</td>
</tr>
<tr>
<td></td>
<td>Brief Tour of the Organization (if necessary)</td>
</tr>
<tr>
<td>9:30 – 10:00 a.m.</td>
<td>Continued Surveyor Planning Session</td>
</tr>
<tr>
<td></td>
<td>Patients selected for tracers should include those receiving:</td>
</tr>
<tr>
<td></td>
<td>- Home health services</td>
</tr>
<tr>
<td></td>
<td>- Community-Based Palliative Care services (varying ages, services, etc.)</td>
</tr>
<tr>
<td>10:00 – 10:30 a.m.</td>
<td>Individual Tracer Activity</td>
</tr>
<tr>
<td>10:30 – 11:00 a.m.</td>
<td>Surveyor Lunch</td>
</tr>
<tr>
<td>11:00 – 11:30 a.m.</td>
<td>Individual Tracer Activity</td>
</tr>
<tr>
<td>11:30 – 12:00 p.m.</td>
<td>Surveyor Team Meeting / Planning Session</td>
</tr>
<tr>
<td>12:00 – 12:30 p.m.</td>
<td>Special Issue Resolution</td>
</tr>
<tr>
<td>12:30 – 1:00 p.m.</td>
<td>Surveyor Team Meeting / Planning Session</td>
</tr>
<tr>
<td>1:00 – 1:30 p.m.</td>
<td>Surveyor Team Meeting / Planning Session</td>
</tr>
<tr>
<td>1:30 – 2:00 p.m.</td>
<td>Surveyor Team Meeting / Planning Session</td>
</tr>
<tr>
<td>2:00 – 2:30 p.m.</td>
<td>Surveyor Team Meeting / Planning Session</td>
</tr>
<tr>
<td>2:30 – 3:00 p.m.</td>
<td>Surveyor Team Meeting / Planning Session</td>
</tr>
<tr>
<td>3:00 – 3:30 p.m.</td>
<td>Surveyor Team Meeting / Planning Session</td>
</tr>
<tr>
<td>3:30 – 4:00 p.m.</td>
<td>Surveyor Team Meeting / Planning Session</td>
</tr>
<tr>
<td>4:00 – 4:30 p.m.</td>
<td>Surveyor Team Meeting / Planning Session</td>
</tr>
</tbody>
</table>
### SAMPLE AGENDA
**Home Care Accreditation with Community-Based Palliative Care (CBPC) Certification**

#### Day 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:30 a.m.</td>
<td>Daily Briefing</td>
</tr>
<tr>
<td>8:30 – 9:00 a.m.</td>
<td>System Tracer – Data Management</td>
</tr>
<tr>
<td>9:00 – 9:30 a.m.</td>
<td>• Home Health – OASIS, QI, Readmissions</td>
</tr>
<tr>
<td></td>
<td>• CBPC – Quality measures, data analysis, patient satisfaction</td>
</tr>
<tr>
<td></td>
<td>• Data related to infection control and medication management</td>
</tr>
<tr>
<td>9:30 – 10:00 a.m.</td>
<td>Individual Tracer Activity</td>
</tr>
<tr>
<td>10:00 – 10:30 a.m.</td>
<td>Includes time for meeting with CBPC interdisciplinary team (<em>Note: This meeting can take place during any Individual Tracer Activity block of time</em>)</td>
</tr>
<tr>
<td>10:30 – 11:00 a.m.</td>
<td></td>
</tr>
<tr>
<td>11:00 – 11:30 a.m.</td>
<td></td>
</tr>
<tr>
<td>11:30 – 12:00 p.m.</td>
<td></td>
</tr>
<tr>
<td>12:00 – 12:30 p.m.</td>
<td>Surveyor Lunch</td>
</tr>
<tr>
<td>12:30 – 1:00 p.m.</td>
<td>Individual Tracer Activity</td>
</tr>
<tr>
<td>1:00 – 1:30 p.m.</td>
<td></td>
</tr>
<tr>
<td>1:30 – 2:00 p.m.</td>
<td></td>
</tr>
<tr>
<td>2:00 – 2:30 p.m.</td>
<td></td>
</tr>
<tr>
<td>2:30 – 3:00 p.m.</td>
<td></td>
</tr>
<tr>
<td>3:00 – 3:30 p.m.</td>
<td></td>
</tr>
<tr>
<td>3:30 – 4:00 p.m.</td>
<td>Special Issue Resolution</td>
</tr>
<tr>
<td>4:00 – 4:30 p.m.</td>
<td>Surveyor Team Meeting / Planning Session</td>
</tr>
</tbody>
</table>

#### Day 3

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:30 a.m.</td>
<td>Daily Briefing</td>
</tr>
<tr>
<td>8:30 – 9:00 a.m.</td>
<td>Leadership Session</td>
</tr>
<tr>
<td>9:00 – 9:30 a.m.</td>
<td>Discussion topics will include:</td>
</tr>
<tr>
<td></td>
<td>• Home health services</td>
</tr>
<tr>
<td></td>
<td>• CBPC program and interdisciplinary team approach</td>
</tr>
<tr>
<td></td>
<td>• Resourcing and promoting the CBPC program</td>
</tr>
<tr>
<td></td>
<td>• Organization performance improvement</td>
</tr>
<tr>
<td>9:30 – 10:00 a.m.</td>
<td>Individual Tracer Activity</td>
</tr>
<tr>
<td>10:00 – 10:30 a.m.</td>
<td></td>
</tr>
<tr>
<td>10:30 – 11:00 a.m.</td>
<td></td>
</tr>
<tr>
<td>11:00 – 11:30 a.m.</td>
<td></td>
</tr>
<tr>
<td>11:30 – 12:00 p.m.</td>
<td>Environment of Care and Emergency Management</td>
</tr>
<tr>
<td>12:00 – 12:30 p.m.</td>
<td>Surveyor Lunch</td>
</tr>
<tr>
<td>12:30 – 1:00 p.m.</td>
<td>Competence Assessment Process and CBPC</td>
</tr>
<tr>
<td>1:00 – 1:30 p.m.</td>
<td>Credentialing/Privileging of Licensed independent Practitioners</td>
</tr>
<tr>
<td>1:30 – 2:00 p.m.</td>
<td>Surveyor Report Preparation</td>
</tr>
<tr>
<td>2:00 – 2:30 p.m.</td>
<td></td>
</tr>
<tr>
<td>2:30 – 3:00 p.m.</td>
<td></td>
</tr>
<tr>
<td>3:00 – 3:30 p.m.</td>
<td></td>
</tr>
<tr>
<td>3:30 – 4:00 p.m.</td>
<td>CEO Exit Briefing and Organization Exit Conference</td>
</tr>
<tr>
<td>4:00 – 4:30 p.m.</td>
<td></td>
</tr>
</tbody>
</table>

Please Note: A Facility Based Hospice would include a 1.5 hour Life Safety Code® Building Assessment.
Sample Agenda for CBPC Certification Extension Survey

Day 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:30 a.m.</td>
<td>Opening Conference (15 minutes)</td>
</tr>
<tr>
<td>8:30 – 9:00 a.m.</td>
<td>- Introductions</td>
</tr>
<tr>
<td></td>
<td>- Brief review of agenda</td>
</tr>
<tr>
<td></td>
<td>Orientation to Program (45 minutes)</td>
</tr>
<tr>
<td></td>
<td>- Program scope, design, structure, team composition, accountability</td>
</tr>
<tr>
<td></td>
<td>- Program philosophy, goals, objectives</td>
</tr>
<tr>
<td></td>
<td>- Program leadership responsibilities and accountabilities</td>
</tr>
<tr>
<td></td>
<td>- Program and organization integration, interaction and collaboration</td>
</tr>
<tr>
<td></td>
<td>- Program performance measurement and improvement (may be deferred until PI session)</td>
</tr>
<tr>
<td></td>
<td>- Program team composition and team member responsibilities</td>
</tr>
<tr>
<td></td>
<td>- Program team member selection qualifications, orientation, training, ongoing education and support</td>
</tr>
<tr>
<td></td>
<td>- Program IDT and staff orientation, training and education relative to the program</td>
</tr>
<tr>
<td></td>
<td>- Communication within the program</td>
</tr>
<tr>
<td></td>
<td>- Communication between the program and organization</td>
</tr>
<tr>
<td></td>
<td>- Communication between the program and other providers within the organization and externally</td>
</tr>
<tr>
<td></td>
<td>- Clinical practice guidelines or evidence-based practices being followed by the program</td>
</tr>
<tr>
<td>9:00 – 9:30 a.m.</td>
<td>Surveyor Planning Session</td>
</tr>
<tr>
<td></td>
<td>Tracer patient selection</td>
</tr>
<tr>
<td></td>
<td>Note: This activity requires a list, census report or other summary of patients currently receiving care from the program, including all age groups. Visits scheduled for the day will be considered for the tracer activity.</td>
</tr>
<tr>
<td>9:30 – 10:00 a.m.</td>
<td>Individual Tracer Activity</td>
</tr>
<tr>
<td>10:00 – 10:30 a.m.</td>
<td>- Two visits with corresponding record review, or</td>
</tr>
<tr>
<td>10:30 – 11:00 a.m.</td>
<td>- One visit with corresponding record review and review of two additional records</td>
</tr>
<tr>
<td>11:00 – 11:30 a.m.</td>
<td></td>
</tr>
<tr>
<td>11:30 – 12:00 p.m.</td>
<td></td>
</tr>
</tbody>
</table>
### SAMPLE AGENDA
**Home Care Accreditation with Community-Based Palliative Care Certification**

**EXTENSION SURVEY**

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00 – 12:30 p.m.</td>
<td><strong>Description</strong>  &lt;br&gt; - Tracer activity begins where the patient is currently receiving care, treatment and services (home, SNF, etc.)  &lt;br&gt;  - Begins with interactive review of patient record(s) with team member or organization staff actively working with the patient—map patient’s course of care, treatment and services up to the present and anticipated for the future  &lt;br&gt;  - Continues with speaking with other program team members and staff caring for the patient  &lt;br&gt;  - Includes a patient and family interview, if they are willing to participate  &lt;br&gt; <strong>Topics</strong>  &lt;br&gt; - Coordination, interaction and communication among program team members and between the team and organization staff  &lt;br&gt; - Program team interaction with patient and family  &lt;br&gt; - Program assessment and reassessment of patient and family needs  &lt;br&gt; - Interdisciplinary team planning w/ patient and family involvement  &lt;br&gt; - Implementation of the patient’s care, treatment and service plan  &lt;br&gt; - Timing of referrals to the program; referral sources (e.g., physicians, nursing, social work)  &lt;br&gt; - Organization staff awareness of the program  &lt;br&gt; - Organization support of the program</td>
</tr>
<tr>
<td>12:30 – 1:00 p.m.</td>
<td><strong>Surveyor Lunch</strong></td>
</tr>
<tr>
<td>1:00 – 1:30 p.m.</td>
<td><strong>System Tracer – Data Management</strong></td>
</tr>
<tr>
<td>1:30 – 2:00 p.m.</td>
<td>- Program performance measurement and improvement activities  &lt;br&gt;  - Performance improvement plan review including priority setting  &lt;br&gt;  - Measure selection process  &lt;br&gt;  - Program leaders, organization leaders and program staff involved in selecting measures  &lt;br&gt;  - Data collection and data quality monitoring  &lt;br&gt;  - Data analysis and dissemination  &lt;br&gt; - Program data available for, and used in decision-making  &lt;br&gt; - Program evaluation by leaders and staff  &lt;br&gt; - Patient and family evaluation of program (satisfaction and complaints)  &lt;br&gt; - Recently implemented program improvements</td>
</tr>
<tr>
<td>2:00 – 2:30 p.m.</td>
<td><strong>Competence Assessment Process and CBPC Credentialing/Privileging of Licensed independent Practitioners</strong></td>
</tr>
<tr>
<td>2:30 – 3:00 p.m.</td>
<td>Discussion during this session will focus on:  &lt;br&gt; - Processes for obtaining team member credentials information  &lt;br&gt; - Orientation and training process for program team/staff (includes content and documentation of orientation)  &lt;br&gt; - Methods for assessing competence of practitioners and team members  &lt;br&gt; - In-service and other ongoing education activities available to program team members  &lt;br&gt; <strong>Note:</strong> The reviewer will request personnel records and credentials files to review based on team members and staff encountered or referred to throughout the day. Program staff should inform the reviewer of how much time is needed to retrieve personnel and credentials files.</td>
</tr>
<tr>
<td>3:00 – 3:30 p.m.</td>
<td><strong>Surveyor Report Preparation</strong></td>
</tr>
<tr>
<td>3:30 – 4:00 p.m.</td>
<td></td>
</tr>
<tr>
<td>4:00 – 4:30 p.m.</td>
<td><strong>CEO Exit Briefing and Organization Exit Conference</strong></td>
</tr>
</tbody>
</table>
State Survey Addendums (AHC, BHC, HAP, OBS, OME)

The Joint Commission has entered into agreements with various state regulatory agencies to enable the recognition of accreditation surveys in lieu of state licensure surveys. To facilitate state reliance on accreditation the Joint Commission must demonstrate that our standards and survey process meet or exceed that of the state licensure regulations. While the vast majority of times, the Joint Commission standards do meet/exceed state requirements, there are a few instances when a state's requirements contain unique requirements or more prescriptive language. The variation between Joint Commission standards and State regulations have led a small number of state regulatory agencies to require a state specific survey addendum for a subset of state regulations that go beyond the Joint 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.

[Link to addendum]

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.

[Link to addendum]

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

[Link to addendum]
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.


OMH and OASAS/NYOASAS Addendums (SRH class type)

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.

New Jersey Audit for Medicaid Waiver Programs

The New Jersey Division of Medical Assistance and Health Services (DMAHS) and Division of Disability services (DDS) requires that every New Jersey health care service firm or home health agency seeking to become or remain a provider to the DMAHS or DDS Private Duty Nursing (PDN) or Personal Care Assistant (PCA) program shall be accredited in order to participate in the designated Medicaid programs.

The Joint Commission is an approved accreditor for the DMAHS and DDS programs and as such is required to complete a triennial audit to verify an organization’s compliance with the New Jersey state PDN and PCA regulations. The audit is completed in conjunction with the TJC accreditation survey. The organizations are required to indicate in their e-application that they are requesting to have The Joint Commission conduct the New Jersey audit. The activities and required documentation associated with the audit process are noted below.

Note: A designated group of surveyors are assigned to conduct the New Jersey audits. These assigned individuals will receive specific education about the audit process and documentation requirements. Sample forms will be provided electronically to those who conduct the New Jersey audit activities.

Review of the New Jersey PCA and PDN regulations is a requirement to conduct New Jersey audits. Applicable State Regulations New Jersey Administrative Code Title 10. Department of Human Service, Chapter 60. Home Care Services (PCA) 10.60 3.1 – 3.9 and PDN 10.60.5.1 – 5.11

New Jersey Audit Requirements

- Audits will occur once every 3 years and are done in conjunction with the full survey
- The triennial audit is considered a comprehensive audit and will include review of the following requirements
  - Clinical Chart review
  - Personnel File
  - Policy Manual Review
  - Financial System/billing process verification
  - Customer Satisfaction Survey
  - Complaint Process review
  - Staff Interviews
  - Verify compliance with Section 6032 of the NJ regulations for organizations with greater than $5,000,000 in Medicaid revenue – see note at the end of this section *

Contact your FD if you do not have access to the audit forms or are unable to access the New Jersey state regulations

- Audit requirements will include the following
  - PCA review of 100% of active patient records up to a max of 30.
  - PDN review of 100% of active patient records up to a max of 30
  - Personnel files
    - Personnel files - review of corresponding aide or nursing files for those involved with the care of patients audited
  - Customer Satisfaction surveys - 50% of active patients up to max of 30

Note – Initial organizations will have not yet admitted any Medicaid patients at the time of the initial survey, therefore Medicaid charts will not be available to review during the initial survey. The surveyor will be required to complete the personnel file and policy review. Since review of the medical records will not occur, the surveyor will indicate zero records were reviewed for the various medical record review items on the comprehensive form.
Surveyor notification and audit process

- Surveyor will receive email notification with the organization demographics, Medicaid ADC volume, audit requirements and number of assigned days. (*this is a temporary 2017 process and will not be required in the future once all scheduling activities are automated*)
- Surveyor itinerary will reflect the TJC survey days and the New Jersey audit days
- If one surveyor is assigned, the surveyor will complete the TJC survey and audit activities throughout the course of the survey.
- If the complement requires the assignment of two surveyors, one surveyor may be responsible for completion of the audit activities. The itinerary will indicate the assigned surveyor and number of days allocated to complete the required audit activities.
- An agenda will be created and published to the organization’s extranet site. Choose the template agenda based on the total number of days and surveyors assigned to the event (e.g. 2 survey days and 2 audit days, chose the 1 surveyor for 4 days agenda template)
  - Modify the agenda as needed to reflect time needed to complete the required patient and personnel file record reviews. *These audit activities can occur at any time during the survey. Coordinate the agenda with the organization as needed. A sample WWW/agenda is included as a reference at the end of this section. It incorporates both survey and audit activities as well as the requested documentation list.*
- Audit worksheets are available and can be used to conduct your individual clinical record and personnel file reviews. Data will be tallied from the worksheet and aggregate data entered onto the PCA or PDN Comprehensive summary form. *Once data has been tallied paper versions of the audit worksheets should be shredded as they contain PHI. Electronic versions must be deleted from your computer.*
- Individual records need to be created in WST for each patient record and each personnel file reviewed.
- Completion of the New Jersey PCA and or PDN Comprehensive Summary form is a requirement for each audit conducted. The surveyor will enter their aggregate audit results on the comprehensive summary form(s) and email the completed comprehensive summary to the assigned Account Executive within 24 hours of completion of the survey. (*It is acceptable to email the Comprehensive summaries as they contain only aggregate data and do not contain PHI*)

The following rules are used to determine the additional days required to complete the audit.

<table>
<thead>
<tr>
<th>Current census</th>
<th>active # of charts that need review</th>
<th>Length of Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care Assistant 1-10</td>
<td>100% of charts</td>
<td>1 days</td>
</tr>
<tr>
<td>11-20</td>
<td>100% of charts</td>
<td>2 days</td>
</tr>
<tr>
<td>21-30</td>
<td>100% of charts</td>
<td>3 days</td>
</tr>
<tr>
<td>31+</td>
<td>Random selection up to 30 charts</td>
<td>3 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current census</th>
<th>active # of charts that need review</th>
<th>Length of Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Duty Nursing 1-7</td>
<td>100% of charts</td>
<td>1 day</td>
</tr>
<tr>
<td>8-16</td>
<td>100% of charts</td>
<td>2 days</td>
</tr>
<tr>
<td>17-24</td>
<td>100% of charts</td>
<td>3 days</td>
</tr>
<tr>
<td>25 - 30</td>
<td>100% of charts</td>
<td>4 days</td>
</tr>
<tr>
<td>31+</td>
<td>Random selection up to 30 charts</td>
<td>4 days</td>
</tr>
</tbody>
</table>
Section 6032 of the Deficit Reduction Act (DRA) established section 1902(a)(68) of the Social Security Act. Effective January 1, 2007, all “entities” as described in the Act were required to comply with the terms of this section:

An organization (entity) which furnishes directly, or otherwise authorizes the furnishing of, the delivery of Medicaid health services where payments are made with respect to those services are received or made under a State Plan approved under Title XIX or under any waiver of such plan approved under section 1115, and total at least $5,000,000 during the most recent federal fiscal year.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

If you or your organization meets the definition of an “entity” under this section as determined by payments received during the federal fiscal year ended September 30, 2006, you are required to establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity’s policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also provide specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity’s policies and procedures for detecting and preventing waste, fraud, and abuse.

