What’s New for Nursing Care Center Accreditation (NCC) 2018

Note: Updates effective in 2018 are identified by underlined text throughout this document. Light editing or extensive changes to a section are not underlined.

Changes Effective January 1, 2018

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

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

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

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

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

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

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

Pre-survey Preparation for All Types of Surveys .......................................................... 7
Surveyor Arrival & Preliminary Planning Session ....................................................... 9
Opening Conference ........................................................................................................ 13
Orientation to the Organization ..................................................................................... 17
Surveyor Planning Session – Initial ............................................................................. 19
Resident Level Quality Measure Report (a.k.a., CMS Form 802) .............................. 21
Individual (Patient or Resident) Tracer Activity ......................................................... 23
Individual Tracer – Addendum ....................................................................................... 27
Program Specific – Individual (Patient or Resident) Dementia Tracer Activity ....... 33
Special Issue Resolution ............................................................................................... 37
Team Meeting / Surveyor Planning Session – End of Day ......................................... 39
Daily Briefing ................................................................................................................ 41

Competence Assessment Session includes Credentialing of Licensed Independent Practitioners 43

Environment of Care and Emergency Management Session .................................. 47
Life Safety Code® Building Assessment ...................................................................... 55
Program Specific Tracer – Staffing ......................................................................... 57
Leadership and Data Use Session ............................................................................. 59
Report Preparation ....................................................................................................... 65
Exit Briefing ................................................................................................................... 69
Organization Exit Conference ..................................................................................... 71
Introduction to Post-Acute Care Certification ............................................................. 73
Evaluation Guide for Optional Post-Acute Care Certification ................................ 75
Post Acute Certification -- Transitions of Care Session ........................................... 79
Introduction to Memory Care Certification ................................................................. 83
Evaluation Guide for Optional Memory Care Certification ...................................... 85
Appendix A – Potential Threat to Health or Safety .................................................... 89
Appendix B - Surveyor Documentation Guidelines .................................................. 93
Appendix C – Surveyor Worksheet .......................................................................... 103
Appendix D – Team Leader Responsibilities ............................................................... 105
Appendix F – Handout for the Nursing Care Center .................................................. 111
Appendix G – Nursing Care Center Accreditation Survey Activity List .................. 113
Appendix H – Accreditation with Follow-up Survey ................................................ 115
Appendix I – Random Unannounced Validation Survey (RUV) ............................. 119
Appendix P – Onsite Evidence of Standards Compliance (ESC), Preliminary Denial of Accreditation Evidence of Standards Compliance (PDA–ESC) Survey .......... 123
Appendix Q – Extension Surveys ............................................................................. 127
Appendix R – Early Survey Policy – Survey Event Guide ............................................ 129

Appendix S – Intracycle Monitoring (ICM) Option 2 & 3 Surveys & Focused Standards Assessment (FSA) Tool ................................................................................... 133
Appendix T – Focused Evaluation Screening Tool & Related Activities .................... 137
Appendix U – Guide for Evaluation of Management of IV Therapy Services in Nursing Care Centers ................................................................. 139
Appendix V – Evaluating Aspects of Health Information Management Requirements 143
Appendix Z – Office of Quality and Patient Safety Survey Activity ............................. 147
Appendix CC – Immediate Threat to Health or Safety Abatement Survey ............... 155
Important Telephone Numbers ..................................................................................... 159
Pre-survey Preparation for All Types of Surveys

Applies to: All accreditation programs, except Laboratory

Participants
Surveyors
As needed:
- Account Executive
- Field Director

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

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

Exceptions: The following survey types are announced.
- Initial surveys (except deemed status surveys for Medicare certification)
- Early Survey Option (ESO) surveys
- 7 day “short notice” is given to:
  - Intracycle Monitoring (ICM) Option 2 and 3 surveys
  - One-day freestanding Medicare/Medicaid certification-based long term care surveys, if not part of a hospital
  - Department of Defense facilities
  - Bureau of Prisons facilities and contracted facilities

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

Four weeks prior to the survey
- Download the following information:
  - 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
  - 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 organization 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 list of program risk areas
- View the organization-specific risk areas, when available
- View the Focused Standards Assessment, if the organization has granted surveyor access
- View report(s) from the previous full accreditation cycle(s)
- Review the organization’s historical SAFER™ matrix(s). The purpose of the review is to determine if there are high risk findings that you may want to discuss or touch upon with the organization during the survey.
  - Find the historical SAFER™ matrix(s) by selecting the quick link in WST.
You will be taken to a page on the organization’s Extranet site with all SAFER™ matrix(s) for that particular organization from historical onsite survey events.