Private Duty Nursing Services - Special Programs
- EPSDT – Early & Periodic Screening, Diagnosis & Treatment
- CRPD – Community Resources for People with Disabilities
- ACCAP - AIDS Community Care Alternative Program
- ABC - Home and Community-Based Services Waiver for Medically Fragile Children

Personal Care Assistant Services - Programs
- ACCAP - AIDS Community Care Alternative Program
- CCPED – Community Care Program for the Elderly and Disabled
- PCA – Personal Care Assistant
### WWW Survey Agenda

**JC and NJ Desk Audit Survey**

*The agenda may be modified following the Opening Conference*

<table>
<thead>
<tr>
<th>WHEN</th>
<th>WHAT</th>
<th>WHO</th>
<th>DONE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>Opening Conference</td>
<td>Leadership / Surveyor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Discussion and Orientation to Organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Organization's Survey Expectations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Name and Phone Number Contact Person</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Business Card</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Discussion of Sites and Branches</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Discussion of Services Provided: PCA PDN Peds Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Current Number Clients on Service _______</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Review of Survey Activity Number of Home Visits _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Number of Client Records to Review_______</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Staff Personnel Files _______</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Client / Family Satisfaction Phone Calls_____</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Discussion of Home Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By 10:00</td>
<td>Place on Desk</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Active Client List</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Visit Schedule for Survey Days</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Organizational Chart</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>List of Employees</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Current State License Expires:</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Marketing Materials</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admission Packet</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Do Not Use Abbreviation Policy - Assesment and Reassessment Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Care Planning Policy -Documentation Policy -Case</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conference Policy -Complaint Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td>Individual Tracer Activity – home visit 1 Copy of Care Plan to Review</td>
<td>Leadership / Surveyor</td>
<td></td>
</tr>
<tr>
<td>11:30</td>
<td>Individual Tracer Activity – home visit 2 Copy of Care Plan to Review</td>
<td>Leadership / Surveyor</td>
<td></td>
</tr>
<tr>
<td>By 12:00</td>
<td>Place on Desk</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance Improvement Data: Client and Staff Perception of Care (Satisfaction) Surveys</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unusual Occurrences (Incidents)</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infections</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Falls</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Client Complaints</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infection Control Plan</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infection Control Risk Assessment and Goals</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infection Control Hand Hygiene Program</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infection Control Influenza Program</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td>By 1:00</td>
<td>Place on Desk</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency Preparedness Plan -Emergency Drill Activation Past 2yr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Event Description</td>
<td>Responsible Party</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>12:30</td>
<td>Surveyor Lunch</td>
<td>Surveyor</td>
<td></td>
</tr>
<tr>
<td>1:30</td>
<td>Individual Tracer Activity – home visit 3 Copy of Care Plan to review</td>
<td>Leadership / Surveyor</td>
<td></td>
</tr>
<tr>
<td>2:30</td>
<td>Record Review / Document Review</td>
<td>Surveyor</td>
<td></td>
</tr>
<tr>
<td>3:30</td>
<td>Special Issue Resolution (if needed)</td>
<td>Leadership / Surveyor</td>
<td></td>
</tr>
<tr>
<td>4:00</td>
<td>Review of Today’s Activities - Items on IOU List Planned Activities for Day 2</td>
<td>Leadership / Surveyor</td>
<td></td>
</tr>
</tbody>
</table>

**IOU List – Day 1**

<table>
<thead>
<tr>
<th>WHEN</th>
<th>WHAT</th>
<th>WHO</th>
<th>DONE</th>
</tr>
</thead>
</table>

**Day 2**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00</td>
<td>Daily Briefing -Discussion of Day 1 Activities -Discussion of Day 2 Plan</td>
<td>Leadership / Surveyor</td>
</tr>
<tr>
<td>9:30</td>
<td>Leadership Discussion</td>
<td>Leadership / Surveyor</td>
</tr>
<tr>
<td>9:45</td>
<td>Emergency Management Discussion</td>
<td>Leadership / Surveyor</td>
</tr>
<tr>
<td>10:15</td>
<td>Data / Infection Control Discussion</td>
<td>Leadership / Surveyor</td>
</tr>
<tr>
<td>10:30</td>
<td>HR Discussion -Competency -Identify HR files for Review - Orientation File Set Up</td>
<td>Leadership / Surveyor</td>
</tr>
<tr>
<td></td>
<td>-Home Health Aide Training – if applicable -Home Health Aide In-Services – 12 hours</td>
<td>Surveyor</td>
</tr>
<tr>
<td>11:00</td>
<td>Record Review / Document Review</td>
<td>Surveyor</td>
</tr>
<tr>
<td>12:00</td>
<td>Surveyor Lunch</td>
<td>Surveyor</td>
</tr>
<tr>
<td>1:00</td>
<td>Record Review / Document Review</td>
<td>Surveyor</td>
</tr>
<tr>
<td>2:00</td>
<td>Questions and Answers Regarding Reviews</td>
<td>Leadership / Surveyor</td>
</tr>
<tr>
<td>4:00</td>
<td>Daily Wrap Up / Discussion / Items on IOU List Exit Conference – if applicable</td>
<td>Leadership / Surveyor</td>
</tr>
</tbody>
</table>

**IOU List – Day 2**

<table>
<thead>
<tr>
<th>WHEN</th>
<th>WHAT</th>
<th>WHO</th>
<th>DONE</th>
</tr>
</thead>
</table>

**Day 3**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00</td>
<td>Daily Briefing -Discussion of Day 2 Activities -Discussion of Day 3 Plan</td>
<td>Leadership / Surveyor</td>
</tr>
<tr>
<td>9:30</td>
<td>Record Reviews / Document Reviews Client / Family Satisfaction Phone Calls</td>
<td>Surveyor</td>
</tr>
<tr>
<td>12:00</td>
<td>Surveyor Lunch</td>
<td>Surveyor</td>
</tr>
<tr>
<td>1:00</td>
<td>Record Reviews / Document Reviews</td>
<td>Surveyor</td>
</tr>
<tr>
<td>2:00</td>
<td>Questions and Answers Regarding Reviews</td>
<td>Leadership / Surveyor</td>
</tr>
<tr>
<td>WHEN</td>
<td>WHAT</td>
<td>WHO</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>4:00</td>
<td>Daily Wrap Up / Discussion / Items on IOU List</td>
<td>Leadership / Surveyor</td>
</tr>
<tr>
<td></td>
<td><em>Exit Conference – If Applicable</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>IOU List – Day 3</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHEN</th>
<th>WHAT</th>
<th>WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DAY 4</strong></td>
<td><strong>9:00</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Daily Briefing</td>
<td>Leadership / Surveyor</td>
</tr>
<tr>
<td></td>
<td>-Discussion of Day 3 Activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Discussion of Day 4 Plan</td>
<td></td>
</tr>
<tr>
<td>9:30</td>
<td>Record Reviews / Document Reviews</td>
<td>Surveyor</td>
</tr>
<tr>
<td>12:00</td>
<td>Surveyor Lunch</td>
<td>Surveyor</td>
</tr>
<tr>
<td>1:00</td>
<td>Record Reviews / Document Reviews</td>
<td>Surveyor</td>
</tr>
<tr>
<td>2:00</td>
<td>Questions and Answers Regarding Reviews</td>
<td>Leadership / Surveyor</td>
</tr>
<tr>
<td></td>
<td>Special Issue Resolution – if applicable</td>
<td></td>
</tr>
<tr>
<td>3:00</td>
<td>Exit Conference</td>
<td>Leadership / Surveyor</td>
</tr>
</tbody>
</table>
## California Home Health Agency Survey Addendum

Below are additional requirements of California law that must be assessed during the Joint Commission’s on-site survey of Home Health Agencies providing skilled nursing services.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>22 CCR</td>
<td>74701(e)</td>
<td>All orders shall be reviewed by the attending physician, dentist, podiatrist, or other licensed and legally authorized practitioner within his or her scope of practice at least every 62 days.</td>
<td>None</td>
<td><strong>Standard LD.04.01.01</strong>&lt;br&gt;The organization complies with law and regulation.&lt;br&gt;<strong>LD.04.01.01, EP 2</strong>&lt;br&gt;The organization provides care, treatment, or services in accordance with licensure requirements, laws, and rules and regulations.&lt;br&gt;Note: For home health agencies that elect to use The Joint Commission deemed status option: A home health agency that wishes to furnish outpatient physical therapy or speech pathology services must meet federal requirements at §484.38 in addition to health and safety requirements at §485.711, §485.713, §485.715, §485.719, §485.723, and §485.727. For the federal definition of outpatient physical therapy services, see 1861(p) of the Social Security Act.<strong>&lt;br&gt;<strong>Scoring Note:</strong> If noncompliance is found, cite at EP above noting that this is a requirement of CA law</strong></td>
</tr>
<tr>
<td>22 CCR</td>
<td>74705(b)</td>
<td>A nurse supervisor shall be a registered nurse with two years’ experience within the last five years in a home health agency, primary care clinic, or health facility, unless the individual has been previously approved for such employment by a program flexibility issued for the individual's current position at the home health agency prior to April 1, 1995.</td>
<td>HR.01.03.01, EP10 (D); HR.01.01.01, EP8 (D) (TJC does not require this amount of experience.)</td>
<td><strong>HR.01.01.01</strong>&lt;br&gt;The organization has the necessary staff to support the care, treatment, or services it provides.&lt;br&gt;<strong>EP 8:</strong> For home health agencies that elect to use The Joint Commission deemed status option: The organization provides skilled nursing services by or under the supervision of a registered nurse.&lt;br&gt;<strong>HR.01.03.01</strong>&lt;br&gt;Staff are supervised effectively.&lt;br&gt;<strong>EP 10:</strong> For home health agencies that elect to use The Joint Commission deemed status option: A physician or registered nurse supervises skilled nursing and other therapeutic services.&lt;br&gt;Note: The registered nurse preferably has at least one year of nursing experience and is a public health nurse.</td>
</tr>
</tbody>
</table>
| 22 CCR | 74709 | (d) Nothing in this section shall be construed as permitting a physical therapy aide, as defined in Title 16, Section 1399, California Code of Regulations, to perform the functions of a home health aide, unless the physical therapy aide meets the definition of a home health aide. Physical therapy aides who are not certified as home health aides may not substitute for home health aides when home health aides are required by a plan of treatment or plan of care. Nothing in this section shall require a physical therapist to supervise home health aides in the same manner as physical therapy aides. Home health aide services shall comply with applicable state law. | None (TJC stds allow PTs to supervise HH aides) | **Scoring Note:** Since the CA regulation is more prescriptive, should noncompliance be found, score at appropriate EP above noting that CA law requires minimum 2 years within last 5 years. 
**Note:** if non-compliance is found on ESP event score at LD.04.01.01 EP2 | Standard LD.04.01.01
The organization complies with law and regulation. 
LD.04.01.01, EP 2
The organization provides care, treatment, or services in accordance with licensure requirements, laws, and rules and regulations. 
Note: For home health agencies that elect to use The Joint Commission deemed status option: A home health agency that wishes to furnish outpatient physical therapy or speech pathology services must meet federal requirements at §484.38 in addition to health and safety requirements at §485.711, §485.713, §485.715, §485.719, §485.723, and §485.727. For the federal definition of outpatient physical therapy services, see 1861(p) of the Social Security Act. 
**Scoring Note:** If noncompliance is found, cite at EP above noting that CA law does not allow. |
| 22 CCR | 74723 | (a) All agencies shall require health assessments and maintain health records for employees with direct patient contact. | HR.01.02.05, EP5 | **Scoring Note:** If noncompliance is found, cite at EP above noting that CA law does not allow. | HR.01.02.05
The organization verifies staff qualifications. 
**EP 5:** Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented. |
| 22 CCR | 74723 | (b) A written health assessment of each employee who has direct patient contact shall: | HR.01.02.05, EP5 | **Scoring Note:** If noncompliance is found, cite at EP above noting that CA law does not allow. | HR.01.02.05
The organization verifies staff qualifications. 
**EP 5:** Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented. |
| 22 CCR | 74723 | (1) Be required as a prerequisite of employment. | HR.01.02.05, EP5 | **Scoring Note:** If noncompliance is found, cite at EP above noting that CA law does not allow. | HR.01.02.05
The organization verifies staff qualifications. 
**EP 5:** Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented. |
| 22 CCR | 74723 | (2) Be performed within six months prior to employment or within 15 days of assuming employment with the agency. | HR.01.02.05, EP5 | **Scoring Note:** If noncompliance is found, cite at EP above noting that CA law does not allow. | HR.01.02.05
The organization verifies staff qualifications. 
**EP 5:** Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented. |
<table>
<thead>
<tr>
<th>Code</th>
<th>Section</th>
<th>Description</th>
<th>Scoring Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 CCR 74723</td>
<td>(3) Be performed and evaluated by a licensed and legally authorized practitioner within his or her scope of practice.</td>
<td>HR.01.02.05, EP5</td>
<td>If noncompliance is found, cite at EP above noting the element of the health assessment missing is a requirement of CA law.</td>
</tr>
<tr>
<td>22 CCR 74723</td>
<td>(c) The written health assessment report shall:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 CCR 74723</td>
<td>(1) Be signed by the person who performed the assessment.</td>
<td>HR.01.02.05, EP5</td>
<td>If noncompliance is found, cite at EP above noting the element of the health assessment missing is a requirement of CA law.</td>
</tr>
<tr>
<td>22 CCR 74723</td>
<td>(2) Verify that the employee is free from health conditions which would interfere with the employee's ability to perform assigned duties.</td>
<td>HR.01.02.05, EP5</td>
<td>If noncompliance is found, cite at EP above noting the element of the health assessment missing is a requirement of CA law.</td>
</tr>
<tr>
<td>22 CCR 74723</td>
<td>(3) Contain verification that the employee is free from signs or symptoms of infectious disease.</td>
<td>IC.02.03.01, EPs 1 and 2</td>
<td>The organization works to prevent the spread of infectious disease among patients and staff.</td>
</tr>
</tbody>
</table>

**Scoring Note:** If noncompliance is found, cite at EP above noting the element of the health assessment missing is a requirement of CA law.
workplace contact is possible, and as required by law and regulation or organization policy.

**EP 2:** When licensed independent practitioners or staff have, or are suspected of having, an infectious disease that puts others at risk, the organization provides them with or refers them for assessment and potential testing, prophylaxis/treatment, or counseling.

| 22 CCR | 74723 (4) | Provide for a tuberculosis screening which shall be administered to all new employees who have direct patient contact and annually thereafter using a test for tuberculosis infection that is recommended by the federal Centers for Disease Control and Prevention (CDC) and licensed by the federal Food and Drug Administration (FDA). | HR.01.02.05, EP5 | HR.01.02.05 The organization verifies staff qualifications. **EP 5:** Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented. **Scoring Note:** If noncompliance is found, cite at EP above noting the element of the health assessment missing is a requirement of CA law.

| 22 CCR | 74723 (A) | The tuberculosis test shall be administered by a licensed health care professional who is specifically trained for the procedure. | HR.01.02.05, EP5 | HR.01.02.05 The organization verifies staff qualifications. **EP 5:** Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented. **Scoring Note:** If noncompliance is found, cite at EP above noting the element of the health assessment missing is a requirement of CA law.

| 22 CCR | 74723 (B) | Employees who present evidence of a previous positive tuberculosis test or that he or she has previously been treated for tuberculosis infection or disease shall be excluded from the tuberculosis screening testing. | HR.01.02.05, EP5 | HR.01.02.05 The organization verifies staff qualifications. **EP 5:** Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented. **Scoring Note:** If noncompliance is found, cite at EP above noting the element of the health assessment missing is a requirement of CA law.

| 22 CCR | 74723 (d) | An employee shall not be required to undergo the annual tuberculosis screening requirements of (c)(4) if the local health officer certifies in writing that less frequent testing may be conducted, and the rationale for Organization should have written documentation of positive test/previous treatment. | HR.01.02.05, EP5 | HR.01.02.05 The organization verifies staff qualifications. **EP 5:** Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented. **Scoring Note:** If noncompliance is found, cite at EP above noting the element of the health assessment missing is a requirement of CA law.
<table>
<thead>
<tr>
<th>Code</th>
<th>CCR 74742</th>
<th>Requirement</th>
<th>Score Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td></td>
<td>less frequent testing is in accordance with applicable federal, state, and local requirements and established professional standards.</td>
<td>required by law and regulation or organization policy. Health screening compliance is documented. <strong>Scoring Note:</strong> If noncompliance is found, cite at EP above noting the element of the health assessment missing is a requirement of CA law. Organization should have written documentation as proof of employee not needing an annual TB screen.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(b) The review of a patient's clinical records shall be based on a sample of five percent of the total patient census with a minimum of twenty records and a maximum of 100 records every six months. The review of the clinical record sample shall be:</td>
<td>RC.01.04.01 EP 2 EP 1: According to a time frame it defines, the organization reviews its patient records to confirm that the required information is present, accurate, legible, authenticated, and completed on time. <strong>Scoring Note:</strong> Since CA Law requires a qualified health professional of equivalent or higher level of training than the care provider, ensure that team includes this individual(s). If not cite at EP above noting it as a requirement of CA law.</td>
</tr>
</tbody>
</table>
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.
  o Significant Life Safety Code or failure to implement Interim Life Safety Code measures (failure of fire alarm system or generator)
  o Significant deviations from standards of practice as outlined by the Joint Commission, CDC, APIC, WHO etc.
  o Failures in the high-level disinfection and/or sterilization processes
  o Intimidation or threatening behavior toward patients, residents, clients or individuals served
  o Physical or sexual abuse or assault
  o Inappropriate use of restraints resulting in injury or death
  o Failure to obtain appropriate care or medical intervention, i.e. failure to respond to a significant change in condition
  o Inadequate or inappropriate staffing that negatively impacts safety
  o Ligature and other patient self-harm risks
  o LIPs performing procedures for which they have not been credentialed or privileged—no evidence of competency
  o Equipment malfunction that impacts safety
  o Issues with clinical alarms—functioning, response to, etc., that jeopardize patient safety
  o Lack of competency or licensure
  o 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.
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. 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 require that the attending staff physician will make ‘daily chart entries indicating review of resident assessment and care.’ There was no attending note in the chart or an attending attestation linked to a resident evaluation, despite the pediatric patient having been on the unit for greater than two days. Staff oversight of residents was not demonstrated. This was confirmed by the unit manager.”

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

There are certain standards where a *timeframe* is necessary because of the TJC standard requirement or because the standard suggests it is required based on organization policy, the law, or regulation. This does not mean a date is necessary to document the finding. Examples are:
BHC CTS.02.01.03 EP 2 The organization conducts each individual’s assessment within the time frame specified by the needs of the individual served, organization policy, and law and regulation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Documenting PHI in WST**

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

1. **In the WST Itinerary Home Page, select the Records section:**

   ![Image of WST Itinerary Home Page with Records section highlighted]

   - View Only: [BHC]
   - Search By: [Standard]
   - Standards: [NPSG]
   - Elements of Performance: [Standard Selection]

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

   ![Image of Add New Record window]

3. **Back on the Itinerary Home Page, select the Standard section:**

   ![Image of Itinerary Home Page with Standard section highlighted]
4. After entering the information regarding the observation, click on the corresponding Record Number to link the observation to the record:

Remember to attach the record, or records, reviewed during tracer activity when completing the Tracer entry:
Validated Conversations
Validate conversations with one member of the staff by speaking to additional staff.
To solidify the finding through agreement from the org, another direct care staff (the survey coordinator, a staff supervisor, etc.) is queried to confirm what was discussed in the initial conversation. This is completed as part of the tracer process.
Examples are:
HAP MM.03.01.01 EP 6 The organization prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation.
Weak: "The staff nurse said medications were kept at the patient's bedside."
Solid: "The staff nurse on the 4th floor medical/surgical unit stated that the organization’s practice was to leave medications at the patient’s bedside; making it possible to misuse, mishandle or divert the medications. This was confirmed with the unit manager who made the same statement."

Document the Policy Title
If a policy is necessitated by the standard or if a policy is referenced, the detail must be included. The formal policy name must be capitalized to distinguish it from a generic description of the policy content. If a written policy is required and not produced, include that information in the observation.
Examples are:
AHC HR.01.02.05 EP 5 Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented.
Weak: "It was noted during review of staff health records that a RN did not have a documented PPD since November 2011 although the organization's policy is to have a TB test every two years."
Solid: "It was noted during review of staff health records that a RN did not have a documented PPD since November 2011. The survey coordinator confirmed the organization’s policy is to have a TB test every two years (Policy: Vaccination and Testing version May 5, 2015)."

BHC RI.01.03.01 EP 13 Informed consent is obtained in accordance with the organization’s policy and processes.
Weak: "The medication informed consent form to administer Xanax was signed by the nurse on 3/13/15 but not signed by the patient until 3/17/15."
Solid: "In one of five medical records reviewed, the medication informed consent form to administer Xanax was signed by the nurse on 3/13/2015 but not signed by the patient until 3/17/2015. There is no evidence that the hospital's informed consent process requiring signature at the time of administration as
articulated in policy "6.5 Informed Consent" (last revised in March 2013 and most recently reviewed in February 2015) was followed. This was confirmed by the quality director."

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

**Use Counts for Detail**
Counts of supplies/equipment are documented when related to observed deficiencies. The actual number of deficient items is documented. This makes the finding more objective and reduces questions from the organization regarding the extent of the deficiency.

Examples are:

**HAP IC.02.02.01 EP 4 The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.**

**Weak:** "Multiple products were expired in the Radiology CT room.

**Solid:** "Observation of the Radiology CT room revealed the following expired products: five (5) Quick Core disposable biopsy needles, one (1) spinal needle, and one (1) BD Vacutainer which leaves patients exposed to possible infection due to out-of-date medical supplies."

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

Changes were made to Web-based Survey Technology to prompt surveyors to capture quantification in a more thorough and consistent manner. A lead-in statement that captures the numerator and denominator can be completed in situations where a numerator/denominator exists and is pertinent to the scoring of the standard or EP. A category drop-down is also available to identify the activity or item that is being quantified.

Examples are:

**HAP MS.06.01.09 EP 1 The decision to grant, limit, or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within the time frame specified in the medical staff bylaws. Requesting practitioners are notified regarding the granting decision.**

**Weak:** "It was observed that three of three newly appointed practitioners did not receive notification of the granting decision for the privileges that they had requested. For example an emergency room physician did not receive notification that all of the privileges that they had requested were granted. A Gastroenterologist did not receive notification that all of the privileges that they had requested were granted. A surgeon did not receive notification that all of the privileges they had requested were granted."

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

**Be Specific to the Standard/EP**
The observation must not contain multiple deficiencies that should be cited under other standards and/or elements of performance. Deficiencies related to different EPs must have their own cited observation. For instance:
Weak: “No biohazard label was placed on the container that was used to transport the dirty endoscope from the procedure room to the cleaning room. Emergency access to the eyewash station blocked. The cabinet in which the endoscopes were stored after reprocessing was not ventilated.”
In the example above, all findings were cited under the same element of performance. Cite under three separate standards and/or EPs.
Examples are:

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

AND  "Emergency access to the eyewash station outside the procedure room was blocked by a chair and a rolling cart.”  (HAP EC.02.02.01 EP 5)
AND    “The cabinet in which the endoscopes were stored after reprocessing was not ventilated which could pose infection risk for the endoscopy patients receiving treatment.”  (HAP IC.02.02.01 EP 4)

Document the Facts
Only use facts to communicate the reasons for the standard deficiency (no embellishment, inference, opinion, or peer review should be added to the citation).
Do not infer that certain facts exist if those facts were not actually observed. Similarly, do not draw conclusions about outcomes that were not actually observed. Do not include personal clinical opinion (peer review). Do not include positive comments to "soften" the impact of the observation.
Do not use statements such as:
“"The documentation suggests...”
“The organization should have...”
“The organization could have...”
“The organization would have...”
“It would be better if the hospital...”
“The organization needs a policy on...”
“The organization should consider..."
Appendix C – Surveyor Worksheet

Home Care Surveyor Worksheet

### Tracer Patient Selection Criteria

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

### Home Care Deemed Status – HH

<table>
<thead>
<tr>
<th>Did you…</th>
<th>Follow the OME: HH Deemed Status Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unannounced surveys</td>
<td>CMS requires specific sampling of the numbers of patient records and home visits to be performed</td>
</tr>
<tr>
<td>Specific Conditions and Standards for Medicare must be evaluated (reference the appendix in the Accreditation Manual for Home Care).</td>
<td></td>
</tr>
</tbody>
</table>

### Home Care Deemed Status – HOS

<table>
<thead>
<tr>
<th>Did you…</th>
<th>Follow the OME: HOS Deemed Status Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unannounced surveys</td>
<td>CMS requires specific sampling of the numbers of patient records and home visits to be performed</td>
</tr>
<tr>
<td>Conditions and Standards for Medicare still need to be specifically addressed (reference the appendix in the Accreditation Manual for Home Care),</td>
<td></td>
</tr>
<tr>
<td>Life Safety Code® building tour must be conducted for each freestanding hospice facility (building) providing 24-hour care.</td>
<td></td>
</tr>
</tbody>
</table>

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

1. Blood and blood product use
2. Conditions in the organization or individual environment*
3. Infection control, surveillance and reporting
4. Medication Management
5. NPSG Data (hand hygiene monitoring) **Reminder:** All applicable NPSGs must be evaluated during the course of the survey
6. OASIS Data, (Medicare Certified HH only)
7. Patient perceptions of care, treatment and services (specific needs and expectations, how the organization meets these needs and expectations, how the organization can improve patient safety)
8. Quality Control
9. Research, when conducted
10. Risk Management
11. Staff opinions and needs*
12. Staff perceptions of risks to individuals and suggestions for improving patient safety*
13. Staff willingness to report unanticipated adverse outcomes*
14. Utilization Management
15. Environment of care issues
16. Other PI activities

*Recommended, not required.
# OME Survey Process Rules For Surveyor Planning

### Did you....

**If freestanding home care survey**, the main site must be visited as the opening conference must occur there. Conduct

- Site visits to additional HH sites are not required, but the surveyor should be certain that at least 51% of the ADC is surveyed
- Site visits to additional HME sites are required, unless 1 day survey – follow guide for CMS multisite criteria for 24 sites or less
- Site visits to additional RX sites are required, unless 1 day survey
- Site visits to additional hospice sites are required only if direct HME and RX services provided by hospice, or hospice owns its own inpatient hospice facility. Surveyors should be certain that at least 51% of the ADC is surveyed.

At a minimum enough sites must be incorporated that reflect at least 51% of the patient census for the services being surveyed. The maximum number of additional sites to be visited are:

<table>
<thead>
<tr>
<th>Days</th>
<th>Sites to Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>none</td>
</tr>
<tr>
<td>2</td>
<td>one</td>
</tr>
<tr>
<td>3</td>
<td>three</td>
</tr>
<tr>
<td>4</td>
<td>five</td>
</tr>
<tr>
<td>5</td>
<td>seven</td>
</tr>
</tbody>
</table>

Selection sites to visit based on:

- If the main site does not provide a service (HH, HME, RX, HOS) noted on the application, visit a site that does. Note: Sites providing a unique, specialty practice should be selected only when the site’s patient census exceeds 10% or the practice is considered high right.
- Highest percentage of patients receiving care and services at the location (higher percentage of patients, higher priority)
- Patient volume of at least 5% for a specific home care service (HH, HME, RX, HOS)
- Based on travel distance from the last site visited – try to take circular route that allows beginning and concluding at the main site. Time in the evening, during lunch break, or late afternoon should be used to get to the next site. If this is not possible, then time in the evening may be required to get to the next site. Returning to the main site is preferable, but not required.

Note:

- One extra day is added (for travel) to the survey length for each site over 200 miles, and surveyors should fly to sites over 200 miles from closest site, unless not feasible.
- If locations are not visited, conduct the individual tracer by phone calls to staff and patients from that site. Include record review and personnel file review as part of remote tracer.
- Record sites that have been visited in survey technology on multi-site survey.

Surveyors must make every effort to select home care sites within a time frame that complies with the 14-day advance notice for making intra-survey travel arrangements. Do not wait until arrival at the main site to select additional sites to visit if intra-survey travel plans are required. Use HCO demographics to plot out site visits in advance.

Length of site visit is usually ½ to 1 full day, depending on the scope and volume of services provided at that location.

At least one Individual Tracer should be conducted on a patient on service for each site visited.
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.

Co-Team Leader Role
The Co-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 Co-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 Co-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 Co-Team Leader assigned)
- 1 - Home Health Care surveyor

**Co-Team Leader Expectations**

Field representatives are assigned the co-team leader skill based upon individual field representative performance and program need. The co-team leader skill set can be assigned or removed from an individual field representative’s job duties at any time. The co-team leader assignment is reviewed, at a minimum, during the annual performance.

The Co-Team Leader role is a survey-specific assignment. Surveyors assigned as Co-Team Leaders fulfill the expectations outlined in this document. In addition to duties outlined in the Surveyor and/or Reviewer Job Description, the Co-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

**Co-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 Co-Team Leader will be assigned)

1. Educates program team members about the organization's centralized and de-centralized functions for your specific program
2. Enter notes in WST corporate comments sections across sites for the program
   a. Record positive attributes within the organization’s program, observed by the program survey team through the course of the survey route
   b. Record leading practices within the organization’s program, observed by the program survey team through the course of the survey route
   c. Record trends that could be considered as leadership insights that did not translate into official survey report observations, (e.g. issues related to supervision, education, quality improvement, customer/patient satisfaction) that the leaders within the organization should be aware of relative to the overall performance of the corporation
3. Participate with the corporate summation as requested by central office
### Appendix E – OME Applicability Grid for Program-specific and System Tracers

<table>
<thead>
<tr>
<th>Tracer</th>
<th>Length of Survey</th>
<th>Included as system tracer on all surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Tracer for Data Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 day</td>
<td>Evaluate the topics addressed by all of the tracers noted in the column to the left while conducting Individual Tracers.</td>
</tr>
<tr>
<td></td>
<td>2 day</td>
<td>Select one additional system tracer from this list as it is applicable to the organization. The session will not be identified on the agenda template; however, you may use time identified as individual tracer activity time to conduct one of these focused tracers.</td>
</tr>
<tr>
<td></td>
<td>3 day</td>
<td>Select one additional system tracer from this list as it is applicable to the organization. The session will not be identified on the agenda template; however, you may use time identified as individual tracer activity time to conduct one of these focused tracers.</td>
</tr>
<tr>
<td></td>
<td>4 day</td>
<td>Select two additional system tracers from this list as it is applicable to the organization. There will be designated time for at least one of these tracers on the agenda, the other session will not be identified on the agenda template; however, you may use time identified as individual tracer activity time to conduct one of these focused tracers.</td>
</tr>
<tr>
<td></td>
<td>5 day</td>
<td>Reference the columns to the left for the number of days that the OME surveyor is on site. Select the number of system/program specific tracers to incorporate into the survey based on these guidelines.</td>
</tr>
<tr>
<td></td>
<td>Complex</td>
<td></td>
</tr>
</tbody>
</table>

- **Program Specific Tracer – Fall Reduction**
- **Program Specific Tracer – Hospital Readmission**
- **Infection Control System Tracer**
- **Medication Management System Tracer**

Evaluate the topics addressed by the remaining tracers while conducting Individual Tracers.
Appendix F – Handout for the Home Care Organization

To access information about your survey, proceed to your Joint Commission extranet site by accessing www.jointcommission.org.
- Click on the “Joint Commission Connect” logo
- Enter your login and password
- You will find the following information
  a. Notification of scheduled Joint Commission event authorizing the presence of the surveyors for the unannounced survey
  b. Surveyor(s) name, picture and biographical sketch
  c. Scheduled survey dates

As a Home Health, Hospice, Pharmacy and or Home Medical Equipment/DMEPOS organization, you will need the following information and documents available for the surveyor to review.

Documents Needed Within One Hour of Surveyor Arrival

General Organization Information
- Name and phone number of key contact person who can assist surveyors in patient visits or observation of service delivery
- A copy of your organizational chart
- Active employee list with discipline or title
- List of all sites, branches and services provided, if applicable
- State licenses, certificates, etc.
- CLIA waiver and Waived tests being performed
- List of contracted agencies or contracted staff and the contract(s)

Tracer Selection Documentation (Lists needed within one hour of surveyor arrival)
- Active patient list with
  o Patient name
  o Diagnosis or therapy, equipment provided
  o Start of care date
- List of scheduled home visits for the duration of the survey including:
  o Type of service (home health, hospice, personal care and support, CBPC, as applicable)
  o Disciplines
  o Diagnosis
  o Date of admission
- List of scheduled deliveries, mail orders or planned walk in business for the days of survey and from specific points in time as delineated by the surveyor, including: Home Medical Equipment/DMEPOS, Pharmacy
  o Type of medication/therapy
  o Durable Medical Equipment, Prosthetics or Orthotics being supplied/delivered
  o Supplier’s date of first encounter/admission
  o Address, IF delivery is part of the service
- List of all active rental equipment patients
Documents Needed During the Course of the Survey

General Organization Information
- Marketing material
- Admission packet – Documents such as patient rights and responsibilities, advanced directives, consents, charges, medication education information
- Policies and Procedures including:
  - Home Safety – safety checklist, O2, signs, fire extinguisher, smoke alarm
  - Do not use abbreviations, approved abbreviations
  - Medication management policy
    - High risk medications and Look Alike Sound Alike (LASA)
  - Assessment and reassessment policies
  - Pain assessment and reassessment policies
  - Process/policy for case conferencing
  - Complaint process/policy
  - Budget & Surety Bond - DMEPOS
  - Equipment cleaning policy - DMEPOS
  - After Hours On-Call log - DMEPOS and Pharmacy
  - Written policies/processes specific to CBPC program and patient care
- Selected personnel files for employees and contractors observed during the survey will be requested for review

Performance Monitoring and Improvement Documentation
- Performance improvement data (12 months for re-surveys) including Perception of care/satisfaction data
- For organizations pursuing CBPC Certification: Information on the required measures (4) being monitored by the program.
- Medication error reports and adverse drug reactions
- Fall reduction program, fall risk assessment and evaluation of program
- Patient event, incident, or unusual occurrence reports logs or summary data
- Complaint logs
- Staff event, incident, unusual occurrence reports (for example: falls, sharps injury)
- Infection Control Summary Reports, 12 months of surveillance data
- Infection Control Plan including risk analysis
- Hand hygiene program, including policy, goals and surveillance data
- Emergency Management plan (Annual drill and evaluation of drills)
- Clean room monitoring records - Providers of Infusion Pharmacy Services

Documents Required on Deemed Status Surveys
1. Unduplicated admissions for the past 12 months with diagnosis, start of care date and disciplines
2. Discharged patients for the past 12 months with diagnosis, start of care date and disciplines
3. Last State survey report, if applicable
4. Professional Advisory Committee meeting minutes, & Board meeting minutes
5. Annual program evaluation
6. Budget, capital expenditures – 3 years
7. Quarterly record review documentation (recent 12 months)
8. HHA training program, if applicable, and 12 month education calendar
9. OBQM/OBQI/HHA provider reports (Please provide this data by lunch of day one)
   a. OBQM Adverse Outcome Report
   b. OBQI (Avoidable Event Report) Outcome Report
   c. OBQI (Avoidable Event Report) Case Mix Report
   d. OASIS Submission Statistics by Agency report
   e. Error Summary Report by HHA
10. HQRP/QAPI reports for the past quarter (initial survey) or past year (re-survey)

**Document List Related to CMS Emergency Management Final Rule applies to Deemed Home Health Agencies and Deemed Hospices**

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

11. Prioritized Potential Emergencies (Hazard Vulnerability Analysis)
12. Emergency Operations Plan
13. Documentation of annual review and update of Emergency Operations Plan, including communication plans
15. Documentation of completed/attempted contacts with local, state, tribal, regional, federal EM officials in organization's service area
16. Annual training
17. Patient evacuation procedures (inpatient hospice)
18. Tracking system for patients sheltered on-site and patients relocated to alternate site (inpatient hospice)
19. Tabletop exercise protocol
20. Patient emergency instructions based on assessed needs (home health agencies)
21. Integrated system risk assessments, plan, and annual review

**For Hospice Inpatient facility based care sites:**
- Environment of care data

**For Pharmacy Surveys:**

1. A list of current patients with start of care date and the type of compounded medication being provided. If there are a limited number of active patients receiving compounded medication, provide a list of discharged patients who received compounded medications representative of those provided by the organization. If the organization does high-risk medication compounding, at least one of the individual tracers should involve a patient that is receiving a high risk compounded medication such as a non-sterile bulk powder that becomes sterile through the compounding process). If no high risk compounding is done at the organization, then medium risk compounded medications should be selected.
2. Pharmacy organizational chart
3. List of staff involved in medication compounding, including the pharmacist in charge
4. Job descriptions for each category of pharmacy staff involved in medication compounding
5. Beyond Use Dating assignment policy
6. List of all Primary Engineering Controls (PECs) and Secondary Engineering Controls (SECs)
7. Clean room monitoring and certification records for all PECs and SECs (certification records for the last year will be needed)
8. All pharmacy facility licenses
9. Most recent State Board of Pharmacy reports
10. Policy, procedures, and software supporting medication recall and compounded medication returns
11. Submitted DEA Form 222 and associated powers of attorney
12. Competency assessments and performance evaluations for staff involved in medication compounding
13. Remedial follow-up on failed competency reviews
14. Pharmacy quality control checks and performance improvement data
15. Performance improvement action plans that demonstrate how data have been used to improve care and services, when available
16. All medication compounding related policies and procedures

Please note that this is not intended to be a comprehensive list of documentation that may be requested during the survey. Surveyors may need to see additional documents throughout the survey to further explore or validate observations or discussions with staff.
## Appendix G – Home 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 - 60 minutes</td>
<td>1st day, upon arrival</td>
</tr>
<tr>
<td>Opening Conference</td>
<td>30 - 60 minutes</td>
<td>1st day, as early as possible; may be combined with the Orientation to Organization on surveys of shorter duration</td>
</tr>
<tr>
<td>Orientation to Organization</td>
<td>45 minutes</td>
<td>1st day, as early as possible; may be combined with the Opening Conference on surveys of shorter duration</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>90 -120 minutes</td>
<td>Individual Tracer activity occurs throughout the survey; the number of individuals that surveyors trace varies by organization. Travel to perform tracer activity (e.g., patient home visits) 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>15 -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>30-60 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization or in conjunction with Leadership session</td>
</tr>
<tr>
<td>Environment of Care and Emergency Management</td>
<td>45-90 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization</td>
</tr>
<tr>
<td>System Tracer – Data Management</td>
<td>60 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization. If this is the only system tracer taking place during survey, the topics of Infection Control and Medication Management will be covered in this discussion.</td>
</tr>
<tr>
<td>Leadership</td>
<td>60 minutes</td>
<td>Towards the middle or end of survey at a time negotiated with the organization</td>
</tr>
<tr>
<td>Report Preparation</td>
<td>90 -120 minutes</td>
<td>Last day of survey</td>
</tr>
<tr>
<td>CEO Exit Briefing</td>
<td>15-30 minutes</td>
<td>Last day of survey</td>
</tr>
<tr>
<td>Interim Exit</td>
<td>30 minutes</td>
<td>Last activity on last day of survey on surveys occurring simultaneously</td>
</tr>
<tr>
<td>Activity Name</td>
<td>Suggested Duration of Activity</td>
<td>Suggested Scheduling of Activity</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Organization Exit Conference</td>
<td>30-45 minutes</td>
<td>Last day, final activity of survey</td>
</tr>
<tr>
<td>System Tracer – Infection Control</td>
<td>30-60 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>30-60 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>Life Safety Code Building Assessment</td>
<td>45-60 minutes</td>
<td>Only occurs on Facility-Based Hospice surveys; at time negotiated with organization</td>
</tr>
<tr>
<td>Regulatory Review</td>
<td>45-60 minutes</td>
<td>Only occurs on DMEPOS surveys; At time negotiated with organization</td>
</tr>
<tr>
<td>Equipment/Supply Management Tracer</td>
<td>60 minutes</td>
<td>Only occurs on HME surveys; After some individual tracer activity has occurred; at a time negotiated with the organization</td>
</tr>
</tbody>
</table>
Appendix H – Accreditation with Follow-up Survey

**Applies to:** All accreditation programs

<table>
<thead>
<tr>
<th><strong>Duration</strong></th>
<th>Per itinerary; one day in most cases.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participants</strong></td>
<td>Joint Commission: Surveyors Organization: Survey coordinator, senior leadership, others</td>
</tr>
</tbody>
</table>

**What’s a Surveyor To Do If…**

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

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

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

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

**Objectives**

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

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

**Before**

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

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

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

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

5. Review the ESC, if it is available.

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

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

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

**Conducting the Survey – Know the Event Type**

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

2. Report to the reception area, security officer, information desk or administrative office upon arrival and:
   a. Provide your name and the purpose for your visit.
   b. Display your Joint Commission identification badge.
the Accreditation with Follow-Up Survey?
A: The surveyor records all observations and findings related to any standard or EP found non-compliant.

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

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

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

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

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

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

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

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

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

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

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

Applies to: All accreditation programs, except LAB

**Duration**
Per itinerary; one day in most cases

**Participants**
Surveyor

Organization:
- Survey Coordinator
- Senior leadership
- Staff throughout the organization
- Licensed independent practitioners if part of the organization

**Pre-Survey Planning**
1. Through your itinerary, locate the organization and click on the event ID. When the event is displayed, click on Quick Links to view:
   a. Previous Recommendations
   b. Available ESC submissions, Basic Building Information (BBI) data
   c. Organization’s application
2. The RUV template agenda is available to surveyors through WST for editing.
3. Review the ESC and the SAFER™ matrix.
4. **Do not contact the organization.** This is an unannounced event. Call the Joint Commission Account Executive if you have any questions.
5. Review the ESC. Note: this includes surveyor findings for non-compliant standards found during the last survey.
6. Identify survey activities that would evaluate each element of performance identified in the ESC. The focus of survey activity for this survey is only the EPs being evaluated. For example, if the organization did not collect data about the perceptions of care, treatment and services, you would need to evaluate the effectiveness of the process it implemented in its ESC. You would not review all of the data collection.
7. Modify the template agenda for review with the organization at the Opening Conference.

**Conducting the survey**
1. Arrive at the organization approximately 10 minutes prior to the designated start time. Note: hospital surveys begin at 8 AM. Other program surveys start when the organization opens as identified in the organization’s demographic data.
2. Report to the reception area, security officer, information desk or administrative office upon arrival and introduce yourself and the purpose of your visit.
3. Display and show the organization’s representative your Joint Commission identification badge.
4. Ask the staff person, first encountered, to contact the administrative office or an organization leader to let them know of your arrival. You may be asked to wait in the lobby or...
5. Direct the survey coordinator or administrative contact to access the Joint Commission’s web page at www.jointcommission.org. Once there, select the link to access The Joint Commission Connect. They will need the user ID and password to sign-on. They should find the following information:
   a. Notification of scheduled Joint Commission event authorizing your presence
   b. Your picture and biographical sketch

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

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

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

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

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

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

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

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

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

15. Transmit the report to the Central Office within 24 hours of the exit following existing survey technology procedures.
Appendix J - Extension Survey (HME Only)
Applies to: HME

<table>
<thead>
<tr>
<th>Duration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable, usually one day survey</td>
<td>- Extension surveys are unannounced surveys designed to review organizations' compliance with CMS Quality Standards</td>
</tr>
<tr>
<td>Participants</td>
<td>Surveyors follow the agenda template for one day deeming extension surveys</td>
</tr>
<tr>
<td>Organization: Per agenda and Survey Activity Guide</td>
<td>- The focus of all survey activity is on the purpose for the extension survey and determining compliance with the standards. For example, if the purpose is:</td>
</tr>
<tr>
<td>Purpose of Extension Surveys</td>
<td></td>
</tr>
<tr>
<td>Extension surveys are provided when an organization notifies the Joint Commission about their:</td>
<td>o Newly acquired equipment or supplies that meet the Joint Commission eligibility criteria, the focus of survey activity is the assimilation of the new equipment/supplies into daily operations.</td>
</tr>
<tr>
<td>- newly acquired equipment or supplies that meets the eligibility criteria</td>
<td>o Newly acquired site, the focus of survey activity is the evaluation of practices at the newly acquired site to ensure consistency with the accredited organization’s practices. This includes an evaluation of the orientation of personnel, review of meeting minutes and staff interviews to evaluate the process by which acculturation occurred and an evaluation of services provided by the newly acquired site.</td>
</tr>
<tr>
<td>- newly acquired site, or expansion of services into a new site</td>
<td>o Expansion of services into a new site, the focus of survey activity is the physical and functional structure, training of staff, operational procedures and processes at the new site.</td>
</tr>
<tr>
<td>- other special circumstances, such as to meet new CMS Quality Standard requirements</td>
<td>o Other special circumstances, for example to meet expanded requirements for compliance with CMS Quality Standards, the focus of the survey is on expanded equipment and supplies that have not been included in past surveys and compliance with new CMS requirements.</td>
</tr>
</tbody>
</table>
Appendix K – Agenda Templates (HME Only)

_Agenda Template – HME One Day Extension Survey_

Present the organization with a copy of Appendix F – Handout for the Home Care Organization, which includes the documents needed for review from HME organizations.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:45</td>
<td>Arrival and Orientation to the Organization</td>
</tr>
<tr>
<td>8:45 – 9:30</td>
<td>Surveyor Planning Session</td>
</tr>
<tr>
<td>9:30 – 12:15</td>
<td>Individual Tracer Activity</td>
</tr>
<tr>
<td>12:15 – 12:45</td>
<td>Lunch</td>
</tr>
<tr>
<td>12:45 – 1:15</td>
<td>Environment of Care Session</td>
</tr>
<tr>
<td>1:15 – 1:45</td>
<td>Competence Assessment Session</td>
</tr>
<tr>
<td>1:45 – 2:15</td>
<td>Regulatory Session</td>
</tr>
<tr>
<td>2:15 – 2:45</td>
<td>Issue Resolution</td>
</tr>
<tr>
<td>2:45 – 3:45</td>
<td>Report Preparation Time</td>
</tr>
<tr>
<td>3:45 – 4:00</td>
<td>Exit Briefing</td>
</tr>
<tr>
<td>4:00 – 4:30</td>
<td>Organization Exit Conference</td>
</tr>
</tbody>
</table>
Agenda Template – HME Two Day Extension Survey

Present the organization with a copy of Appendix F – Handout for the Home Care Organization, which includes the documents needed for review from HME organizations.