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

Focus the review on the findings placed in the dark orange or red areas of the SAFER™ matrix (these areas represent higher risk findings) and the Evidence of Standards Compliance corrective action submitted by the organization.

Identify the higher risk findings that you would like to include or discuss with the organization during the survey to ensure sustainment has been maintained.

Incorporation of the identified findings to review during survey will entail the following:

- Discuss the finding with the organization
- Ask if they are still utilizing the corrective action plan outlined within the previously submitted ESC
- Determine if compliance still remains.
- If compliance has been sustained, no further action is needed.
- If compliance has not been sustained, score the same standard and determine if scoring LD.04.01.01 EP 3 is also appropriate.

NOTE: Findings of lower risk (light orange and yellow areas of the SAFER™ matrix) will be included in the SAFER™ visual as well for reference, but are NOT required to be reviewed or discussed during the survey.

- Note the previous accreditation events/activity
- Print a copy of Appendix F: Handout for the Nursing Care Center for the Preliminary Planning Session

Any time prior to survey

- Discuss questions regarding the organization or survey logistics to the Account Executive or your Field Director
- Call your Field Director with any survey process questions
Surveyor Arrival & Preliminary Planning Session
Applies to: All accreditation programs, except Laboratory and LT2- Medicare/Medicaid certification-based long term care surveys

<table>
<thead>
<tr>
<th>Duration</th>
<th>30 - 60 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>All surveyors on site</td>
</tr>
<tr>
<td>Organization:</td>
<td>Survey Coordinator</td>
</tr>
<tr>
<td>Organization leaders and staff</td>
<td></td>
</tr>
</tbody>
</table>

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>
<th>1. Announce the start of the survey</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Allow the organization time to gather documents and staff in order to proceed with the survey</td>
</tr>
<tr>
<td></td>
<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.
- Report to the reception area, security officer, information desk, or administrative office upon arrival and provide your name and the purpose for your visit.
- Display your Joint Commission identification badge.
- Direct the organization to their Joint Commission extranet site accessible through www.jointcommission.org to verify the survey event.
- 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 for the unannounced survey
  - Surveyor name(s), picture, and biographical sketch
  - Scheduled survey dates
  - The survey agenda template that you prepared and posted
NOTE: If the organization is unable to validate the authenticity of the survey via computer: 1) ask the organization to contact their Account Executive for validation; 2) You should call the Field Director on call with the information; and 3) Do not begin the survey until the organization verifies who you are or until the Central Office directs you to begin

During

- Once the organization validates the authenticity of the survey:
  - Provide the organization with the list of documents that will be needed during the survey. This list is available in Appendix F of this guide. (Note: The document list was provided to the organization on their Joint Commission Connect extranet site and also appears in the Organization Survey Activity Guide.)
  - Ask to be taken to a location where you can work and secure your belongings.
  - Begin document review activity if the organization has materials readily available
    - If the organization does not have documents immediately ready for review, ask to begin with an individual tracer. Select this tracer based on the ICM Profile data that you reviewed in preparation for the survey.

- If you discover that the organization has a significant change in volume, sites, and services, before or upon your arrival onsite:
  - Call the Account Executive or the Field Director On-Call immediately. Do not assume a 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

<table>
<thead>
<tr>
<th><strong>Duration</strong></th>
<th><strong>Participants</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>15 minutes</td>
<td>All surveyors on site</td>
</tr>
</tbody>
</table>

**Organization:**
Senior leadership (representing all programs/settings 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 Administrator.)
- Senior organization leaders from all programs/settings. (e.g., as applicable, Administrator, COO, CFO, CIO, VP for clinical services, nurse executive, laboratory medical director, director of resident services or branch manager, chief administrator/director of each program.)