**DAY 1**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:30 a.m.</td>
<td>Surveyor Arrival and Preliminary Planning Session</td>
</tr>
<tr>
<td>8:30 – 9:00 a.m.</td>
<td></td>
</tr>
<tr>
<td>9:00 – 9:30 a.m.</td>
<td>Opening Conference and Orientation to Organization</td>
</tr>
<tr>
<td>9:30 – 10:00 a.m.</td>
<td></td>
</tr>
<tr>
<td>10:00 – 10:30 a.m.</td>
<td>Continued Surveyor Planning Session</td>
</tr>
<tr>
<td>10:30 – 11:00 a.m.</td>
<td>Individual Tracer Activity</td>
</tr>
<tr>
<td>11:00 – 11:30 a.m.</td>
<td></td>
</tr>
<tr>
<td>11:30 – 12:00 p.m.</td>
<td></td>
</tr>
<tr>
<td>12:00 – 12:30 p.m.</td>
<td></td>
</tr>
<tr>
<td>12:30 – 1:00 p.m.</td>
<td>Surveyor Lunch</td>
</tr>
<tr>
<td>1:00 – 1:30 p.m.</td>
<td>Individual Tracer Activity</td>
</tr>
<tr>
<td>1:30 – 2:00 p.m.</td>
<td></td>
</tr>
<tr>
<td>2:00 – 2:30 p.m.</td>
<td></td>
</tr>
<tr>
<td>2:30 – 3:00 p.m.</td>
<td>Individual Based System Tracer – Data Use</td>
</tr>
<tr>
<td>3:00 – 3:30 p.m.</td>
<td></td>
</tr>
<tr>
<td>3:30 – 4:00 p.m.</td>
<td>Special Issue Resolution</td>
</tr>
<tr>
<td>4:00 – 4:30 p.m.</td>
<td>Surveyor Team Meeting / Planning Session</td>
</tr>
</tbody>
</table>

**DAY 2**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:30 a.m.</td>
<td>Leadership Session</td>
</tr>
<tr>
<td>8:30 – 9:00 a.m.</td>
<td></td>
</tr>
<tr>
<td>9:00 – 9:30 a.m.</td>
<td>Regulatory Review</td>
</tr>
<tr>
<td>9:30 – 10:00 a.m.</td>
<td></td>
</tr>
<tr>
<td>10:00 – 10:30 a.m.</td>
<td>Individual Tracer Activity</td>
</tr>
<tr>
<td>10:30 – 11:00 a.m.</td>
<td></td>
</tr>
<tr>
<td>11:00 – 11:30 a.m.</td>
<td></td>
</tr>
<tr>
<td>11:30 – 12:00 p.m.</td>
<td>Environment of Care Session</td>
</tr>
<tr>
<td>12:00 – 12:30 p.m.</td>
<td></td>
</tr>
<tr>
<td>12:30 – 1:00 p.m.</td>
<td>Surveyor Lunch</td>
</tr>
<tr>
<td>1:00 – 1:30 p.m.</td>
<td>Competence Assessment Process</td>
</tr>
<tr>
<td>1:30 – 2:00 p.m.</td>
<td></td>
</tr>
<tr>
<td>2:00 – 2:30 p.m.</td>
<td>Surveyor Report Preparation</td>
</tr>
<tr>
<td>2:30 – 3:00 p.m.</td>
<td></td>
</tr>
<tr>
<td>3:00 – 3:30 p.m.</td>
<td></td>
</tr>
<tr>
<td>3:30 – 4:00 p.m.</td>
<td>CEO Exit Briefing and Organization Exit Conference</td>
</tr>
</tbody>
</table>
Appendix L – Addendum for Home Health Deemed Status Surveys

Overview

Initial, Repeat Initial, Interim and Triennial Recertification

This survey activity addendum addresses initial, repeat initial, also known as a Medicare Survey (MEDSRV), interim and triennial recertification home health surveys with deemed certification. Initial and triennial surveys are unannounced, and are conducted concurrently with Joint Commission Accreditation surveys. These cover all applicable Joint Commission standards and Medicare Conditions of Participation (COPs) for home health. Repeat initial and interim surveys are conducted separately from the Joint Commission accreditation survey cycle and the focus is on compliance with the standards that crosswalk to the CoPs.

This survey activity addendum supports surveyors in preparing for and conducting deemed home health surveys and supplements The Joint Commission’s Home Care Survey Activity Guide. One cannot be used without the other when conducting deemed home health surveys!

In order to be eligible for home health deemed status survey, the organization:

- Must have at least 7 active patients receiving skilled services at the outset of an initial survey
- Must have provided services to at least 10 skilled patients. These patients may or may not be Medicare recipients
- Must provide nursing and at least one other therapeutic service. One service must be provided directly, but the second service may be provided via contract
- Must demonstrate operational capability of all components of the Home Health Services (e.g. have done OASIS practice submission, staff have been hired, etc.)
- Must meet the Joint Commission’s eligibility criteria for survey. (Criteria located at the front of the CAMHC)

This information is verified by The Joint Commission Central Office. Call your Field Director or the Field Director On-Call if you arrive on site and find that the organization is not meeting the deemed eligibility criteria.

Prior to conducting your first deemed survey download the following reference materials to your laptop from the surveyor portal. Save them in your “My Documents” folder. Or, access via Quick Links in WST.

• The State Operations Manual, Appendix B –Guidance to Surveyors: Home Health Agencies (this includes the interpretive guidelines)

Prior to Survey-
In addition to information provided in the section about pre-survey preparation check the demographics report or electronic application (E-app) for patient volumes, ADC, unduplicated admissions over the past 12 months, branches, services etc, and survey process rules against this information. If the information is not available, call or email the Account Executive to validate this information. (The survey process rules can be found on the portal or in Appendix C of the SAG on the Home Care surveyor worksheet)

MATERIALS
Reference the following materials prior to the survey and use them to conduct the survey:
• State Operations Manuel (SOM) – in Quick Links
• Interpretive Guidelines in WST
• The Joint Commission crosswalk between standards and COPs (in WST)
• Copy of agenda
• OME Survey Activity Guide electronic version
• Copies of Survey tools, provided during orientation:
  o OBQM & QI Worksheet (on portal; not required for initial Medicare surveys)
• Copies of survey tools, available in the document library on surveyor portal:
  o Home-visit consent forms (These are CMS Consent Forms found on Surveyor Portal in English and Spanish.)
  o Calendar worksheets
  o Bring a blank 1572

Helpful Tip
Access the organization’s information on the Home Health Compare website. This provides you with information on the organization’s quality data before you arrive. This data may help you hone in on the OBQI/OBQM data.

Surveyor Arrival & Preliminary Planning Session-Deemed Addendum
In addition to the information provided in the OME Survey Activity Guide, use the following guidelines when you arrive.
• Validate unduplicated admissions from the past 12 months and ADC
• Request all OBQM and OBQI reports and begin analysis of data for resurveys. Not available/required for initial deemed surveys.
• Begin selecting tracers for home visits by using the current patient census list. Although you may have an idea of the patients you want to visit on subsequent days, you may not want to commit to which patients you will visit. Keep your
options open so you can adjust tracers if a need exists to evaluate similar patients based on information gleaned in tracer activity.

- Begin opening conference with appropriate staff.
- Provide the organization with a copy of the Deficiencies Report (1572) printed from CMS Forms in Survey Technology and ask them to complete all sections excluding numbers 12, 21 and 23, prior to the close of the survey.

### Opening Conference & Orientation to the Organization

If leadership staff members are not on site for the Preliminary Planning Session, ask if they can join by conference call or inquire when they will be available and reschedule the Opening Conference for as early as possible and proceed with other survey activity.

In addition to the content for this conference in the OME Survey Activity Guide:

- Ask the organization if the State or any other regulatory authority has made a visit since the last deemed survey. If they have, request a copy of the report.
- Ask the organization for a copy of its governing body’s bylaws

### Call your Field Director or the Joint Commission Field Director On-Call immediately if you discover that the organization:

- Does not meet eligibility requirements or
- Provides information that might change the length of the survey or survey activities, such as variations in expected volumes, sites, branches, services, etc., and
- has recently been surveyed by the state (within 9-12 months)

### Surveyor Planning Session

In addition to considering the Tracer Selection information in the Home Care Survey Activity Guide, the following should also be factored into making tracer patient choices in the case of an initial Medicare survey:

- Include all payer sources, including private pay
- A range of primary admitting diagnoses (stratification)
- "High-tech" services, if provided
- An adequate number to accommodate possible refusals of home visits
- Active patient records; Note: You may choose discharged records only if:
  - The sample size is low and inadequate to meet active record review requirements.
  - A service is not being provided to an active patient at the time of the survey, e.g., home health aide

### NOTE: Initial Deemed Surveys re Home Health Aide (CNA) Services at Time of Survey the following criteria must be met:

On initial deemed surveys:

- If the organization has not utilized CNA services at all, then they will not be certified for this service and the organization will be directed by the surveyor to
contact the account executive as notification if aide services are implemented, as follow-up survey activity may be required.

- The organization must have provided CNA services to either an "active patient" or "discharged patient" at the time of survey in order to be recommended for certification of Aide Services to Medicare. It is not required that the Surveyor observe a CNA in person for recommendation for certification—only that the organization has utilized CNA services and that the surveyor was able to verify compliance with the CoPs through either a home patient tracer visit OR a chart review for a discharged patient that utilized CNA services, and personnel file(s) for the CNA.
- Other disciplines can be surveyed and certified even if services have not yet been provided as long as they have the resources and policies in place to offer the service in the future.)
- Ask the organization to obtain verbal patient consent for home visits. Have the written consent form signed at the start of the home visit. (NOTE: The organization files written consent forms in the patient record. Surveyors do not maintain copies of the consent for Joint Commission records.)
- Tracer selection: Records and visits reflect:
  - Service(s) representative for the branches and subunits
  - Encompasses the 12-month period immediately prior to survey (interim and triennial surveys only)
  - Includes site/branch visits (While site/branch visits will be determined pre-survey, verify the sites/branches again with the organization. Not all sites need to be visited per the Survey Process Rules)
  - Review of the organization’s Outcome Based Quality Management (OBQM) and Outcome Based Quality Improvement (OBQI) reports for resurveys using the CMS worksheet to focus the survey.
    - OBQM Adverse Event Outcome
    - OBQI Outcome
    - OBQI Case Mix
    - OASIS Submission Statistics by Agency
    - OASIS Error Summary by HHA
  (NOTE: When completing the OBQI worksheet it is helpful to have a knowledgeable staff member available to review these reports together.)
  (NOTE: Reference the OBQM and OBQI worksheet and practice exercises for additional guidance. The reference materials are found in the Deemed Status Resource materials provided during orientation to deem status surveys.)

Selection of Records and SAMPLES

- Initial survey: Select tracers based on the clinical services
- Resurvey: Select individual tracer patients using the OBQM and OBQI data (worksheet) and clinical services as preliminary selection criteria
Use Outcome Reports to Focus Sample Selection for Home Health Record Review With a Home Visit

- Focus first on **Adverse Event Outcome (AE outcome)** Reports.
  - Select:
    - One or two patients triggered to be “at risk” for Tier 1 AE outcomes
    - One or two patients triggered to be “at risk” for Tier 2 AE outcomes
    - One or two patients with a medical condition relevant to the **OBQI outcomes** (e.g., if the outcome “Improvement in Urinary Incontinence” is a focus outcome, select a patient with urinary incontinence)

Use Outcome Reports to Focus Sample Selection for Home Health Record Review Without a Home Visit

- Use the Case Mix report to help identify Individual Tracer patients, select:
  - Active records to meet the sample size requirement based on the Adverse Event and OBQI outcome(s) triggered for focus and targeted case mix characteristics
  - One or two records for each Tier 1 AE outcome triggered
  - One or two records for each Tier 2 AE outcome triggered

---

**Home Health Clinical Record and Home Visit Selection**

**NOTE** – All initial surveys must have five visits completed to meet minimum CMS requirements.

**Required** sample sizes are as follows:

<table>
<thead>
<tr>
<th># of Admissions</th>
<th>Records with home visit</th>
<th>Records without home visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;150</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>150-750</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>751-1,250</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>1,251+</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

- Identify the number of unduplicated admissions in the past 12 months in the left column of the grid. Follow that row across to identify the number of record reviews.
- In the second row, identify the number of home visits including record reviews that you must conduct.
- In the third row, identify the number of additional records that you must review without home visits.
Additional records may need to be reviewed if condition-level deficiencies are identified.

Reminder in Survey Tech - Record Type selection: for all home visits and record reviews - Choose the HH Deemed with home visit or HH Deemed w/o home visit. This is required to assure the system accurately counts your record and visit activity.

*Special Circumstances: RESURVEYS ONLY
If unable to draw the required minimum sample size for home visits, you must call your Field Director or the Field Director on Call to discuss the situation. Every attempt should be made to complete the minimum number of home visits. In the event a special circumstance exists (such as the organization only has four active patients therefore it is impossible to complete five home visits) the clinical record review without home visits should be increased by one for each home visit not made.

If unable to meet the minimum sample size for record review, document the reasons (e.g., low census) why the minimum sample size requirements were not met in WST in Comments tab. A minimum of 10 charts must be reviewed for an initial survey.

Call the Home Care Field Director for any clarifications.

Calendar Worksheet: Prescribed Visits/Frequency
Use the calendar to track:
- visits by each discipline
- MD orders (484.18a Plan of Care)
• due dates for OASIS assessments/re-certifications (484.18b Periodic Review of POC)
• drug regimen review (484.55)
• supervisory visits (HHA, LPN, COTA, PTA)

Survey Process Activities

The Joint Commission Home Care Survey Activity Guide provides information on how these activities are conducted.
• Review and analyze information collected during all survey activities and determine whether the organization is meeting the regulatory requirements. Most routine survey activities include additional topics for discussion or exploration related to regulatory requirements, some of these unique topics are highlighted below.

Note: CMS has identified their highest priority standards as Level 1 standards. The Level 1 standards are addressed in 9 of the 15 CoPs. A review of Level 1 standards should occur on all initial, full and interim deemed surveys. Evaluation of the Level 1 standards under the nine CoP's must be documented into WST via the record review screen. Your record review information should be copied into the tracer screen as appropriate. See WST User Guide for further instructions on documenting evaluation of the required Level 1 standards/CoPs.
• Level 1 Standards/CoPs (subset of G tags are included)
  o 484.10 Patient Rights (G 107, 109)
  o 484.12 Federal/State/Local Laws of Ownership (G 121)
  o 484.14 Organization Services and Admin (G 123, 133, 143, 144)
  o 484.18 Plan of Care (G 157, 158, 159, 164, 165, 166)
  o 484.30 Skilled Nursing Services (G170, 172, 173, 174, 175, 176, 177)
  o 484.32 Therapy Services (G 186, 187, 188)
  o 484.36 Home Health Aide (G 224, 229)
  o 484.48 Clinical Records (G 236)
  o 484.55 Comprehensive Assessment -
    • (G 331, 332, 334, 335, 336, 337, 338, 340)

Other routine survey activities include:
  o Evaluation of home health Professional Advisory Committee (PAC)
  o System tracers (e.g., data use, medication management, infection control)
  o During the Data Management systems tracer, the surveyor addresses OASIS data¹-related to:
    ▪ Data collection
    ▪ Ensuring data quality

---------
- Encoding
- Transmission
- Resubmission of data if needed
  - Investigation of OASIS data transmission if problems were identified related to:
    - Submission statistics by agency report
    - Error summary report by HHA
  - Program specific tracers
    - Fall reduction
    - Hospital Readmission

The Level 1 standards under the nine of the 15 CoPs at a minimum are reviewed as part of the standard survey protocol and the review should be conducted as part of the routine accreditation survey process.

Review of the Level 2 standards under the nine CoPs may occur as part of the routine Accreditation survey process, however please note that if concerns are identified at a Level 1 standard /CoP, than the surveyor should always expand their review to include the appropriate level 2 standards (G tags) under the same CoP found out of compliance. (Refer to the HHA survey protocol or SOM for further guidance.)

- **Level 2 standards (additional subset of G tags may be reviewed include)**
  - 484.10 Patient Rights (G101,108,111,114)
  - 484.12 Federal/State/Local Laws of Ownership and Accepted Standards (G118)
  - 484.14 Organization, Services and Admin (G 124,125,137,138,139,150)
  - 484.18 Plan of Care (G 160, 162, 163)
  - 484.30 Skilled Nursing Services (G 169, 170)
  - 484.32 Therapy Services (G 190, 193)
  - 484.36 Home Health Aide (G 212, 215, 225, 226, 230, 232)
  - 484.48 Clinical Records (G 239)
  - 484.55 Comprehensive Assessment (G 339, 341)

Review of all CoPs should occur if a Condition Level Deficiency is identified.

Reference the OASIS web-based training site at [www.oasistraining.org](http://www.oasistraining.org) for further information.

**Competence Assessment Session**

In addition to the information in the Home Care Surveyor Activity Guide, be sure to:
- review home health aide in-service training requirements (12 hours annually based on hire date)
- review home health aide documentation of competency evaluation and training and competency
(NOTE: A review of home health aides’ personnel files is required if the organization is seeking certification for HHA services).

**Scoring and Determining Deficiency Level**

A *deficiency* is based on statute or regulation, and is not based on the interpretative guideline alone.

- The State Operations Manual (SOM) and the crosswalk (electronic version accessible via WST through Quick Links) can be used as a reference.
- The accuracy of the selection of the CoPs and the corresponding Joint Commission standards/EP is critical (i.e., multiple CoPs might be cross-walked to the EP in survey tech; therefore, make sure to choose the correct one). When uncertain regarding placement of an observation, call SIG.
- Multiple observations at a CMS standard can accumulate or roll-up to a Condition-Level Deficiency. Call SIG if you are unsure about assigning a deficiency level.
- There are three levels of deficiency identified by CMS:
  - Condition Level, and
  - Standard Level
  - Finding Level (Although CMS documents Finding Level deficiencies during the course of State surveys, Joint Commission surveyors will not have the option of entering an observation at the Finding Level.)
- **CMS requirements, although viewable in survey technology, should not be selected** (e.g., CFR 484.4 is a requirement, not a CoP, therefore should not be selected).

The level of deficiency is identified by the impact the deficiency can have on the following:
- Patient safety and care,
- Whether or not it occurred in isolation,
- Whether the deficiency occurred at a stand-alone CoP and
- The number of standards within a CoP that are non-compliant.
- Based on the surveyor's judgment, using the definition of **manner or degree**, he/she may decide to override the deficiency level at the observation level. This can be done by completing the field in the "override deficiency" section of the EP observation window. When overriding the deficiency level, reason and rationale fields are required.
- The override function can also be accomplished at the CoP summary screen. Survey tech will prompt you for the deficiency level reason and rationale fields. Review with SIG is encouraged.
- All observations should be cited at the most stringent level – flagging the standard for a review with SIG is encouraged prior to overriding a deficiency level.
Documenting Findings
- Clearly document your observations. Reference the Home Care Survey Activity Guide Appendix on Documenting Observations in Survey Technology.
- All observation findings must be entered individually. Do not enter multiple or compound observations in one paragraph.
- The verbiage "This Standard is not met as evidenced by," or "This Condition is not met as evidenced by" will automatically populate the citation in survey technology.
- Call SIG if unsure with your determination of a deficiency level or choice of EPs
- Complete Form 1572 in Survey Technology - see tab CMS Forms.

Survey Report Preparation
Survey Technology for Deemed Home Health Surveys

Important Points!
- Carefully review the report prior to conducting the Exit Conference. Make certain that all individual Condition-level and Standard-level deficiencies are scored appropriately. Review the Summary of CoP Findings page to verify all items are scored appropriately.
- Lock and publish your report to the organization's extranet site. Ask the organization to print a copy of the preliminary report for use during the Exit Conference.

Exit Briefing (CEO) Organization Exit Conference/Closing Conference
- Review and explain the Summary of Survey Findings report, including Direct, Indirect, and CMS standards.
- Describe the Joint Commission standards and the regulatory requirements not met by the organization, and the observations that substantiate the findings (Note: usually the surveyor starts with the Medicare part of the report)
- Review form 1572 with the organization to assure all required fields have been completed.
- Review the "What Happens After Your Joint Commission Survey" flier.
- Describe the Evidence of Standards Compliance (ESC) process and timeframes for submitting information to the Joint Commission.
- Explain that organizations undergoing an INITIAL deemed status survey may receive an interim survey in 12 months. Interim surveys may also occur for organizations after the recertification survey, depending on the number of Condition-level and Standard-level deficiencies.
- Explain that the Recommendation for Medicare certification will be determined at the Joint Commission Central Office. This will occur after the organization submits clarifying evidence, if desired, and the ESC has been approved by Central Office. CMS will use the date that the Joint Commission accepts the ESC as the certification date for initial organizations and the date the organization may begin to submit for reimbursement.
• Check and return any documents containing protected health information to the organization prior to leaving.

Adverse Decisions
If the Joint Commission accreditation decision is an adverse decision the organization will NOT be recommended for Medicare certification. The exceptions to this are:
   (1) If the adverse decision is driven by another home care program (i.e., HME or Pharmacy).

On an initial deemed survey, if the organization has any CONDITION-level deficiencies, it will NOT be recommended for Medicare certification. The organization will need to contact their Account Executive for next steps as a repeat survey will be required.

If Condition Level Deficiencies are identified on a resurvey, the organization will receive a Medicare Deficiency (MedDef) follow-up survey within 45 calendar days to verify that the Condition Level Deficiency has been resolved. The organization will need to follow up with the Account Executive for next steps.

Post Survey Activities
Using Web-based Survey Technology, the surveyor will submit their findings within 24 hours of completion of the survey. Review the web-based survey technology section for additional guidance as needed.

• The surveyor report will be posted to The Joint Commission extranet as soon as it has been fully processed according to Central Office protocols.
• In the event of a preliminary adverse decision, the report will be posted to The Joint Commission extranet once it has gone through the scan and clarification process.

Complaint Investigation/PII- See Home Care Survey Activity Guide
Complaint investigations are received from (individuals, CMS, and State Regional Offices) by the Office of Quality and Patient Safety (OQPS). The surveyor will be notified by their Field Director of a complaint and should follow Joint Commission complaint investigation procedures in researching the complaint, and determine whether or not immediate jeopardy exists.
Appendix L (continued) - Home Health Deemed Status – Interim Survey Process

Interim Certification
A sample of organizations will receive Interim surveys. The survey will usually be scheduled 9-15 months after their last full survey or the last Interim survey.

- Joint Commission standards are not the primary focus during an Interim Survey. The focus is the review of CoPs, however, if a TJC standard is identified as non-compliant this should be scored accordingly.
- Interim surveys are unannounced.
- Survey length is based on the approximate number of unduplicated home health admissions over the previous 12 months prior to survey. Unduplicated admits of less than 750 will generate a two-day survey, and three-day survey for unduplicated admits of greater than 751.
- Provide the organization with a copy of the Deficiencies Report (1572) printed from CMS Forms in Survey Technology and ask them to complete all sections excluding numbers 12, 21 and 23, prior to the close of the survey.
- The goal of the survey is to evaluate the organization’s performance with regard to the CoPs.
- On-site survey activity includes home visits and medical record review*, with the sample size determined by unduplicated annual admission data.
- Use individual tracer methodology to conduct home visits and follow the Clinical Record review and Home Visit requirements noted below. Every effort should be made to complete the minimum number of required visits. If you encounter challenges completing the minimum required home visits, contact your Field Director or the Field Director On-Call to discuss the situation. If a special circumstance exists to support the visit shortfall (e.g., census less than five) you must complete one additional record review for each visit shortfall and enter a note in WST comments tab to explain the circumstance and who you spoke with to obtain approval for the visit shortfall.

Required sample sizes are as follows:

<table>
<thead>
<tr>
<th># of Admissions</th>
<th>Records with home visit</th>
<th>Records without home visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;150</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>150-750</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>751-1,250</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>1,251+</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

- Reminder: In Survey Tech Record Type selection for all home visits and record reviews, you must choose the HH Deemed with home visit or HH Deemed w/o home visit option. This is required to assure the system accurately counts your record review and visit activity.
There is no agenda posted for Interim surveys. The agenda is formulated by the Surveyor with a focus on patient care and compliance with the CoPs. (See Sample Two-Day agenda presented at the end of this Addendum) The surveyor may generate an agenda using survey technology if desired.

**Interim Certification**

Interim certification evaluates the following:

- All Level 1 CoPs from the Standard Survey Protocol
  - 484.10 Patient Rights
  - 484.12 Federal/State/Local Laws of Ownership and Accepted Standards
  - 484.14(g) Coordination of Care
  - 484.18 Plan of Care
  - 484.30 Skilled Nursing Services
  - 484.32 Therapy Services
  - 484.36 Home Health Aide
  - 484.48 Clinical Records
  - 484.55 Comprehensive Assessment

Partial Extended surveys occur when standard-level deficiencies are found and one of the following occurs:

- The surveyor thinks that deficient practice may exist at the Condition Level
- The surveyor needs to determine if standard- or condition-level deficiencies are present in the Level 2 CoPs that are NOT routinely examined in the standard survey. See the list of Level 2 CoPs below.

Extended surveys are used to:

- Fully investigate the presence of condition-level deficiencies
- Review and identify P&Ps that produced the substandard care
- Determine compliance with ALL CoPs
NOTE: Additional days are not usually assigned, but if additional CoP review is required (partial extended or extended survey) the surveyor may call the Field Director when this situation occurs to discuss, as needed.

Interim certification may include the following Level 2 CoPs from the Partial Extended/Extended Survey Protocol as necessary:

- 484.4
- 484.12 (a-c)
- 484.14 (a-f and h-j)
- 484.16
- 484.20

-----------------------------------------------

INTERIM Survey Agenda-------SAMPLE

DAY ONE
8:00 - Arrival and Preliminary Planning
8:30 - Opening Conference and Orientation to the Organization
9:00 - Surveyor Planning Session
10:00 - Individual Tracer Activity
12:30 - Surveyor Lunch
1:00 - Individual Tracer Activity
3:30 - Issue Resolution

DAY TWO
8:00 - Daily Briefing
8:30 - Individual Tracer Activity
12:30 - Surveyor Lunch
1:00 - Individual Tracer Activity
2:30 - Surveyor Report Preparation
3:30 - CEO Exit Briefing
4:30 - Organization Exit Conference
Form CMS 1572 -- Home Health Agency Survey & Deficiencies Report & FAQs

Please refer to the copy of CMS Form 1572 that appears on the pages immediately following these frequently asked questions. Not all item numbers on the CMS Form 1572 are addressed here; only those items that are the subject of frequently asked questions.

#7. State/County Code: (G5)---See the Quick Links WST for the Codes needed.

#8. State/Region Code: (G6)---Leave Blank.

#11. Provider No.—This # use to be the Medicare Provider # and is now called the CCN #. On Initial Deemed Surveys this will remain blank as the Org may not have their CCN #. An organization may be classified as initial and have an existing CCN, they may be those who have been accredited and have chosen to add deeming or they are certified but are coming to TJC for the first time for accreditation and also requesting deemed status.

#12. Type of Survey---Indicate if you are on an Initial Survey or Resurvey by putting the appropriate # in the box. Surveys start out at the Standard Level (#1), but once you score a finding in the Level One Tier it moves to a Partial Extended Survey (#2). If you have a finding that leads to a CLD, then you would indicate in the appropriate box the number for Extended Survey (#3).

# 16. Type of Agency: (G18)---Most HHA are 07=Other, but can be VNA (if it is indicated as such) or Hospital Based Program if tailored with the Hospital.

#17. Type of Control: (G20)---Most HHA are usually 03=Other under Voluntary Non-Profit. You would choose 04=Proprietary for the For Profit HHA.

#18. Service Offered: (G21)---Do Not Put an “X” in the Boxes. Please ensure to enter 1, 2, or 3 in the appropriate box for each service offered by the organization. Under Arrangement is contracted staff. The organization must provide at least two services and at least one has to be provided 100% by the organization’s own employees.

#19. Staffing (list full-time equivalent)---Calculate the FTE count to include the Orgs direct hire employees only. Per Diem Staff can be calculated by the # of hours worked on the average. If an Administrator is an RN and seeing patients then count under Registered Nurse (G22), but if not performing patient care, then can be indicated under All Others (G31). Office/clerical staff etc falls under All Others (G31). Contracted staff are not included in the FTE count.

#20. Home Health Agency provides directly: (G32)---Home Health aide training program (#1) is if the Org provides a formal Aide Program to certify for Home Health Aide status. Most agencies are indicated under (#2) Home Health aide competency evaluation program which the Orgs are required to provide competency annually.

#22. Patient census since last standard survey— refer to the Orgs unduplicated admission volume for the most recent 12 months.

#23. Surveyor summary---Surveyors are to leave this section blank and the AE at CO will fill this in.
Deemed Surveys – Brief Description and Survey Process

<table>
<thead>
<tr>
<th>Survey Type</th>
<th>Acronym</th>
<th>Stands For</th>
<th>Meaning</th>
<th>What Do You Review*</th>
<th>Number of Days</th>
<th>Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDSRV</td>
<td>MEDSRV</td>
<td>Medicare Survey or Repeat Initial Deemed Survey</td>
<td>Occurs for orgs who are not currently Medicare certified and had a CLD on initial survey. They will have completed their ESC from the first survey and received contingent accreditation</td>
<td>Review all CoPs in the standard survey other CoPs as needed. Follow minimum sample size for records and visits</td>
<td>2</td>
<td>YES</td>
</tr>
<tr>
<td>MED DEF</td>
<td>MED DEF</td>
<td>Condition Level Deficiency (CLD) Follow-up Survey</td>
<td>Occurs for currently certified orgs who have a CLD cited – follow-up occurs within 45 calendar days, if CLD not cleared then a repeat MED DEF occurs in 30 calendar days</td>
<td>Review only the EPs/CoP(s) tied to the previously cited CLD(s). No minimum sample size required for visits or records.</td>
<td>1</td>
<td>NO</td>
</tr>
<tr>
<td>MEDSRV MC</td>
<td>MEDSRV MC</td>
<td>Medicare survey mid-cycle (org is adding deemed)</td>
<td>Occurs for orgs who are accredited and want to have deemed added outside of their survey cycle. Previously have had state or federal Medicare surveys</td>
<td>Review all CoPs in the standard survey, other CoPs as needed. Follow minimum sample size for records and visits.</td>
<td>Min. 2, longer if unduplicated is &gt;751</td>
<td>YES</td>
</tr>
<tr>
<td>HHI</td>
<td>HHI</td>
<td>Interim</td>
<td>TJC determined survey based on risk criteria – 5% sampling is chosen</td>
<td>Review all CoPs in the standard survey, other CoPs as needed. Follow minimum sample size for records and visits.</td>
<td>Min. 2, longer if unduplicated is &gt;751</td>
<td>YES</td>
</tr>
</tbody>
</table>

* Note: Review of TJC standards or conducting system tracer survey activities is not required. However, if non-compliance with TJC standards is identified they can be scored as needed.
Appendix M – Addendum for Hospice Deemed Status (HDS) Surveys

Surveys with Deemed Certification (HDS)

Overview of Hospice Deemed Status (HDS) Initial and Recertification Surveys

This Home Care Survey Activity Guide, HDS Addendum addresses initial and recertification hospice surveys with deemed certification. The purpose of the addendum is to support surveyors in preparing for and conducting Hospice deemed status surveys. The addendum is designed for use as a supplement to The Joint Commission’s Home Care Survey Activity Guide (SAG). One cannot be used without the other when conducting Hospice deemed status surveys.

Hospice Deemed Status initial and recertification surveys are unannounced and are conducted concurrently with Joint Commission Accreditation surveys. These surveys include an evaluation of compliance with all applicable Joint Commission standards contained in the Comprehensive Accreditation Manual for Home Care (CAMHC) and validation of compliance with the Medicare Conditions of Participation (CoPs) for Hospice.

Interesting Fact: Interim surveys are not conducted for hospice deemed organizations. Hospice deemed surveys follow a full three-year survey cycle.

An initial certification survey ensures that Hospice organizations seeking Medicare certification through the deeming process are providing or are fully prepared to provide all required services, including inpatient services.

Eligibility for a Hospice Deemed Status Survey

Organizations seeking Hospice Medicare certification through deeming must:

- Demonstrate operational capability of all facets of Hospice services including short term inpatient services for pain control, symptom management and respite care, twenty four hour continuous care and routine in home care.
- Have admitted five patients for Hospice services. Patients from any payer source can be counted to meet the patients served criteria.
- Have at least three active patients at the time of survey (In medically underserved areas, the Centers for Medicare and Medicaid Services (CMS) Regional Office may reduce the minimum number of patients from 5 to 2. In this case, at least one of the two patients should be receiving care from the hospice at the time of the survey).
- Meet the Joint Commission’s eligibility criteria (reference the ACC section of the CAMHC).

Eligibility information is verified by the Joint Commission Central Office Account Executive prior to scheduling the initial certification survey. Call the Field Director On-
Call if you arrive on site and find that the organization is not meeting the Hospice deemed status eligibility criteria.

Additionally, Medicare requires that the:
  - Hospice provides all services needed by the patients actually being admitted for service.*
  - Hospice employees directly provide a substantial portion of all core services on a routine basis.*
  - Following hospice core services be provided directly by hospice employees:
    - Nursing care on a 24 hour basis provided by or under the supervision of an RN functioning within a medically approved plan of care. (Hospices may be eligible for a waiver for contracted nursing services.)*
    - Medical Social services under the direction of a physician; and
    - Counseling (including dietary and bereavement counseling) with respect to care of the terminally ill individual and adjustment to death.*
  *
*Note 1: Hospices may use contracted staff for core services only under extraordinary circumstances (i.e. to supplement hospice employees in order to meet patients’ needs during periods of peak patient load.)

Note 2: Hospices may provide other services by contract as delineated in the CoPs.

  - Hospice provides and coordinates services by an interdisciplinary group (IDG) to meet the needs of patients who are diagnosed with a terminal illness and have a limited life span.

Pre-Survey Preparation

In addition to information provided in the Home Care Survey Activity Guide (SAG) regarding pre-survey preparation:

1) Download the following reference materials to your laptop. Save them in your “My Documents” folder or access via Quick Links through WST:
     (This includes the Hospice CoP Interpretive Guidelines)
   - The State Operations Manual, Chapter 2- The Certification Process-Hospice

2) Review the electronic application (E-app) accessed through the Survey Itinerary in the Surveyor Portal to determine the services being provided, patient volumes (ADC and unduplicated admits), contracted services and if the organization has a free-standing hospice facility. If HME and Pharmacy services are listed and have specific ADC’s identified, the hospice may own the HME and Pharmacy businesses and be providing services to patients that are not served solely by the Hospice.
3) Review the survey process rules against the information noted in the E-App. The survey process rules can be found on the Surveyor Portal and in the SAG appendix behind the Team Leader Worksheet. If the necessary information is not available or the surveyor has questions, the Account Executive should be contacted prior to the survey. The surveyor can communicate by voicemail but should follow up with an e-mail to the Account Executive and include a copy of the communication to the appropriate Home Care Field Director.

Documents
Utilize the following documents (electronic) to support your survey activity.
- Hospice State Operations Manual (SOM) downloaded to laptop. The SOM includes Interpretive Guidelines associated with the Hospice CoPs.
- The Joint Commission crosswalk between the CAMHC standards and the Hospice CoPs
- Survey Activity Guide (reference the Appendix -- Hospice Accreditation Surveys with Deemed Certification
- Home visit consent form (English and Spanish, if needed)
- Calendar worksheets
- Bring a copy of form 643

Surveyor Arrival and Preliminary Planning Session/Information Gathering

In addition to the information provided in the Home Care Survey Activity Guide, use the following guidelines when you arrive.

- Request a current list of patients and scheduled visits to include routine care/home patients, (routine care/home patients include those whose residence is in a skilled nursing facility/nursing home/assisted living facility as well as those in private residences), those patients receiving continuous care, those patients receiving inpatient care for symptom management or respite care and those patients currently receiving care in a free standing facility based unit. This list should include the name, diagnosis, initial certification date and discipline of the visiting staff member if possible, to assist with individual patient tracer selection.
- Ascertain the date and time of the next Hospice interdisciplinary group meeting in the event that the surveyor may have the opportunity to attend briefly.
- Request a list of unduplicated patients who were admitted and received hospice services during the most recent 12-month period.
- In the event that the hospice patients presently being served are not inclusive of the full scope of hospice services, verify that the hospice is fully prepared to provide all services necessary to meet the hospice CoPs (example—Inpatient Services; Continuous Care).
- It is not necessary to schedule another survey to inspect the arranged for inpatient services if the contracts for such services have been reviewed and
there is no doubt that the hospice is providing the service or is fully prepared to provide the service when needed.

- Complete Form 643 found under tab CMS Forms in WST. Consult with the organization as needed.

**Reminder:** *Effective date of Medicare participation cannot be earlier than the date the hospice is prepared to provide all of the required services and meets all the Hospice Conditions of Participation. In no case can the effective date be earlier than the date of the survey.*

### Opening Conference and Orientation to the Organization/Entrance Interview

If leadership personnel are not on site for the Preliminary Planning Session or are delayed in arriving to the site, request to conduct a conference call with them. If a conference call option is not possible, schedule the opening conference for as early as possible in the day and proceed with survey activities including individual patient tracers.

In addition to the content for this conference found in the Home Care Survey Activity Guide:

- Discuss the type of deemed status survey being conducted (initial or recertification).
- Ask if the State or any other regulatory authority has made an onsite visit to the Hospice within the past twelve months or since the last deemed status survey.
- If a State survey has been conducted in the past twelve months, request a copy of the State survey report for review along with the organization’s corrective action plan. In addition, contact the Field Director On-Call to verify that the survey may proceed as planned.
- If the State has been on site to investigate a complaint, request a copy of the State report and related Corrective Action plan. Contact the Field Director or Field Director On-Call to discuss if additional activities are required.

**Tip:** *Call your Field Director or the Joint Commission Field Director On-Call immediately if you discover that the organization:*

- Does not meet survey eligibility requirements or
- Provides information that might change the length of the survey or survey activities, such as expected volumes, multiple locations, services, etc.) or
- Has had a state survey in the past twelve months.
Surveyor Planning Session and Information Gathering (continued)

In addition to the information found in the Home Care Surveyor Activity Guide:

- Verify the number of unduplicated hospice patients admitted during the twelve month period prior to the survey as well as the ADC. This information will be used to determine the number of patient visits and records to be reviewed.
- Review the types of hospice services that have been provided to date.
- Verify sites if the organization has multiple locations. Plan to visit additional locations or request records for review.
- Not all sites need to be visited—see Survey Process Rules for Surveyor Planning in Appendix C—Home Care Surveyor Worksheet
- Request and review the organization’s HQRP/QAPI reports
- Life Safety Code® Requirements
  - If the organization has a free standing Hospice facility, that location must be visited since Life Safety Code® standards may need to be surveyed. Life Safety Code® applies to free standing facilities that provide inpatient care
  - Life Safety Code® Building Assessment does not occur if the hospice provides care in an inpatient facility (owned, leased or shared space) with a Medicare Certified hospital, SNF or Certified nursing facility.

**Tip:** Free standing facilities that provide care associated solely with the Routine Home Care benefit are considered to be “residential only” facilities. The owners of the facility are considered to be “landlords”. They are responsible for all equipment in the building and must conduct the required tests at the appropriate intervals. Survey of Life Safety Code® does not apply in this circumstance. When in doubt regarding applicability of LSC, be sure to contact one of the Standards Interpretation Group (SIG) Engineers for guidance.

Hospice Clinical Record Selection and Home Visit Selection

Select individual patient tracers using the clinical services and the ICM Profile, and include the different types of patients and settings as preliminary selection criteria. Areas to consider:

- Include all payer sources in patient visit and record review selection.
- Include a representative sample of any multiple locations and the different types of service settings in patient visit selection (i.e., routine home care in a private residence or nursing facility, inpatient care provided directly or under arrangement, continuous care).
- Include patients with a range of primary admitting terminal diagnoses.
- Include patients who meet one or more of the following criteria:
  - Reside in a SNF/NF or other residential facility
  - Receive four or more different hospice services
- Receive infrequent visits
- Have frequent contact with the hospice
- Have been at home for two or more months
- Have made a complaint
- Receive two or more contracted hospice services
- Select active patients.
- Select a sample of patients’ records to review in addition to those reviewed during individual patient tracer activity so that capacity to provide all required services is fully evaluated and meets the minimum requirements noted below, including volunteer services.
- Select two to three records of survivors who received bereavement services, focusing on those survivors identified at moderate to high risk of anticipatory grief reaction undergoing counseling. This will facilitate a review of the bereavement care planning process. \_ Review to determine if the services provided reflect the needs of survivors.
- Include records for those survivors receiving routine bereavement services as well as records of those survivors receiving ongoing counseling and/or interventions conducted by Hospice bereavement staff.
- Remember to take copies of the Consent for Visit form and ask the organization to obtain patient verbal consents for home visits. The organization files the signed consent forms in the patient’s record. \_ Do not make copies for Joint Commission records.\_ Required sample sizes are based on the following matrix:

<table>
<thead>
<tr>
<th>Unduplicated admissions</th>
<th>Minimum # of record reviews without home visit</th>
<th>Minimum # of record reviews with home visit</th>
<th>Minimum # of bereavement records</th>
<th>Total Record Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;150</td>
<td>8</td>
<td>3</td>
<td>2-3</td>
<td>13-14</td>
</tr>
<tr>
<td>150 – 750</td>
<td>10</td>
<td>3</td>
<td>2-3</td>
<td>15-16</td>
</tr>
<tr>
<td>751 – 1250</td>
<td>12</td>
<td>4</td>
<td>2-3</td>
<td>18-19</td>
</tr>
<tr>
<td>1251 or more</td>
<td>15</td>
<td>5</td>
<td>2-3</td>
<td>22-23</td>
</tr>
</tbody>
</table>

If there are concerns about discharge or revocation, in addition to the sample records selected, review a hospice patient who has been discharged from a nursing home and a patient whose hospice benefit has been revoked.

Reminder in Survey Tech - Record Type selection: For all home visits and record reviews choose the HOS Deemed with home visit or HOS Deemed w/o home visit option. This is required to assure the system accurately counts your record and visit activity.
The minimum number of visits should occur but, if the surveyor is unable to draw the required sample size for individual patient tracers/patient visits, contact the Field Director or Field Director On-Call to discuss the situation. If a special circumstance exists (organization has a census of two, therefore unable to conduct three visits) increase the clinical record review by one for each home visit not made (reference the State Operations Manual). Additionally, the surveyor is directed to document the reasons for not meeting sample size in the Comments tab in Survey Technology.

All initial and recertification hospice surveys must verify compliance with ALL regulatory requirements contained in 42 CFR 418.52 - 418.116, including the minimum requirement for sample size.

Questions regarding individual patient tracer activity and/or record review selection should be directed to your Field Director or the Field Director On-Call.

Survey Process Activities

The Joint Commission Home Care Survey Activity Guide provides instruction and guidance on the conduct of specific onsite activities. Additional information for deemed status surveys is provided below.

Information is obtained throughout the survey during all activities, including:

- Leadership Session (include the Medical Director)
- Evaluation of Hospice Interdisciplinary Group (IDG) function, bereavement, volunteer services, and contracted services
- Evaluation of Hospice Professional Advisory Committee (PAC) minutes, if PAC is a State requirement
- Hospice inpatient care in relation to the Life Safety Code® (LSC) scored at EC and LS standards specific to inpatient hospice (use revised Hospice crosswalk and updated guidelines for Building Tour in the Home Care Surveyor Activity Guide)
Competence Assessment Session

In addition to the information in the Home Care Survey Activity Guide, be sure to:

- Select personnel files for review based on staff encountered while on individual patient tracer activity. Include nurses, social worker, chaplains, counselors, hospice aides, medical directors, volunteer coordinator, bereavement supervisor/staff and therapy staff, if provided.
- Include files for volunteer staff in order to assess their orientation, training, competence, and licensing (e.g., massage therapist, music therapist)
- Review the files of at least three staff members hired within the past 12 months. In addition to the information in the Home Care Survey Activity Guide, be sure to look for evidence of training on the use of restraint and seclusion if the organization has a free-standing hospice facility.
- Include files of SNF/NF or ICF/MR staff members caring for the hospice’s patients to assure those staff members were oriented according to the requirements in CFR 418.112(f).
- Review hospice aide documentation of competency evaluation and training and record of in-service education participation (must meet hospice aide requirements for training, ongoing education and competence set forth in CFR 418.76).

NOTE: A review of hospice aides’ personnel files is required.

Scoring and Determining Deficiency Level

A deficiency is based on statute or regulation, and is not based on the interpretive guideline alone.

An isolated incident is defined as having little or no effect on care delivery, and may not warrant a citation.