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

**Objectives**

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

**During**

- Surveyor(s) introduce themselves providing a **brief** background of relevant experience.
- Thank the organization for participating in accreditation as it is a voluntary commitment to improving quality and safety of health care.
- Explain that the purpose of survey is to provide an external validation of compliance with standards and provide education/consultation.
- Ask organization attendees to introduce themselves and make a note of each person’s name and title/functional responsibility.
- Describe each component of the survey agenda and make any changes, if necessary.
- Identify the specific data (previous reports, data about their services, risk areas noted in the ICM Profile) that you are using to guide your initial on-site activity, such as locations to visit, people to interview, and documentation that will be reviewed.
- Confirm with the organization what care treatment and services they are providing and the locations as reported in their e-application.
- Explain that the majority of survey activity occurs at the point where care, treatment and services are provided. The term “Individual Tracer” denotes the survey method used to evaluate the organization’s compliance with standards as it relates to the care and services provided to an individual patient.
- Emphasize with the organization that it is important for surveyors to interact with the direct care givers. Remind leaders that staff members can often become uncomfortable with large numbers of observers.
- Give an example of an Individual Tracer, if the organization is unfamiliar with the on-site survey process.
- Describe the Systems Tracer(s) you will conduct, if the organization is unfamiliar with the on-site survey process.

**Other information**

The survey team leader facilitates this session.
• 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:
  o Daily Briefings
  o Special Issue Resolution
  o Team Meetings
  o Report Preparation Time
  o Other times pre-arranged with the surveyors

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

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

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

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

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

- Ask if there are any questions about the survey, answer those questions and indicate that questions may be asked throughout the survey

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

**Applies to:** All accreditation programs

<table>
<thead>
<tr>
<th>Duration</th>
<th>45 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participants</strong></td>
<td>All surveyors on site</td>
</tr>
<tr>
<td>Organization:</td>
<td>Senior leadership (representing all programs/settings in a complex organization).</td>
</tr>
<tr>
<td>- 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.)</td>
<td></td>
</tr>
<tr>
<td>Attendees may include:</td>
<td></td>
</tr>
<tr>
<td>- At least one member of the governing body, or organization trustee. (In single owner organizations, this individual may also be the Administrator.)</td>
<td></td>
</tr>
<tr>
<td>- Senior organization leaders from all programs/settings. (e.g., as applicable, Administrator, COO, CFO, CIO, VP for clinical services, nurse executive, laboratory medical director, director of resident services or branch manager, chief administrator/director of each program.)</td>
<td></td>
</tr>
</tbody>
</table>

### Objectives

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

### During

- If an organization leader wants to provide a formal presentation, ask how long the presentation will be and if they would be open to your asking questions throughout as they pertain to topics being discussed. If they indicate a preference for questions at the end, ask if the presentation can be limited to 15 minutes so that you have sufficient time to ask follow-up questions.
- This session addresses all programs and services and, as applicable, the team leader or his/her designee serves as facilitator.
- Suggested discussion topics are governance and operations-related that help you to better understand:
  - The organization’s mission, vision, goals, and strategic initiatives
  - Organization structure
    - Staff and administrative turnover since the last Joint Commission survey
    - Operational management structure
    - Planning, resource allocation, and decision-making processes
    - Information management and resident record-keeping
    - Contracted services and monitoring performance
    - Initiatives for resident centered care, if any
    - Health care errors reduction and resident safety initiatives
    - Organization performance in adhering to National Patient Safety Goals
    - Community involvement initiatives
    - Leaders’ roles in emergency management planning
- Review with the organization any activities related to risk awareness, detection and response as it relates to cyber emergencies. Suggested discussion topics include:
  - Identification of any 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 patient care related to IT systems (critical data...
and applications, servers, computers, and digitally connected infrastructure).

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

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

- Ask the organization to identify Nursing Care Center-based physicians, (e.g., Medical Director, other). Explain that physicians are included in individual tracers either in person or through phone contacts.