- The State Operations Manual (SOM), and the hospice standards crosswalk (hard copy or electronic version) can be used as a reference.
- The accuracy of the selection of the CoP and the corresponding Joint Commission standard/EP is critical (i.e., multiple CoPs may be cross-walked to an EP in survey tech; therefore, make sure to choose the correct one). When uncertain regarding placement of a citation call the Standards Interpretation Group.
- Multiple observations at a CMS Standard can accumulate or roll-up to a Conditional Level Deficiency. Call the Standards Interpretation Group if you are unsure about assigning a deficiency level.
- There are three levels of deficiency identified by CMS:
Condition Level, and
Standard Level
Finding Level (Although CMS documents Finding Level deficiencies during the course of State surveys, Joint Commission surveyors will not have the option of entering an observation at the Finding Level.)

**CMS requirements, although viewable in survey technology, should not be selected (e.g., CFR).**

The level of deficiency is identified by the impact the deficiency can have on the following:

- Patient safety and care,
- Whether or not it occurred in isolation,
- Whether the deficiency occurred at a stand-alone CoP and
- The number of standards within a CoP that are non-compliant.

Based on the surveyor’s judgment, using the definition of manner or degree, he/she may decide to override the deficiency level at the observation level. This can be done by completing the field in the “override deficiency” section of the EP observation window. When overriding the deficiency level, reason and rationale fields are required.

- The override function can also be accomplished at the CoP summary screen. Survey tech will prompt you for the deficiency level reason and rationale fields. Review with SIG is encouraged.
- All observations should be cited at the most stringent level – review with SIG is encouraged prior to overriding a deficiency level.

### Documenting Findings

- Clearly document your observations. Reference the Home Care Survey Activity Guide Appendix on Documenting Observations in Survey Technology.
- All observation findings must be entered individually. Do not enter multiple or compound observations in one paragraph.
- The correct verbiage will automatically populate the citation in survey technology (i.e., "This Standard is not met as evidenced by," or "This Condition is not met as evidenced by"). The surveyor should carefully review each observation to assure the correct language regarding the level of deficiency has populated the observation.
- Writing a citation at a Joint Commission non-Medicare EP can occur; however, this clearly requires an observation that does not correlate or crosswalk to a Medicare Hospice COP/CFR.
- Be very specific when documenting any additional non-compliance with Joint Commission standards and related elements of performance.
- Call SIG if unsure with your determination of a deficiency level or choice of EPs.

**Tip:** Call the Standards Interpretation Group if unsure about the level of deficiency or correct placement of the citation. The Field Director On-Call can be contacted for guidance in the event that SIG is not readily available.
Survey Report Preparation

*Important Points!*
Check your report prior to conducting the Exit Conference to assure that all individual Condition-level and Standard-level deficiencies are scored appropriately.

Review the CoP Summary page to verify all items are scored appropriately.

If you believe you have a Condition level deficiency on an initial survey, you may call the Standards Interpretation Group (SIG) to discuss further. If SIG is not available, your Field Director or the Field Director On-Call may be utilized as a resource before exiting the survey to discuss the survey citations.

Lock and publish your report to the organization’s extranet site. Ask the organization to print a copy to use during the exit conference.

Exit Briefing (CEO)/ Organization Exit Conference/Closing Conference
During these sessions:
- Review and explain the Summary of Survey Findings Report.
- The written observations (RFIs) in the Summary of Survey Findings Report will require follow up through the Evidence of Standards Compliance (ESC) process.
- Describe the Joint Commission standards and the regulatory requirements not met by the organization, and the issues that substantiate the observations.
- Explain that the nature of the deficiencies cited dictates the necessity for and scope of any follow-up visits. The purpose of the follow-up visit is to re-evaluate the specific care and services that were cited during the survey.
- Twelve month surveys may occur for organizations depending on the number of Condition level and Standard level deficiencies.
- Explain that recommending an organization for Medicare Certification will be determined at the Joint Commission Central Office and reported to CMS. This will occur after the organization: Submits clarifying evidence, if desired, and the ESC has been approved by Central Office staff.

Check and return any documents containing protected health information to the organization prior to leaving.

- Review the *What Happens After Your Joint Commission Survey* flier carefully with the organization so that the organization understands the scan process, the opportunity to provide clarifying evidence and the timeframes associated with the ESC process. In the event of an adverse outcome, the final decision will be made by the Joint Commission Accreditation Committee after all information, including the Summary of Survey Findings Report undergoes final review.
Important Points:
For Initial Medicare Certification/Joint Commission surveys, advise the organization that if a Condition Level deficiency remains on the Summary of Survey Findings Report after clarification and scan then The Joint Commission cannot recommend for Medicare Certification and a repeat deemed survey will need to occur.

Adverse Decisions
If The Joint Commission accreditation decision is adverse the organization will NOT be recommended for Medicare certification.

Post Survey Activities
The surveyor is required to submit the Summary of Survey Findings Report to the Central Office within 24 hours of completion of the survey.
- The surveyor report will be posted to the organization's Joint Commission extranet site as soon as it is fully processed according to Central Office protocols.
- In the event of a preliminary adverse decision, the report will be posted to The Joint Commission extranet once it has gone through the scan and clarification process.

Complaint Investigation/PII
Complaint investigations are received from (individuals, CMS, and State Regional Offices) by the Office of Quality and Patient Safety (OQPS). The surveyor will be notified by the Field Director of a complaint and should follow Joint Commission complaint investigation procedures in researching the complaint, and determine whether or not immediate jeopardy exists.
Hospice Conditions of Participation Glossary of Terms

Physician:
For hospices that elect The Joint Commission’s deemed status option: A doctor of medicine or osteopathy, including an osteopathic practitioner; a doctor of dental surgery or dental medicine; a doctor of podiatric medicine; a doctor of optometry. Also includes a chiropractor who has, if licensed or authorized to practice before July 1, 1974, had preliminary education equal to the requirements for graduation from an accredited high school or other secondary school, graduated from a college of chiropractic approved by the State’s chiropractic examiners after completing a course of study covering a period of not less than 3 school years or six months each year in actual continuous attendance and covering adequate courses of study in the subjects of anatomy, physiology, symptomatology and diagnosis, hygiene and sanitation, chemistry, histology, pathology, and principles and practice of chiropractic, including clinical instruction in vertebral palpation, nerve tracing and adjusting; and passed an examination prescribed by the State’s chiropractic examiners covering these subjects. Also includes a chiropractor who has, if first licensed or authorized to practice after June 30, 1974, had preliminary education equal to the requirements for graduation from an accredited high school or other secondary school; satisfactorily completed 2 years of pre-chiropractic study at the college level; satisfactorily completed a 4-year course of 8 months each year offered by a college or school of chiropractic approved by the State’s chiropractic examiners and including at least 4,000 hours in courses in anatomy, physiology, symptomatology and diagnosis, hygiene and sanitation, chemistry, histology, pathology, principles and practice of chiropractic, and clinical instruction in vertebral palpation, nerve tracing and adjusting, plus courses in the use and effect of X-ray and chiropractic analysis; passed an examination prescribed by the State’s chiropractic examiners covering these subjects; and attained 21 years of age.

Bereavement counseling:
For hospices that elect The Joint Commission’s deemed status option: emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment.

Clinical note:
For hospices that elect The Joint Commission’s deemed status option: notation of contact with the patient or family that is written and dated by any person providing services and that describes signs and symptoms, treatments, and medications administered, including the patient’s reaction or response and any changes in the patient’s physical, emotional, psychosocial or spiritual condition during a given period of time.

Comprehensive assessment:
For hospices that elect The Joint Commission’s deemed status option: a thorough evaluation of the patient’s physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions. This includes a thorough evaluation of the caregiver’s and family’s willingness and capability to care for the patient.

Dietary counseling:
For hospices that elect The Joint Commission’s deemed status option: education and interventions provided to the patient and family regarding appropriate nutritional intake as the patient’s condition progresses. Dietary counseling is provided by qualified individuals, which may include a registered nurse, dietitian or nutritionist, when identified in the patient’s plan of care.

Employee:
For hospices that elect The Joint Commission’s deemed status option: a person who (1) works for the hospice and for whom the hospice is required to issue a W-2 form on his or her behalf; (2) if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice; or (3) is a volunteer under the jurisdiction of the hospice.
Hospice:
For hospices that elect The Joint Commission’s deemed status option: a public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care.

Hospice care:
For hospices that elect The Joint Commission’s deemed status option: a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

Initial assessment:
For hospices that elect The Joint Commission’s deemed status option: an evaluation of the patient’s physical, psychosocial and emotional status related to the terminal illness and related conditions to determine the patient’s immediate care and support needs.

Licensed professional:
For hospices that elect The Joint Commission’s deemed status option: a person licensed to provide patient care services by the State in which services are delivered.

Multiple location:
For hospices that elect The Joint Commission’s deemed status option: a Medicare-approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice issued the certification number. A multiple location must meet all of the conditions of participation applicable to hospices.

Palliative care:
For hospices that elect The Joint Commission’s deemed status option: patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

Physician designee:
For hospices that elect The Joint Commission’s deemed status option: a doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available.

Representative:
For hospices that elect The Joint Commission’s deemed status option: an individual who has the authority under State law (whether by statute or pursuant to an appointment by the courts of the State) to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill patient who is mentally or physically incapacitated. This may include a legal guardian.

Restraint:
For hospices that elect The Joint Commission’s deemed status option: (1) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely, not including devices, such as orthopedics prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort); or (2) A drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.

Seclusion:
For hospices that elect The Joint Commission’s deemed status option: the involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving.
**Terminally ill:**
For hospices that elect The Joint Commission’s deemed status option: the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

**Homemaker services:**
For hospices that elect The Joint Commission’s deemed status option: homemaker services provide assistance in maintaining a safe and healthy environment and help the patient carry out the treatment plan.

**Qualified Hospice Aide:**
A person who has successfully completed one of the following:
- a training program and competency evaluation
- a competency evaluation as specified in 42 CFR 418.76(b) and (c )
- a competency evaluation as specified in 42 CFR 418.76(c )
- a nurse aide training and competency evaluation program approved by the State as meeting the requirements of 42 CFR 483.151 through 483.154 and is listed in good standing on the State nurse aide registry
- a State licensure program that meets 42 CFR 418.76(b) and (c )
## Appendix N – CMS Required Product Specific Service Standards

<table>
<thead>
<tr>
<th>Product Specific Service Standards</th>
<th>Category A</th>
<th>Category B</th>
<th>Category C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comply with CMS regulation, policies and Medicare contractor policies and articles</td>
<td>X X X X X X X</td>
<td>X</td>
<td>X X X X X X</td>
</tr>
<tr>
<td>Consult with prescribing physician, as needed, to confirm the order and recommend any necessary changes or refinements or additional evaluations to the prescribed items and services</td>
<td>X X X X X X X</td>
<td>X</td>
<td>X X X X X</td>
</tr>
<tr>
<td>Assure that the item delivered is consistent with the prescribing physician’s order and other identified “beneficiary” (patient/ client) needs, risks, and limitations of which the supplier is aware.</td>
<td>X X X X X X X</td>
<td>X</td>
<td>X X X X X</td>
</tr>
<tr>
<td>Maintain a record and incorporate any necessary revisions, related to the beneficiary’s conditions, which affect the provision of the DMEPOS and related services or to the actual items and services provided, in collaboration with the prescribing physician.</td>
<td>X X X X X X X</td>
<td>X</td>
<td>X X X X X</td>
</tr>
</tbody>
</table>

### DELIVERY AND SET UP

- Deliver and set up, or coordinate set up with another supplier, all equipment and items in a timely manner as agreed upon by the beneficiary/caregiver, supplier and prescribing physician.

- Provide all items that are necessary to operate the equipment or item and perform any further adjustments, as applicable.

- Provide, or arrange for, loaner equipment equivalent to the original equipment during any repair period.
<table>
<thead>
<tr>
<th>Product Specific Service Standards</th>
<th>Category A</th>
<th>Category B</th>
<th>Category C</th>
</tr>
</thead>
<tbody>
<tr>
<td>DELIVERY &amp; SET UP (cont)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long Term Invasive Mechanical</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ventilation in the Home (AARC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Practice Guidelines)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen Therapy in the Home or</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Extended Care Facility (AARC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Practice Guidelines)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermittent Positive Pressure</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Breathing (AARCP Guidelines)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRAINING/INSTRUCTION to</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Beneficiary and Caregiver</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Provide, or coordinate the</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>provision of, appropriate</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>information related to the setup</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(including preparation of</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>formulas), features, routine use,</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>troubleshooting, cleaning and</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>maintenance of the items provided.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Advise the beneficiary and</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>caregiver about appropriate safety</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>considerations.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Provide relevant information and/or</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>instructions about infection</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>control issues related to the use</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>of the equipment and items</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Verify that the beneficiary has</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>received training and instructions</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>on the use of items at the time of</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>initial mail order deliver of</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>items</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Record in the beneficiary’s record</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>that such instruction was provided.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beneficiary training and instructions shall be commensurate with the risks, complexity and manufacturer’s instructions and/or specifications for items. The supplier shall tailor training and instruction materials and approaches to the needs, abilities, learning preferences, language and readiness to learn of individual beneficiaries or caregivers.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Copyright: 2018 The Joint Commission
### Product Specific Service Standards

<table>
<thead>
<tr>
<th>Category A</th>
<th>Category B</th>
<th>Category C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilators</td>
<td>O2 concentrators, etc.</td>
<td>CPAP, RAD, IPPB, Nebulizers, PMD/Accessories, Manual wheelchairs etc.</td>
</tr>
<tr>
<td>O2 concentrators, etc.</td>
<td>CPAP, RAD, IPPB, Nebulizers, PMD/Accessories, Manual wheelchairs etc.</td>
<td>Prosthetic devices, Customized orthotics, Other Prosthetics, Therapeutic Shoes/Inserts</td>
</tr>
</tbody>
</table>

**TRAINING/INSTRUCTION to Beneficiary and Caregiver Compliance with**

**Long Term Invasive Mechanical Ventilation in the Home (AARC Clinical Practice Guidelines)**

<table>
<thead>
<tr>
<th>Trainings</th>
<th>Category A</th>
<th>Category B</th>
<th>Category C</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Oxygen Therapy in the Home or Extended Care Facility (AARC Clinical Practice Guidelines)**

<table>
<thead>
<tr>
<th>Trainings</th>
<th>Category A</th>
<th>Category B</th>
<th>Category C</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Intermittent Positive Pressure Breathing (AARC Clinical Practice Guidelines)**

<table>
<thead>
<tr>
<th>Trainings</th>
<th>Category A</th>
<th>Category B</th>
<th>Category C</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Providing Patient and Caregiver Training (AARC Clinical Practice Guidelines)**

<table>
<thead>
<tr>
<th>Trainings</th>
<th>Category A</th>
<th>Category B</th>
<th>Category C</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Suctioning of the Patient in the Home (AARC Clinical Practice Guidelines)**

<table>
<thead>
<tr>
<th>Trainings</th>
<th>Category A</th>
<th>Category B</th>
<th>Category C</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**FOLLOW UP**

The supplier shall provide follow-up services to the beneficiary, consistent with the types of equipment, items and service(s) provided, and recommendations from the prescribing physician or healthcare team members.

<table>
<thead>
<tr>
<th>Trainings</th>
<th>Category A</th>
<th>Category B</th>
<th>Category C</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

* Guidelines provided to surveyors -- relates to delivery, set-up and education only.
## Appendix O -- Medicare Condition-Level Deficiency Follow-up Survey

**Applies to:** Organizations that use Joint Commission accreditation for deemed status purposes (Existing Medicare Certified Organizations)

### Purpose

1. To evaluate the organization’s follow-up actions in response to Medicare Condition-Level Deficiencies.
2. To evaluate current compliance with requirements that generated Condition-Level Deficiencies.
3. To document that an evaluation of the Condition-Level Deficiencies occurred (see survey technology instructions on next page).

### Pre-Survey Planning

1. Through your itinerary, locate the organization and click on the event ID. When the event is displayed, click on Quick Links to view:
   a. Previous Recommendations
   b. Available ESC submissions
   c. Organization’s application
2. Review the application for accreditation for information about the organization, travel directions, hotel accommodations, and other logistical information. Make note of the survey coordinator name and phone number.
3. **Do not contact the organization.** This is an unannounced event. Call the Joint Commission Account Executive with any questions.
4. Review the last survey report (Previous Recommendations under Quick Links) and, if available, any Evidence of Standards Compliance submitted by the organization. **Note:** MEDDEF surveys are typically scheduled to occur prior to the organization’s submission of all ESC responses due to the time frames specified by CMS. Therefore, it is likely that an ESC will NOT be available for review prior to the MEDDEF survey. Surveyors are still encouraged to check.
5. Identify survey activities that would evaluate the element(s) of performance and the associated condition-level deficiencies previously found out of compliance. **The primary focus of this follow-up survey is on the area(s) identified as condition-level deficiencies.** However, if additional areas of non-compliance are discovered during the follow-up survey, document the additional observations in survey technology.
6. Plan for the on-site visit. While not required, consider selecting an agenda template from those available in WST that closely matches the survey length and complement for the assigned event. Revise the template to reflect activities that will allow for evaluation of the standards and the associated condition-level deficiencies you are reviewing. The agenda can include individual tracers, system tracers, building tours and review of documents.
7. One to two days before the scheduled MEDDEF survey date, access the organization’s extranet site and check the last survey report (Previous Recommendations) for any Central Office updates. If an ESC was not available at the time of assignment, also check to see if the organization has since submitted one.

### Standard Level Deficiency: An issue(s) that demonstrates non-compliance with a CMS standard but does not rise to a level that impacts patient safety or quality of care based on manner or degree.

### Condition Level Deficiency: An issue(s) that demonstrates non-compliance that has a strong potential or does impact patient safety and quality of care based on manner or degree.

---

**Please note:**

This survey differs from an Accreditation with Follow-Up Survey, which is described in Appendix H.
Manner – Frequency
- Pertains to the frequency that an issue of non-compliance occurs at a particular CMS standard (8 of 10 charts)
- If the occurrence/frequency is significant then the issue should be raised to a Condition Level

Degree – Severity
- Pertains to the seriousness of an issue (e.g., patient was re-hospitalized, wound status has worsened)
- Multiple standards under a CoP are non-compliant (e.g., Aide did not have 12 hours of training and competencies were not evaluated)
- Only one patient may be affected; but if serious, the issue should be raised to a Condition Level

NOTE: Completion of The CMS Home Health 1572 or Hospice 643 is not required.

No minimum number of visits or record reviews is required.

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

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

3. Direct the survey coordinator or administrative contact to access the Joint Commission’s web page at www.jointcommission.org. 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:
   a. Notification of scheduled Joint Commission event authorizing your presence
   b. Your picture and biographical sketch

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

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

6. Select tracers based on the reason for the Medicare Condition-Level Deficiency Follow-up survey. For example, proceed to the care setting(s) that was identified in a Requirement for Improvement (RFI) and the associated condition, select individuals currently receiving care and services in the area, and trace a patient there, focusing on the subject of the RFI/condition level deficiencies.

7. Focus interviews and group discussion on the requirements/condition level deficiencies being evaluated.

8. If the Medicare requirement(s) that generated condition-level deficiencies continues to be non-compliant or if there are new condition-level deficiencies identified, document and flag the observations as required. Call SIG to discuss the situation and to receive further instruction, if needed.

9. If the organization has only one or a small number of condition-level deficiencies, use the remainder of the time to discuss other RFIs with the organization, or offer to review and discuss aspects of their planned ESC submission, if requested. If the organization declines further discussion proceed with concluding the survey. See Early Departure Procedures below.
10. At the conclusion of the survey:
   a. Prepare your report using Survey Technology.
      1. Access each standard reviewed related to a Condition-Level Deficiency (CLD), including existing CLD(s), and any additional CLD(s).

      If there is only one EP under the standard that is related to the CLD:

      2. Flag the standard (not the EP) using one of the following reason codes: Condition Level Deficiency cleared; Recurring Condition Level Deficiency; New Condition Level Deficiency.

      3. Enter a flag note (not required when selecting "Condition-Level Deficiency cleared").

      If there are multiple EPs under the standard that roll-up to generate the CLD:

      4. Review each EP that is tied to the CLD and determine current compliance.

      5. If all EPs are compliant, flag the standard with the cleared code and enter a comment, such as, "EPs 1, 2 and 3 are compliant. No observations will be entered into survey technology. In this instance, the report will show no findings."

      6. If all EPs are non-compliant, flag the standard with the Recurring code and enter a comment, such as, "EPs 1, 2 and 3 remain non-compliant." Enter your observations into survey tech under the appropriate EP.

      If there are multiple EPs under the standard that roll-up to generate the CLD, but only some of the EPs are compliant and one or more remain non-compliant:

      7. Determine if the remaining non-compliant EP is a Condition Level deficiency, or can this be reduced to a Standard Level deficiency. Manner and Degree should be the basis of your decision as to whether or not the issue is Condition or Standard Level. Contact SIG to verify as needed.

      8. If you determine that the Condition Level deficiency still remains, flag the standard and choose the Recurring code, enter a comment, such as, "EP 1 is compliant, but EPs 2 and 3 remain non-compliant." Enter your observations into survey technology under the non-compliant EPs as appropriate.

      9. If you determine the Condition Level deficiency is cleared, but there still remains a Standard Level deficiency, flag the standard and choose the Cleared code. Enter a note, such as, "EP 1 and 2 are compliant, but EP 3 remains non-compliant, but based on manner/degree it is now a Standard level deficiency." Enter your observations into survey technology under the appropriate EP.

      If several EPs at multiple standards roll up to generate the CLD:

      10. Each EP must be reviewed to determine compliance.

      11. If EPs remain non-compliant, determine if the issue is a Condition or Standard Level deficiency using Manner and Degree as your guide.
12. Use the same steps described above to indicate if the various EPs are Cleared or Recurring.

Your survey activity should be focused on the previously identified CLD. However, if during the course of the MED DEF survey you identify a new CLD,

13. You are required to enter the observation at the appropriate Standard/EP

14. Flag the Standard, choose the New CLD code and enter your observation at the appropriate EP(s).

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

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

13. EARLY DEPARTURE PROCEDURES: Once the survey is complete and the customer has been given the opportunity for additional education or consultation and they have declined; please email the Field Director On-Call indicating the reason for the early departure. Please place the following content in the “Subject” line – “Early Departure Med Def HCO #_____”. Additionally, enter a note in the CO Comments tab in WST to document the reason for the early departure and approximate time of departure.