- Ask leaders what they are doing to assess the organization's culture and attention to safety

- Ask leaders what initiatives have been implemented in support of culture transformation and person-centered care (e.g., care practices, workplace practices, and environmental changes)

- 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 proactive risk assessment topics, resulting improvements, and Board member involvement in safety issues
  - Provision of resources including personnel, information systems, data management, and staff training

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

After

Orientation Tour of the organization – surveyor and an organization escort will conduct a brief, 10-15 minute, tour of resident care areas. The purpose of this tour is to become familiar with the arrangement of patient and resident care areas as well as observe resident care issues that could be explored later in the survey. As this activity does not involve evaluation of care issues, interaction with staff and residents should be kept to a minimum; introductions to staff and residents can occur later in the survey.

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

Applies to: All accreditation programs

<table>
<thead>
<tr>
<th>Duration</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-60 minutes</td>
<td>1. Begin the review of requested documentation, especially material that is critical to guiding subsequent onsite survey activity</td>
</tr>
<tr>
<td></td>
<td>2. Begin the selection of individuals served for tracer activity</td>
</tr>
</tbody>
</table>

Participants
All surveyors on site

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

Other information
MDS data should be used in Nursing Care Center surveys, when available.

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 resident lists, Resident Level Quality Measure/Quality Indicator Resident Roster (Form CMS-802), a sample of which appears on the next page

During
Tracer Selection (25% of session)
- Request and review the most recently submitted facility Resident Level Quality Measure/Quality Indicator Resident Roster (Form CMS-802) if the facility is Medicare/Medicaid certified or voluntarily completing this report. See page 18 for an image of this report. Identify residents that triggered high risk quality indicators.
- If the Resident Roster noted above is not in use by the organization, or not available in a timely manner, use the ICM Profile data (services, previous RFIs) to identify your initial resident tracer for the day.
- If a census is not available, select a unit or program on which to begin tracer activity.

Performance Review (50% of session)
- Complete the review of materials listed in the Surveyor Arrival and Preliminary Planning Session.
- Discuss the scope of the survey and which sessions will be conducted by which surveyors. Under the direction of the team leader, review organization data.
- Surveyors conducting the Leadership and Data Use Session should complete a review of performance improvement data including aggregation, analysis and action related reports.
- Identify which system / program specific tracers will be conducted in each program using the guidelines in the appendix.
- Nursing Care Center surveyors are responsible for reviewing and evaluating all Nursing Care Center data related to performance improvement, infection control, medication management, etc.
- Surveyors responsible for the Life Safety Code (LSC) Building 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.
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.
- Identify preliminary topics for discussion at the Leadership and Data Use Session.

After

- Communicate information to the organization about subsequent survey activity.
Resident Level Quality Measure Report (a.k.a., CMS Form 802)

Organizations that are Medicare/Medicaid certified complete this form and submit it quarterly to CMS. Some organizations that are not Medicare/Medicaid certified and not required to submit this roster to CMS, may be voluntarily completing the report for their own internal monitoring, so please check. For Joint Commission purposes the form does not need to be up-to-date as of the day of survey. The most recently completed quarterly report will serve the need for selecting residents to trace.
## Individual (Patient or Resident) Tracer Activity

**Applies to:** Nursing Care Center Accreditation

<table>
<thead>
<tr>
<th>Duration</th>
<th>60 – 120 minutes</th>
</tr>
</thead>
</table>

### Participants
One surveyor

**Organization:**
Staff and leaders who have been involved in the patient’s or resident’s care, treatment, or services.

For learning purposes, governing body and senior leaders may want to accompany a surveyor during an individual tracer. This should be discussed with the surveyor.

### Targeted Tracer Selection to evaluate systems:
- Person-Centered Focus
- Infectious Process, preferably a HAI, multi-drug resistant infection
- Patient or resident on a high risk medication
- Patient or resident on a unit with considerable staff turnover

### Objectives
1. To evaluate the organization’s compliance with standards as they relate to the care, treatment and services provided
2. To learn how the organization supports the patient’s or resident’s quality of life through direct and indirect observation and interviews
3. To evaluate the organization’s provision of a person-centered, homelike environment
4. Evaluate the implementation of person-centered care by tracing and experiencing what the resident experiences
5. To identify processes and possibly system issues contributing to a lack of person-centered care

### Before
- Request and review the most recently submitted facility Resident Level Quality Measure/Quality Indicator Resident Roster (Form CMS-802, see image on page 18) if the facility is Medicare/Medicaid certified or voluntarily completing this report. Identify patients or residents that triggered high-risk quality indicators.
- If the Resident Roster noted above is not in use by the organization, or not available in a timely manner, use the clinical services, ICM Profile risk areas, and information discovered during the Orientation session to identify your initial patient or resident tracer for the day.
- As the survey progresses, you may select:
  - Patients or residents with more complex situations and more contact with various parts of the organization to assess continuity of care issues
  - Patients or residents that cross programs (e.g., a resident admitted from or discharged to another level of care, such as home care, the hospital, post-acute rehabilitation)
  - Patients or residents with dementia
  - Patients or residents that cover multiple additional criteria
- You do not need to visit every unit or branch of the organization as long as you follow the Survey Process Rules for Surveyor Planning located in Appendix C. All important aspects in the Individual Tracer should be addressed.

### During
- Begin the Individual Tracer in the setting/unit where the patient or resident and clinical record is currently located
- Start the tracer by reviewing a clinical record with the staff person responsible for the patient’s or resident’s care. If the staff person is not available, the discussion can be held with a clinical supervisor or other staff member. The primary purpose of using a clinical

### Note about language:
Be sensitive to and use the language used by the organization when referring to the person served, i.e., resident, veteran, elder, etc.
associated with what they are doing at this moment and system issues, e.g. data collection and use, medication management, infection control activities, and staffing issues.

Meet with, ask questions of, and observe care provided by staff and physicians whenever possible. Be sure to include ancillary department staff, volunteers and physicians in tracer activity.

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

If you obtain conflicting information about a policy or process, ask the leader accompanying you on the tracer to obtain it for review during the next scheduled issue resolution session.

**Person-Centered Care Rationale**

Person-centered care is emphasized in the long term care industry throughout the country. Joint Commission’s standards address a number of components of person-centered care, many of which are patient and resident rights. Data indicates that patient or resident rights issues are rarely cited in accreditation reports; however, publicly reported complaint follow up indicates that patient or resident rights are at the heart of problems in the NCC industry. This tracer provides an opportunity for surveyors to experience the care while shadowing a patient or resident. It is an opportunity to use peripheral observation to evaluate what is happening with other patients or residents. Surveyors will shadow patients or residents during activities of daily living, treatments, transportation, activities, therapy and meals.

The record is not to audit its contents, but to use it as a tool for following care, treatment, and services.

- Trace the 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:

- Level of engagement with organizational leaders to develop person-centered care strategies
- Specific person-centered care strategies that have been implemented
- How leaders empower staff to solve problems and make decisions based on resident needs
- Consistent assignments in caring for residents
- Processes and compliance with standards from the general program and organization-specific risk areas
- Compliance with other applicable standards pertinent to the patient or resident being traced
- Intradepartmental and interdepartmental communication for coordination of patient or resident care. (Pay particular attention to hand offs – these are critical points in time when errors occur.)
- Address data use; ask about data collection in units/departments
- Medications – ask about issues that may impact medication management. For example, medication availability, how newly prescribed medications are obtained, any after hour problems, any missed doses, any problems with physician pre-authorization for new medications, substitution protocols especially as they relate to high risk medications, etc.
- Processes and role to minimize risk
- National Patient Safety Goals (NPSGs) (Reminder: All applicable NPSGs must be evaluated during the course of survey). Prevention of catheter-associated urinary tract infection (CAUTI) has been added as an NPSG for the NCC program in 2017.
- Patient or resident education processes
- Orientation, training and competency testing
- Emergency management roles and responsibilities, including mitigation, preparedness, response and recovery/business continuity related to the following:
  - Communication with patients
  - Communication with staff
  - Communication with relevant external entities (such as vendors, contracted providers, parent company, public health or other public authorities, other health care organizations, alternative care sites, etc.)
- Awareness of content of APR.09.02.01 (Any individual who provides care, treatment, and services can report concerns about safety or the quality of care to The Joint Commission without retaliatory action from the organization.
- 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 service if all of the IT systems are not available, including training in back up/alternative work procedures
  - Contingency plans if the following systems are disabled by a cyber emergency:
    - Electronic health record (EHR) (acute and prolonged events)
    - Radiology
    - Laboratory
    - Pharmacy
    - Medical devices
    - Telemedicine services
- Other issues, as applicable to care, treatment or services
- Validation of information learned during other survey activity