Post Survey Process

Transmit the report to the Central Office following 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>
</tbody>
</table>

### Participants

<table>
<thead>
<tr>
<th>Organization:</th>
<th>Purpose:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Survey coordinator</td>
<td>• Has implemented the corrective action documented in its ESC submission, and</td>
</tr>
<tr>
<td>• Senior leadership</td>
<td>• Is demonstrating current compliance with the elements of performance addressed in the 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

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?

#### Purpose

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

- Has implemented the corrective action documented in its ESC submission, and
- Is demonstrating current compliance with the elements of performance addressed in the ESC.

### Objectives

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.
2. Determine if the organization has sustained compliance since implementing corrective action plans.
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.
4. Provide coaching and mentoring to the organization on sustaining and improving performance in those areas addressed in its ESC.

### 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).
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.

6. Identify survey activities that will provide you with access to organization staff and documentation that will allow you to evaluate current compliance with each EP identified as being corrected in the ESC report. For example,

   - Issues with orders, patient care or medical record content should be addressed through tracer activity. Conduct a number of tracers to evaluate current compliance.
   - Issues related to medication management should prompt the selection of a patient to trace that allows the best view possible of medication processes addressed in the ESC.
   - Issues related to collecting data would prompt evaluating the implementation of the process described in its ESC to facilitate this data collection (e.g., view the collection instrument, plans to administer the instrument, results desired, follow-up plan when results are not achieved, etc.). Reviewing the collected data is not required. Perhaps a 30-minute Data Management System Tracer with a targeted group of organization staff would reveal current compliance.
   - Environment of care issues could require touring various building areas, so scheduling time for a Building Tour with appropriate staff is recommended.
   - If the organization underwent a focused Medicare Deficiency survey to validate resolution of a Condition Level Deficiency (CLD) you will review the EP’s associated with the CLD again to assure sustained compliance.

7. The following guidance is offered regarding template agendas for Onsite ESC and PDA–ESC surveys
Accreditation surveyors will select a one-day template agenda through survey technology and edit to reflect the activities you believe will help reveal the organization's ESC implementation.

Surveyors should be prepared to discuss the agenda with the organization at the Opening Conference and make adjustments to activities and timing as needed.

**Conducting the survey**

1. Arrive at the organization approximately 10 minutes prior to the designated start time. **Note:** Most surveys begin at 8 AM unless the organization opens at a later time as identified in the organization’s e-application data.

2. Report to the reception area, security officer, information desk or administrative office upon arrival and introduce yourself and the purpose of your visit.

3. Display and show the organization’s representative your Joint Commission identification badge.

4. Ask the staff person, first encountered, to contact the administrative office or an organization leader to let them know of your arrival. You may be asked to wait in the lobby or in a different location.

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

6. Ask to meet with the CEO or senior leader, and other staff at their discretion, for a brief opening conference.

7. Provide the organization with a list of any documents that you want to review during the survey so that representatives have time, as necessary, to gather them. Remind the organization that you prefer to review the materials that are in everyday use.

8. Provide the organization with the draft agenda template and determine if any adjustments are needed to the activity timing.

9. Review with the organization the distance evaluation method/remote tracer activity you are planning to use to verify ESC implementation and current standards compliance for those instances where the RFI was based on observations and performance at other organization sites. If none of these approaches will work, call the Field Director on Call for direction.

10. Evaluate the organization’s current compliance with the elements of performance addressed in the ESC. Discuss with the organization what the data revealed about their performance. **Evaluating compliance with other standards and EPs beyond those addressed by the ESC identified as the focus for the follow-up event is out of scope for this survey type.** If other standards non-compliance is identified, call the Field Director on call for further guidance.

   - If the organization still has not achieved compliance or is struggling to sustain compliance, you should consider the corrective action details (who, what, when, how) and/or the measure selected to monitor performance. You may be able to help the organization identify where the actions were ineffective or help them understand why selected measures are not accurately reflecting performance.
11. If the review of current compliance on the identified ESC is completed any time before the noted departure time on the agenda, surveyors should provide coaching and mentoring to the organization on sustaining and improving performance in those areas addressed in the ESCs. Surveyors should offer assistance to the organization relative to compliance with other standards where performance is a concern. If the organization does not need or want to take advantage of this assistance, proceed to concluding the visit. If the departure time is adjusted greater than one hour before or after the noted agenda departure time, the surveyor should contact the program Field Director or the Field Director On-Call.

12. At the conclusion of the survey, prepare a report using survey technology. Note: If you document observations during the On Site ESC survey that lead to an RFI at the same standard: you are required to:
   a. Hover on the Standard tab to see the drop-down menu. Select “Manual Rules”
   b. Click on “ESC02.” Document the location of unresolved RFIs.

   Note: The PDA–ESC survey, with or without findings, does not require the selection of a manual rule. All PDA–ESC reports will stop in Central Office for SIG review and SIG will recommend follow-up survey activity as required.

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

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

15. At the conclusion of the survey, review the report as part of the exit conference. Explain that if the organization has any follow-up questions they should contact their Account Executive.

**Post-Survey**
Submit the report to Central Office following existing survey technology procedures.
Appendix Q – Extension Surveys

Applies to: All accreditation programs.

**Duration**
Per itinerary; one day in most cases.

**Unannounced Format**

**Participants**
All surveyors on site.

Organization: Survey Coordinator, Senior leadership

**Reasons for Extension Surveys**
An extension survey is conducted at an accredited organization or at a site that is owned and operated by the organization if the accredited organization’s current accreditation is not due to expire for at least nine months and when at least one of the following conditions is met:
- Changed ownership and has a significant number of changes in the management and clinical staff or operating policies and procedures
- Offered its services at a new location or in a significantly altered physical plant
- Expanded its capacity to provide services by 50% or more, as measured by patient volume, pieces of equipment, or other relevant measures
- Provided a more intensive level of service

**Extension Survey Agenda**
The day begins with 30 minutes for Arrival and Preliminary Planning followed by 30 minutes for an Opening and Orientation. The remainder of the day is spent on individual tracer activity. During individual tracer activity consider the following as applicable to the reason for the extension survey:
- Life Safety Code,
- Environment of Care,
- Emergency Management,
- Staff Competency,
- Infection Control,
- Medication Management, and
- National Patient Safety Goals

**Pre-Survey Activity**

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

**Onsite Process and Survey Conclusion**

1. It is recommended that surveyors arrive no earlier than 10-minutes before the intended start time for an unannounced survey.
2. If the survey includes multiple surveyors, surveyors should enter the organization together.
3. All surveyors will report to the reception area, security officer, information desk or administrative office upon arrival and indicate your name and purpose for your visit.
4. Display your Joint Commission identification badges.
5. Have the organization’s survey coordinator name and phone number from the e-app available to give to the staff person greeting you.
6. If the organization’s survey coordinator is unavailable, ask the staff person to contact the administrative office or an organization leader to let them know of your arrival.
7. Direct the survey coordinator or administrative contact to access their Joint Commission Connect extranet site. They will need the user ID and password to sign-on. The morning of your arrival, the HCO’s extranet site will have the following information available:
   a. Notification of scheduled Joint Commission event
   b. Surveyor picture, biographical sketch,
   c. Extension survey agenda template, and
8. Allow the organization an opportunity to access the information on their extranet site.
9. Ask the organization to print the extension survey agenda from their extranet site.
10. Once the organization verifies the authorization ask if they have a space where you can get settled while they begin to gather needed information as well as people to participate in the first activities of the day.
The day ends with time for issue resolution, report preparation and an Exit Conference.

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

What’s a Surveyor To Do If…
Q: The extension survey cannot be completed in the scheduled time?
A: Discuss with the HCO at the outset that the day may go beyond the agenda end time. Provide the HCO with updates as the day progresses and you begin to determine if you will need additional time.

Q: The extension survey cannot be completed in a day?
A: Call the Field Director On-Call for instructions.

Q: The reason for the extension survey does not exist when the surveyor arrives on site?
A: Call the Account Executive and your Field Director or the Field Director On-Call for instructions.

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

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

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

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

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

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

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

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

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

Duration
Per itinerary
Varies by program

Participants
One or more Joint Commission surveyors

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

This is an unannounced survey event.

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

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

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

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

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

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

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

Overview of Event

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

**Procedures**

**Before**

- Access the HCO information in the usual manner through the surveyor itinerary on the Surveyor Portal.
- Scroll through the surveyor assignments to find the Early Survey Policy (ESP) event. Select the event by clicking on the Event ID.
- Surveyors use Web-based Survey Technology (WST) to access all available TJC information related to the organization through the Quick Links option. Click on the Quick Links button in the lower right corner of the screen to view the menu of available information.
- Surveyors should review the subset of standards that applies to this type of survey to prepare for the event. This will assist surveyors in planning the agenda for the onsite visit.
- Surveyors will select a template agenda that is appropriate for the event through WST and edit accordingly.
- The survey agenda will include:
  - Opening Conference and Orientation to Organization
  - Surveyor Planning Session
  - Life Safety Code Building Tour (HAP and CAH only)
  - System Tracer – Data Management that includes review of Infection Control and Medication Management structures and processes – **data collection and analysis is not required**
  - Competence Assessment processes
  - Credentialing and Privileging structure and processes, as applicable
  - Environment of Care and Emergency Management
  - Report Preparation
  - Exit Conference
- **NOTE: No individual tracer activity takes place on this survey, even if the organization is already engaged in patient care.**

**During**

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

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

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

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

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

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

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

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

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

Other information
As organizations complete their Intracycle Monitoring (ICM) Profile, they tailor their

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

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

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

ICM Template Agenda
ICM Option 2 & 3 surveys are educational in nature. The agenda is intentionally generic so that you may focus attention on the needs of the organization based on the ICM Profile, rather than on all activities. Remind the organization you will be following the Survey Activity Guides in conducting all onsite activities. The agenda template, which can be found under the FSA tab of the ICM Profile, includes the core activities of the first and last days of survey:
1. 1-hour Opening Conference and Orientation session, including a review of the ICM Profile
2. 1-hour Surveyor planning session
3. 4.5-hours of Individual Tracer Activity
4. 30-minute lunch
5. 1-hour Surveyor Report Preparation
6. 1-hour CEO Exit Briefing and Organization Exit Conference
ICM Option 2 or Option 3 visit to meet their needs by determining:
- Which accreditation programs will participate?
- How many surveyors will participate?
- How long the surveyors will be on-site?
Surveyors should not expect to do the same scope and depth of evaluation on an ICM Option 2 or Option 3 survey that they would on a full survey.

Only cross-trained surveyors are scheduled to conduct ICM touch point surveys in organizations with multiple programs. If more than one surveyor is scheduled, the team will cover all the programs that need to be addressed in the ICM on-site event.

The template agenda is used for any length of survey or with any number of surveyors. When multiple surveyors are on-site, activities must be coordinated and should address all programs being covered by the ICM.

**Web-based Survey Tech FSA Instructions**

1. Access your itinerary and then select appropriate event ID
2. Click on Quick Links button
3. Select ICM Option 2 or 3 Survey from the list of links
4. Enter your login/password
5. On the HCO’s Intracycle Monitoring Profile Dashboard page, in the center column, click the orange ‘Go to History’ button.
6. The ICM History page displays; select the appropriate historical ICM submission (GEN or LAB). The ICM Accreditation Status page displays. From the horizontal menu bar at the top click the Focused Standards Assessment (FSA) tab.
7. The ICM Focused Standards Assessment page displays. Click on Access the focused Standards Assessment Tool option.
8. The FSA History Page displays. Under the Historical Submissions section, Option Submitted column, click on the View button next to the appropriate FSA Event.

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

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

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

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

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

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

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

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

The last day of an ICM Option 2 survey, you will:
1. Designate 1-1.5 hours to enter findings into the extranet-based FSA Tool, as well as to confirm your response to any noted ICM Profile risk area or Topics for Discussion. **NOTE: You must be connected to the internet in order to access the ICM Profile and FSA Tool, enter data, print reports and submit findings.** 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.
9. The FSA tool opens and displays the Standards/EPs tab.

10. In the left navigation column, select the desired Program, View and Chapter.

11. Click Show Standard Detail to expand the view for a standard for which you have a finding.

12. Change the score of the desired EP from Sufficient to either Partial or Insufficient.

13. Enter your finding statement

14. Click Save button to save entered data

15. When finished scoring standards, click on Scoring Summary tab and review. Select the Program name in the left navigation column to display the summary detail.

16. For ICM Option 2 Surveys ONLY: To print a report of your findings for use during the exit conference,
   a. Exit the completed FSA tool—the screen will return to the historical ICM Profile.
   b. Select the ICM Profile’s Submission tab—click the SUBMIT button. This will lock the FSA tool and change your access to read-only. In real-time, the historical ICM Profile becomes active again on the organization’s extranet site.
   c. Exit the ICM Profile.
   d. Ask the organization contact to access the appropriate historical FSA tool; on the Reports tab of the tool they should print copies of the Organization-level Not Compliant Standards report for use during the exit conference. (You may also refer the contact to the lower center tile of the ICM Dashboard for these instructions—“After an ICM Option 2 Survey.”

The last day of an ICM Option 3 survey, you will:
1. Designate 1-1.5 hours to organize a summary of survey findings. If you have used the FSA Tool to document findings for your own review, any entries made in the FSA Tool will be deleted when you submit the acknowledgement of exit conference completion.
2. Present a verbal report of findings; no report is left with the organization. The organization will NOT be able to see your findings on their Joint Commission Connect extranet site.
Appendix T – Focused Evaluation Screening Tool and Evaluation Activities

Topic Area: ___(e.g. Contracted Services)  Program: _____(e.g. Home care)_____

Part I: Focused Evaluation Topic Screening Checklist

Verify if services are provided by contract. If yes - note services included: Integrate risk assessment activities into present survey process when possible, rather than dedicating a specific time period. Observations should be noted in the record review or tracer screen as appropriate and scored at the appropriate standard/EP as needed.

HH _____ PC&S _____ DME _____ RX _____ Hospice _____

___Contract Review to verify the existing items are included in the contract (LD 04.03.09) (Review the contract(s) specific to tracer activity. There is no requirement to review every contract)

Information to request/verify during opening conference:

- List of contracted providers – verify if TJC accredited
- Copies of contracts/written agreements
- Identify individual responsible for oversight of contracted providers and discuss expectation to speak with or interview contract staff or managers.
- Review contract responsibilities to determine if commitments are being met

- The organization describes, in writing, the nature and scope of services provided through contractual agreements. **Note:** A written description of the expectations can be provided either as part of the written agreement or in addition to it.

  **Home Health Deemed** - LD.04.03.09 - EP 11, 12, 13 14 (reference manual for specific requirements)
  **Hospice Deemed** – LD.04.03.09 - EP 15, 16, 17 21, 22 (reference manual for specific requirements)

___ Patient tracer activity with emphasis on contract staff performance, coordination of services including timeliness, patient satisfaction

Select patient receiving one or more contracted service, observe care provision , interview contracted staff, conduct remote tracer if current patient not available, phone interview with contractor liaison as needed

- Observe provision of care by contracted staff member – reference corresponding standards
- Interview contracted staff about the scope and nature of services they provide and how they were oriented to the organization’s processes – reference corresponding standards

  - Patient education provided  PC.02.03.01
  - Perception of services PI.01.01.01
  - Care Coordination PC.02.02.01 (including timeliness of services)
  - Staff compliance with NPSGs - (corresponding NPSG)

___ Contracted staff clinical documentation review medical record from patient tracer activity. Verify documentation is complete submitted timely and compliant with organization policy.

___ HR files # of files reviewed ____ verify the following items for staff members observed during individual tracer.

**Not required if contractor is TJC accredited as this was verified during the contractor’s survey. However, pursue if concerns identified on tracer**

Ask for access to HR files during the opening conference as files may not be available on site

- License /PSV HR.01.02.05
- Competence HR.01.06.01
• Orientation HR.01.04.01

___ Leadership review during leadership or at other times such as during individual tracer or data session (LD.04.03.09)

• Interview organizational leaders about their oversight process for contracted services and contracted individuals
• How do leaders decide which items/issues they will monitor – establishes priorities
• Leaders monitor contracted services by establishing expectations for the performance of the contracted services
• Verify Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services
• Verify Leaders monitor contracted services by evaluating these services in relation to the organization’s expectations
• Verify Leaders take steps to improve contracted services that do not meet expectations

___ PI Data review (LD 04.03.09 or PI 01.01.01) Specific data review not required if contractor is TJC accredited. However, pursue if concerns are identified during tracer or leadership discussion. During opening conference request to have PI data collected and used to monitor contracted services provided to you

• Verify that collection and review of contractor data occurs. Data is segregated for staff and contractors. Matches leadership priorities.
• Data is monitored and actions are appropriately taken in response to trends – monitored at least annually.
• Offer consultative comments on how to build PI tracking system.

If initial review indicates compliance – STOP. There is no need to pursue additional review.
WST – Check off Focused Evaluation Topic Evaluated – YES

PART II: If the severity and or frequency of issues identified through the Focused Evaluation Topic Screening Checklist drives the need for further exploration, continue with the evaluation activities which may include:

• Additional patient tracer activity
• Additional HR file review
• Additional Clinical record review
• Interview organization’s individual responsible for supervision of contracted staff
• Review of referral process, staffing, scheduling, supervision of contracted staff
• Review Communication process between organization and contracted provider
• Verify education, orientation and competency process for contracted staff
• Evaluate organization’s process to determine selection of contracted services, evaluation of contracted services, verify information accessible to leadership

WST - Check off Focused Evaluation for Contracted Services if screening drives the need for further exploration. Observations should be noted in the record review or tracer screen as appropriate and scored at the appropriate standard/EP as needed.

NOTES: (optional)
Appendix U – Evaluating Contracted Services in Home Care Organizations

Applies to:
Home Health, Hospice, Personal Care and Support, Pharmacy and HME

Surveyor Tips & Tools
June 2012

Patient Tracer Selection When selecting patients to trace consider those who receive services from a contracted provider.

Organization Suggested individuals to speak with during patient tracer activity include:
- Administrator or CEO, Director, or whoever has authority to sign contracts and or supervise contracted staff
- PI individual who is monitoring contracted services for compliance with contract
- HR individual who makes sure contracted staff meet the licensure requirement including primary licensure verification and competencies and orientation
- Contractor liaison individual(s) (those who interact with the organization)
- Contracted staff members and organization staff who interact with contracted staff

Suggested Documents for Review
- Written agreements /contracts
- Addendum to contract, such as a job description
- Marketing brochures
- PI data, EM and IC Plan
- Patient Care policies and procedures
- HR files
- Clinical records

Resources:
CAMHC manual - Introduction to LD 04.03.09 - Monitoring contracts

Survey Tips
It is helpful to speak directly with the contractor, in person or by phone.

Objectives
1. Identify if a written agreement exists which includes:
   a. The applicable service provided by the organization seeking accreditation
   b. All the applicable elements required by the element(s) of performance
2. Compare the implementation of the contracted services to the representations made in the written agreement and to the services directly provided by the HCO
3. Evaluate the method used by the HCO to monitor the safety and quality of the contracted services.

The evaluation of these processes is to be incorporated into the following existing survey activity sessions:
- Orientation to the Organization
- Individual Patient Tracers
- Leadership
- HR/ Competence Assessment
- Data

Process
It is important to initially gather basic information about the organization’s processes related to the use of and management of contracted services. Review of the data will help with the selection of tracers and support the need for additional evaluation if required. Survey activities that should be utilized include:
- Individual Tracer Activity
- Data Tracer
- Leadership

Initial Information Gathering: During opening and orientation session:
1. Identify the contracted services used by the organization and determine who is responsible for management and oversight of the contracted services
2. Ask for the list of contracted providers. Verify if TJC accredited.
3. Discuss the expectation to speak with or interview contract staff or managers from the contractors
4. Ask to have the HR files of contract staff available for review
5. Ask for copies of the written agreements
6. Ask for information to be provided about the data that is collected and used to monitor the performance of the contracted services
7. Ask for marketing brochures to verify services offered and possible use of contracts especially for specialty programs
Ask the organization how frequently they use the contractor(s). Infrequent use may indicate a need for limited review of contracted services.

Review the contracts tied to tracer activity or those used most often—no requirement to review every contract.

Discuss those contractors used infrequently to assess the organization’s understanding of the contract and how they would access the service as needed.

Rehab Tech providers need to have an ATP as a W-2 employee. This service cannot be contracted.

During contract review assess to assure basic requirements are met, and educate if additional components would enhance the contract.

TJC vs. Non-TJC Accredited -- Steps to Follow

If Non-TJC accredited, review:
- Contracts
- Clinical documentation
- HR file components
- Contractor PI data

Additionally,
- Conduct a Tracer
- Discuss contract management with leadership

If TJC Accredited, review can be limited to:
- Conducting a tracer
- Discussing contract management with leadership

Review the following
- Contracts
- Clinical documentation
- Review of HR files and specific PI data
- May not be necessary as these issues are reviewed when the contractor undergoes their own TJC survey
- If concerns are identified during tracer activity, review of HR files and PI data may be appropriate

PART I: Topics to be routinely evaluated during tracer activity

Contract Review
Review content of the contract(s) (see checklist for applicable items reference the applicable standards)

During Individual Tracer Activity

a. Select a patient who is receiving one or more contracted services
b. Trace the implementation of the contracted services with at least 1 patient
c. Include observation of care or services via patient tracer and interview contracted staff
   i. If contracted staff member is not available, conduct a remote tracer with an active or recently discharged patient OR
   ii. Conduct a phone interview with the contractor liaison

Other Activities
- Review HR files of sub contractors observed on home visit (see checklist for minimum items to be reviewed. If TJC accredited review of HR files may not be necessary). Discuss staff competency. May need to request to have HR file information of the sub contractor brought /faxed to the organization as it may not be maintained at the organization
- Clinical record review of documentation by a contract staff member
- Review contract responsibilities. Discuss with leadership, contracted staff member, organization staff. Review timeliness of referrals

During Data System Tracer
Review the collection, aggregation, and evaluation of data used to monitor the contracted services. If contractor is TJC accredited detailed review of PI data is not required global discussion to occur during Leadership session.

During Leadership Session
- Discuss with the leaders the information that they receive about contracted services
- Discuss how the leaders use the data to determine the ongoing use of contracted services by the organization
- Discuss with leadership the process used to evaluate the effectiveness of the contracted service

If initial review indicates compliance - STOP. There is no need to pursue additional review.