Ask for private time with the patient or resident and when appropriate, family members, to explore:

- How their care is person-centered, that is, ask in what ways care promotes, supports and honors their:
  - Cultural background
  - Beliefs about health and health care
  - Spiritual preferences
  - Interests and hobbies
  - Personal preferences for dining, bathing, waking, daily activities, visitors, etc.
  - Freedom to make choices and decisions about their care and treatment
  - Need for companionship from another human being
  - Physical environment preferences – homelike, personalized living space, availability of private space for visitors, accommodation of pets, etc.
- Coordination of services including timeliness
- Education provided
- Response time when call bell is initiated or alarms ring
- Perception of services
- Understanding of discharge instructions
- Staff compliance with each of the NPSGs
- Patient or Resident rights
- Other issues, as applicable to care, treatment or services
- Validation of information learned during other survey activity

Observe:
- Potential environmental issues that might impact patient or resident or staff safety
- Care planning processes (e.g. timing of patient or resident assessments). If possible, observe discharge planning or care coordination meetings
- Clinicians, including physicians, providing direct patient or resident 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
- Observing rights and inclusion of patients or residents in person-centered care
- Evaluating staffing issues and associated outcomes data.
  - Ask about data collection in units/departments, e.g. MDS outcomes, resident falls, medication errors etc.

After
- Review pertinent meeting minutes and procedures if needed
- Validate observations with Resident Council member interviews during issue resolution, when necessary
- As necessary, pull additional records to verify standards compliance issues identified during the Individual Tracer
- Consider the relationship of your observations to system level issues
- Share problematic issues with other team members, if applicable, so they can be further explored in subsequent survey activity
Individual Tracer – Addendum

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.

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

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

Dental Services
- Evaluate the use of dental services with residents, e.g. dental complaints by residents, timeliness of referral, coordination of care, follow up and integration of complications into data collection.

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

### Discharge Planning – Retrospective Review

- Ask for a list of patients or residents who were discharged over the past 48 hours.
- Review the resident’s old medical/clinical 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 resident to explain the purpose of your call and obtain permission for a phone interview.
- Interview the patient or resident to determine their understanding of discharge instructions provided. The patient’s or resident’s level of understanding should include the following:
  - The purpose for taking any new medication
  - How to take the medication including dose and frequency
  - Possible side effects of medication
  - The medication regimen including continuation or discontinuation of those medications taken prior to admission to the hospital
  - Contraindications between prescribed medications and over the counter medications and herbal remedies
  - Changes in diet and dietary restrictions or supplements
  - Signs and symptoms of problems and who to call with questions and concerns.
  - Information regarding continued self-care (wound care, activity, etc.)
  - Follow-up process with physician(s)
  - Arrangements made for home health needs (i.e. oxygen therapy, physician therapy)
- Explore the patient’s or resident’s and family member’s, as applicable, perception of their discharge instructions. Do they believe they were given all of the information needed?

### Food and Dietetic Services

- Identify the national standards used for recommended dietary allowances
- Evaluate the nutritional assessment process and compare it to MDS indicators for hydration and nutrition, patient or resident weight loss and facility acquired pressure ulcers.
- Observe hygiene practices and kitchen sanitation
- Discuss:
  - Safety practices for handling food
  - Assessment process to determine resident dietary needs
  - Process for prescribing and evaluating therapeutic diet orders
  - Process for accommodating special medical, cultural or religious diets and varied, resident desired eating schedules
  - Follow up process when the patient or resident 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 or residents (e.g. medication administration, bathing, physical exam etc.)