Issues that may indicate the need to conduct a more in depth evaluation of contracted services:
- Contracted staff unaware of org P&P, law & regulations
- Concerns with coordination/timeliness, privacy and security of patient paperwork; (Notes, consents, etc.)
- Evidence of ineffective communication between staff and contracted staff related to the care treatment, services and patient safety issues. Delays in communication/responsiveness
- Identifies lack of, or concerns with contracted staff supervision
Applicable Standards/EPs may include:

LD.04.03.09 (contract standard includes PI monitoring)
HR.01.02.05 (PSV)
HR.01.02.07 (license/scope of practice)
HR.01.04.01 (orientation)
HR.01.06.01 (competency)
PC.02.01.01 (provides care according to POC)
PC 02.03.01 (pt education)
PC 02.02.01 (care coordination)
PI 01.01.01 (pt satisfaction)
MM 01.01.01 (pt info accessible to staff)
IM.02.01.03 (security of PHI) loss
IM.02.01.01 (privacy of PHI/monitor compliance with privacy policy)
LD.04.01.05 (oversee pt care/directed by qualified individual)
EM.02.02.07 (mgt of staff)
EM.02.02.01 (communication with staff)
IC.02.01.01 (implements IC plan)

Related Systems
- Leadership
- Competency
- Data

- Problems with visit schedules and timeliness of care
- Discrepancy between staff, contractor and or patient comments about the care/equipment services provided
- Discrepancies between staff and contractors regarding care provided to the same or similar types of patients. (lack of adherence to policy or POC)
- Witnessing discrepancies with care provision between organization staff and contractors
- Review of HR files, or education records demonstrates insufficient evidence of orientation and or determination of competency of contracted staff
- Risk management issues such as incidents with contractor staff or patient injury, complaints about contracted staff
- Lack of PI information about the subcontractors in the organization’s or contractors Performance Improvement data

PART II: To perform a more in-depth evaluation of contracted services: These conversations may occur during the designated session or throughout the course of the survey or an alternate session if on a one day survey.

- Conduct Individual tracer or remote tracer activity with additional contract staff members (in person, if staff member available or a phone interview, if at all possible)
- May include more in depth review of HR files or review of additional HR files
- Review additional clinical records or contract staff documentation
- Interview the organization’s individual responsible for supervision of contracted staff
- Review of referral process /communication with contracted provider
- Review of staffing, scheduling & supervision of contracted staff
- Review Communication process with contract staff. Discuss verify process with leadership, contracted staff member & organization staff
- During Competency Session interview leadership, HR, education personnel and or manager of contracted services related to implementation of processes for orientation, competency review for contracted staff (1 day survey may be done during data session)
- During Leadership Session evaluate the organization’s process to:
  - Determine selection of services managed by contract
  - Regularly evaluate contracted services
  - Verify information provided to leadership which allows them to evaluate the contracted services
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
- Environment of Care and Emergency Management
- Special Issue Resolution

Initial Screening:

During Orientation to the Organization explore:

- The format of health information systems – all electronic; all paper; or a combination of electronic and paper
- How well computer systems, are integrated throughout the organization
- Medical equipment and devices that connect to the internet for installation, set-up, use, or maintenance.
- How mobile devices and equipment are used remotely by staff or patients to access or transmit information on patient care, treatment, or service.
- How long the existing state of systems has been in place
- Anticipated future state of systems and timeline for implementation

Topics for routine evaluation during patient tracer activity

- Staff and practitioners knowledge and ability to access data they need to provide patient care
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, 8
IM.01.01.01
IM.01.01.03
IM.02.01.01
IM.02.01.03
IM.02.02.01
IM.02.02.03
IM.04.01.01
RC.01.01.01
RC.01.02.01, EP 1
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

- Orientation and training that staff received on accessing data needed to provide patient care
- Availability of data to staff — 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 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 when help with automated systems is needed; responsiveness of the support system
- Procedures followed by staff 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 processes for suggesting changes and improvements to current health information technology systems
- Staff 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 patient health information – such as inaccurate data resulting
from access to health records from multiple systems that are not updated or refreshed simultaneously; or from "cutting and pasting" data from one area of a record into another without regard for selecting accurate content (such as the latest laboratory results)

- Staff are unable to obtain data and information for performance improvement initiatives

**To perform a more in-depth evaluation of information management systems and processes:**

- Interview staff responsible for health information management or health records about the records maintenance systems and processes
- Interview staff that support the clinical end-users; ask if calls for assistance are being tracked and trended to identify problematic systems for end-users
- Interview those individuals responsible for staff orientation, training and ongoing education on use of the data and information systems in day-to-day patient care
- Ask to see results of patient health data and information audits for completeness and accuracy; ask if audits include reviewing and comparing contents of documentation that is available through multiple systems or for cutting and pasting from one area of a record (e.g., lab results) into another (e.g., progress notes); ask about actions taken to address undesirable audit results
- Ask to see logs or reports that track information systems (computer) down-time, scheduled and unscheduled
- Review policies and procedures for checking the integrity of data and information
- Review procedures related to protections from risks due to spam, phishing, weak passwords, viruses or malware in USBs, and potential points of intrusion such as the following:
  - Email
  - Phone calls
  - Internet/web sites
  - Wi-fi
  - Public access spaces (meeting rooms, waiting rooms, cafeteria)
- Review organization emergency management planning to determine if and how health information management is addressed in terms of
  - potential risks to care, treatment, or services 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 services
- Review with leaders the organization’s approach to risk awareness, detection and response as it relates to cyber emergencies
Appendix W – Medicare Survey Mid-Cycle – Survey Event Guide

Applies to: All CMS deemed accreditation programs

<table>
<thead>
<tr>
<th>Duration</th>
<th>Reasons Organizations Assigned this Event Type (MEDSRVMC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per itinerary</td>
<td>• An organization requests to add deemed status to their existing accreditation somewhere between full accreditation surveys</td>
</tr>
<tr>
<td>Varies by program</td>
<td>• An organization acquired another hospital that was not Joint Commission accredited AND the organization decided to reject the existing Medicare provider agreement for this facility, and has elected to add the hospital as an additional (provider-based) inpatient location to the existing provider agreement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants</th>
<th>Overview of Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or more Joint Commission surveyors</td>
<td>• Serves as the initial deemed status survey for the organization</td>
</tr>
<tr>
<td>This is an unannounced survey event.</td>
<td>• CMS expects that a new initial Medicare survey take place at the acquired facility, and that the organization demonstrate compliance with all of the CoPs prior to being considered eligible for inclusion under the acquiring organization’s provider agreement and eligible for Medicare reimbursement.</td>
</tr>
<tr>
<td></td>
<td>• The approach to the survey is the same as conducting a full initial accreditation survey at the acquired location according to the Survey Activity Guide.</td>
</tr>
<tr>
<td></td>
<td>• If there are any Medicare Condition-level deficiencies identified, The Joint Commission will not be able to issue a recommendation for Medicare certification for the new location, and the organization will have to undergo another full, initial Medicare survey.</td>
</tr>
<tr>
<td></td>
<td>• Contact the Field Director or Account Executive for further information or guidance regarding this event type.</td>
</tr>
</tbody>
</table>
# Appendix Z – Office of Quality and Patient Safety Survey Activity

**Applies to:** All accreditation programs

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

## Participants

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

## 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

## 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
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.

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.

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.
Exploring an OQPS Incident During a Full-Survey Event

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

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

Before

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

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

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

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

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

During

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

2. Organizations may be surprised to see you, especially if Joint Commission leadership has decided to pull an organization’s full survey forward. This can sometimes be 12-18 months before the organization is expecting a survey. See the attachment to this section for sample scripting to assist you in discussing the purpose for your visit.
Script for Introducing the Exploration of a Patient Safety and Quality Issue during a Full Survey Event

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

3. Survey the organization integrating OQPS incident exploration into your tracer and other on-site activities to explore standards compliance and to evaluate processes in place to support patient safety. If a particular name is noted in the incident, please include the medical record, credentials or staff personnel file in your review sample.

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

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

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

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

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

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

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

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

12. Inform the organization that the Central Office will need to review the report and that the final report will be available on their extranet site within ten calendar days.
Appendix Z – Attachment: Scripts for OQPS Survey Activity

Suggested Comments during Opening Session with Leadership (related to an OQPS Incident being the trigger of a For-cause (OQPS) Survey or related to an OQPS Incident being a component of a Full or other type Survey)

The guiding principle is to be as transparent as possible, while still to be thoughtful in not inadvertently disclosing either the complainant, or even, the nature of the complainant, i.e. “an employee,” or “a physician.” The HCO should be made aware, at the onset, of the nature of the allegation. It may be easiest to use standards areas, or focus areas, as well as clinical service categories, such as Medication Management in the PICU, or OPPE/FPPE processes for non-physician LIPs, etc. Here are some examples:

For a for-cause (OQPS) survey: “Information representing a possible patient safety issue has come in to The Joint Commission’s Office of Quality and Patient Safety. It has been analyzed thoroughly, and reviewed by Joint Commission leadership, who has asked that we spend some time with you today evaluating systems and processes related to the patient safety issue. The main focus of our assessment will start in the NICU, related to Infection Control processes, although we may look at other areas throughout the day.”

For a ‘feed to full survey’: “We want for you to know that during this full survey, we also will be evaluating information which has come into The Joint Commission's Office of Quality and Patient Safety. This information, which represents a possible patient safety issue, has been analyzed thoroughly and reviewed by Joint Commission leadership. They have asked that during the course of your full survey, we evaluate the systems and processes related to the patient safety concern. The area of focus in the information is the process for Competency Assessment in the critical care area. As you know, looking into your competency assessment processes is a customary part of a full survey, so this will be incorporated into our time with you.”

For a Pull-Full Forward, with an OQPS Incident attached- if asked why the survey has come early: “ As you know, the full survey can come anytime within a 18-36 month window. While we’ll be conducting a full survey, we want to share with you that The Joint Commission’s Office of Quality and Patient Safety has received information about a potential patient safety issue. This has been analyzed thoroughly and reviewed by Joint Commission leadership who has asked that we evaluate the systems and processes involved in the patient safety issue as a component of our full survey. The area of focus in what we received has to do with the credentialing and privileging processes particularly in the surgical service line. As you know, a customary part of a full survey includes a review of these processes, so we will incorporate this into our survey day.”

If it is a media article, its okay to say: “We know you’ve had some press coverage recently, and along with related information, this has been analyzed thoroughly and reviewed by leadership, who has asked that we spend some time reviewing this issue. We will focus, at least initially, on the cleaning, disinfection and sterilization processes related to endoscopy, and we’d like to begin there now.”

If it has to do with a government agency report, we can say: “We know you’ve had some recent visits from your State Agency [or CMS]. These reports came in to The Joint Commission’s Office of Quality and Patient Safety and have been analyzed thoroughly there. Joint Commission leadership has reviewed the information and asked that we review some of the follow up actions which have been undertaken since that CMS visit. The main area of our evaluation is restraint practices in your gerop-sych unit.”

If there is a written organizational response attached to the OQPS Incident: “We understand that you’ve been working with The Joint Commission’s Office of Quality and Patient Safety on a patient safety issue which came into that Office. Your response was thoroughly reviewed by Joint Commission
leadership who has asked that we spend some time looking at that area during survey. The focus of our assessment will be in the ED, and how care, security and communication practices work in that environment, particularly with boarded patients.”
Appendix AA -- Medication Compounding Tracer Review Tool

Topic Area: Sterile and Nonsterile Medication Compounding

Verify if pharmacy does sterile compounding. **If yes:** Integrate risk assessment activities into present survey process. Enter comments in the record review or tracer screen as appropriate and score at the appropriate standard/EP as needed.

I. Information to review during pharmacy and facility tour

1. Discuss sterile and nonsterile medications that the pharmacy compounds (to validate low, medium, high risk compounding for sterile compounding; and complexity level for nonsterile compounding: simple, moderate, complex)
2. Discuss sterile and nonsterile medications that are compounded outside of the Pharmacy, in patient homes (to validate immediate use criteria are met)
3. Discuss medication supply chain of ingredients (pharmacy managed, supply chain managed, and those that may be acquired outside pharmacy’s oversight)
4. Notify the organization that you will be observing the actual compounding process (and reviewing applicable policies as needed); the surveyor should enter the clean room to observe, following all requirements of the organization for staff entering the clean room (eg level of garb used for a pharmacist observing a technician or validating accuracy of a compounded product or compounding equipment) but not engaging in actual sterile compounding. This observation can occur as part of your tracer process or pharmacy tour.
5. Request a list of compounding staff; notify the organization that you will review HR records for some of these staff members focusing on competency (see “Competency” section)
6. Review competency records either as paper records or as recorded in an electronic clean room monitoring system, taking into consideration the frequency of competency assessment based on risk level for sterile medication compounding and complexity level for nonsterile medication compounding.
7. Review remedial follow up done in the event that staff does not pass a competency assessment (documentation electronically or in writing)
8. Request the clean room monitoring records for primary engineering controls (PEC) such as compounding aseptic isolators (CAI), compounding aseptic containment isolators (CACI), laminar airflow workbenches (LAFW), biological safety cabinets (BSCs), and secondary engineering controls (SEC) provided by buffer areas, ante-areas, and segregated compounding areas (either hard copy or electronic) for at least the last 12 months, in order to review the organization’s monitoring of the compounding process. At a minimum, must see:
   a. Report from current clean room certification (hoods, room, etc.) and certification reports from last 12 months
   b. Have a discussion with pharmacy supervisor or pharmacist in charge including what time of day certification was conducted and whether the certifier reviewed the results of the certification report with this individual. In addition, the pharmacy supervisor or pharmacist in charge must require that the certifier has shared proper credentials with the organization validating competency to conduct the clean room certification process.
   c. Quality management of PEC and SEC quality including environmental sampling, aseptic techniques, beyond use dating, sterility and stability techniques, precision and accuracy (per policy and state regulations)
   d. Organization’s cleaning requirements (for every shift, or daily, weekly, monthly as required) and validation that these requirements were completed (per policy and state regulations)
9. Verify that leaders analyze and respond to the data collected regarding the monitoring of the clean room
10. Review all pharmacy facility licenses as required by law (include all non-resident pharmacy licenses)
11. Review most recent Pharmacy Board report (if the Board was onsite in last 3 years)
12. Verify that the pharmacy staff has access to current reference materials (paper or electronic)
II. Compounded medication tracer activity

Select a patient that has orders for a compounded medication/infusion therapy. Use the identified compounding process focus areas on the Compounding Risk Assessment Checklist (Environment, Competency, Products, Performance Improvement, Quality Control, and Leadership), to survey against organization’s policies and state regulations.

1. Interview staff about the scope and nature of pharmacy services they provide and how they were oriented to the organization’s processes
2. Observe the dispensing process from receipt of physician order, through the entire compounding process, including the five identified topic areas below:

Environment

Facilities:
1. Review clean room monitoring reports (surveillance and proper technique)
2. Review PEC and SEC certification reports
3. Review policy on refrigerator temperature ranges/checks if need be in case staff in unable to clarify
4. Check documentation of temperature checks in refrigerators and storage areas and validate what occurs when temperature in the refrigerator or storage area is out of range focusing on any time an out of range reading was documented.

Hand washing, gowning and gloving:
1. Review policy/process
2. Observe staff
* Carefully observe attention to the “line of demarcation” in the prep or ante room and proper donning of sterile gloves.
* Also pay attention to order of gowning and gloving process, complete covering of hair (head and facial), and jewelry removal.

Equipment:
1. Auto-dispenser (e. g., Baxa Pump): Pharmacist oversight of calibration process/documentation. Check interface with electronic healthcare record making sure that dose and units are matching
2. Automated Compounding Devices (TPN, IV robots): Pharmacist oversight of calibration process/documentation
3. Review documentation for technological, clinical, and architectural assessment
4. Other equipment
5. PI/Quality control/Monitoring of clean room, cleansing and sanitizing:
   a. Review of plan/process
   b. Review documentation of data collected (hard copy or electronic)

Products

Product selection:
1. Inquire about ordering process and staff responsibilities

Storage:
1. Review drug storage areas, specific to temperature ranges, security, etc.
2. Review process for quarantining products if temperature for storage fall outside of range and/or sterility
3. Ingredients must be stored in tightly closed containers under temperature, humidity, and lighting conditions consistent with those indicated in official monographs or specified by the suppliers/manufacturer.
Labeling:
1. Observe labeling process, information on labels

Product testing:
1. If organization does this due to state law, discuss their policy/process

Packing and shipping methods:
1. Review policy (if available)/process for packing medications, related to maintaining medications in acceptable temperature ranges
2. Discuss with staff packing sterile products, process for validation that products remain in acceptable temperature range until delivery to the next destination point (or level of care).

Extended dating:
1. If organization does this, discuss their policy and process

Beyond use dating:
1. If organization does this, ask why and for what products, and what resources are used to support extending dates (e.g., documented research findings on both stability and sterility, either from their own organization or in the literature).

Compounding records:
1. Review all pharmacy records, including the compounding record(s), The Master Formula Record (MFR) for sterile compounding, and Safety data sheets (SDSs) for nonsterile compounding
2. Verify documentation is complete and compliant with organization policy, law, and regulations

Controlled substances, at a minimum, review the following items:
1. Storage
2. Destruction/disposal process

Drug recalls:
1. Review organization’s policy (in accordance with state law)
2. Interview staff to determine knowledge
3. Review of segregated storage of drugs recalled and outdated

Competency and Education
1. Review responsibilities of compounding staff (e.g., job descriptions)
2. Review personnel training and competency per policies and procedures, laws and regulations
3. Review competency requirements for compounding staff per risk and complexity level (e.g., continuing education, exams, etc.)
4. Validate process for evaluation of compounding staff’s aseptic skills per risk and complexity level (e.g., media fills, finger-tip testing, hand hygiene, garbing)
5. Review documentation that validates direct observation of staff competency of aseptic skills (may be in HR files, in IV room software or in clean room binder/records)

Oversight and Monitoring by Leaders
1. Verify that leaders monitor compounding process.
2. Verify leaders take steps to improve the compounding process if it does not meet expectations
PI / Quality Control

1. Review pharmacy PI Plan as it applies to medication compounding (what the organization has been collecting data on, what data analysis has shown, and how improvements have been made; if the organization is monitoring criteria specific to sterile compounding, do a focused review)

2. Data is monitored and timely actions are taken in response to trends

3. Review contracting with outsourcing pharmacies and suppliers to validate documented competency of the compounding staff.

4. Review all quality control policies and procedures pertaining to compounding: high risk, medium level risk, low risk sterile compounding and nonsterile compounding if need be if staff is unable to explain process and practice.
Appendix CC – Immediate Threat To Health or Safety Abatement Survey
Applies to: All accreditation and certification programs

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

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

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

Conducting the Survey
8. Arrive at the organization no earlier than 10 minutes before the designated start time for the unannounced survey. If the survey includes multiple surveyors, all surveyors should enter the organization together.
9. Report to the reception area, security officer, information desk or administrative office upon arrival and:
   a. Provide your name and the purpose for your visit.
   b. Display your Joint Commission identification badge.
   c. Ask to speak with the survey coordinator, by name. If the coordinator is unavailable, ask to speak with an administrator or the most senior leader available.
   d. Clearly explain the purpose of the survey to the organization.

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

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

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

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

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

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

16. If activities are completed in less than 8-hours, the surveyor should enter a note in the CO Comments tab indicating their time of departure from the organization and notify the FD on Call.

17. At the conclusion of the survey, provide organization leadership with the evaluation results, focusing on the abatement of the immediate threat to health or safety.
   a. Explain that follow-up questions should be directed to the organization’s Account Executive.
b. Indicate that you will not be posting a preliminary report to the HCO’s extranet site for this on-site survey.

c. Indicate that Joint Commission Central Office will review the findings and will then post a final report to the organization’s extranet site indicating the results of this event.

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

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

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

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

22. Lock and transmit a report for the event to Central Office within 24 hours of the exit. The event type automatically stops the report.
# Appendix DD – Medication Compounding Competency Checklist

<table>
<thead>
<tr>
<th>Required Competencies/Training</th>
<th>Employees Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training on procedures related to job functions (facilities, compounding, use of equipment, packaging, storing &amp; dispensing (MC.02.01.03, EP 1)</td>
<td></td>
</tr>
<tr>
<td>Training re: hazardous medication storing, safe handling, disposal for staff that work with hazardous medications (MC.02.01.03, EPs 2-3)</td>
<td></td>
</tr>
<tr>
<td>Training re: cleaning and removing of waste from hazardous medication areas for staff assigned to these areas (MC.02.01.03, EP 4)</td>
<td></td>
</tr>
<tr>
<td>Training for staff conducting sterile compounding: use of all equipment, apparatuses, and devices; ability to identify malfunctions (MC.02.01.07, EP 1)</td>
<td></td>
</tr>
<tr>
<td>Training and competency assessment: avoidance of touching critical sites (MC.02.01.07, EP 2)</td>
<td></td>
</tr>
<tr>
<td>Sampling of compounding staff glove fingertips for all CSP risk levels per USP 797 (MC.02.01.07, EP 3)</td>
<td></td>
</tr>
<tr>
<td>Visual observation and documentation of garbing and gloving (MC.02.01.07, EP 4)</td>
<td></td>
</tr>
<tr>
<td>For ancillary support services that clean and disinfect the clean room: training in hand hygiene, garbing, cleaning, and disinfection procedure (MC.02.01.07, EP 5)</td>
<td></td>
</tr>
<tr>
<td>Annual competency for sterile compounders: Aseptic technique through written, media-fill and fingertip sample testing (Media Fill and Fingertip sampling every 6 months for High Risk Compounding) (MC.02.01.09, EP 2)</td>
<td></td>
</tr>
<tr>
<td>Prior to beginning to compound, completion of initial 3 fingertip samples (documentation for employees that started compounding in the last 12 months (MC.02.01.09, EP 4)</td>
<td></td>
</tr>
<tr>
<td>Staff who fail assessment of aseptic technique are retrained and re-evaluated (may be NA) (MC.02.01.09, EP 5)</td>
<td></td>
</tr>
<tr>
<td>Competency assessment and documentation of procedural breaches; administrative errors; complications associated with medication dose or administration (MC.02.01.13, EP 1)</td>
<td></td>
</tr>
</tbody>
</table>
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)

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 Buturus)

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