- Donning sterile gloves when inserting a central intra-vascular catheter
- Inserting indwelling urinary catheters, peripheral vascular catheters or other invasive devices that do not require a surgical procedure

**After:**
- Contact with a patient’s or resident’s intact skin, e.g. when taking a pulse or blood pressure, administering medications and lifting a patient
- Contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings
- Removing gloves

**Infection Control**

- Observe clinicians, including physicians, for compliance with CDC or WHO hand hygiene techniques
- Interview staff about and observe, as appropriate, resident treatments, 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

**Environment of Care**

- Observe the condition of the facility areas used by patients and residents (e.g., safe, clean, functional, and comfortable)
- Discuss:
  - The process and frequencies for conducting environmental tours to identify environmental deficiencies, hazards, and unsafe practices
  - Management of hazardous materials and waste from receipt or generation through to disposal
  - The process and controls implemented to address security risks (i.e., elopement, violence, etc.)
- Ask various staff members to explain their role in
  - Minimizing the risk of fire and their roles and responsibilities during a fire drill or an actual fire
  - During a building system utility disruption (e.g., electrical, piped oxygen, water, etc.)

**Emergency Management**

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

**Laboratory Services**

- Discuss:
o Patient or resident identification and protocols used before administering blood products, taking blood samples and other specimens for clinical testing
o Blood product usage
o Point of care testing, if performed,
o Specimen collection and transportation process
o Confidentiality of information
o Blood product management
o Process for communicating critical values

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

Dialysis Services
• Review contract and contracted services
• Evaluate hand off communications
• Ascertain how dialysis services are incorporated into the patient’s or resident’s plan of care
• Evaluate competency of contracted staff and credentialing of LIPs writing orders.

Medication Management
• Review and discuss how medications are prepared (e.g., using clean or sterile techniques, minimizing contamination, use of laminar airflow hood or other class 100 environment while preparing IV admixture in the pharmacy, etc.)
• Verify:
o Proper emergency medication storage (sealed or locked containers; in a locked room; or under constant supervision)
o Appropriate labeling of medications
o The presence of a list of medications approved for dispensing or administering (must be readily available)
o Safe storage of medications, including controlled substances
o Process for pharmacy review and monitoring of medications
o Process for clarifying unclear medication orders
o Process for reviewing all prescriptions for the following: appropriateness of the drug, dose, frequency, and route of administration; therapeutic duplication, real or potential allergies or sensitivities; real or potential interactions between the prescription and other medications, food, and laboratory values; other contraindications; variation from organizational criteria for use; and other relevant medication-related issues or concerns
o Patient or resident rights as related to the Medicare Modernization Drug Act

• Antimicrobial stewardship:
o Focus on the following population only:
  ▪ Patients who will be discharged on antimicrobials.
  ▪ Do not interview patients, residents or family members for the antimicrobial stewardship standard.
• Interview select staff involved in dispensing and administering of antimicrobials regarding the education they have been provided on antimicrobial resistance and the organization’s antimicrobial stewardship program.
• Interview select staff involved in dispensing and administering of antimicrobials regarding the education they provided to patients being discharged on antimicrobials.
• Review documentation in the medical record indicating that the discharged patient was provided with education regarding their antimicrobial therapy.

• Discuss:
  o Process for ensuring safety with high risk/high alert medications
  o Process for acceptance and use of the patient’s or resident’s own medications
  o Access to medications when the pharmacy is closed
  o Control and transportation process for unused, expired, or returned drugs
  o Education of staff on medication safety the administration of psychotropic medications
  o Education of patients or residents on medication safety

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

• Observe:
  o Preparation and administration of high risk medications, as defined by the organization

Performance Improvement
• Discuss, as appropriate, at the unit or branch level:
  o Data collection process and responsibilities (e.g., MDS and other, such as medication errors, infections, restraints and seclusion, etc.)
  o Applicable undesirable patterns or trends in performance
  o Use of data analysis in the identification and implementation of process improvements
  o Process for identifying and implementing changes to reduce the risk of sentinel events
  o Evaluation of whether performance improvement changes achieved the expected results
  o Process for taking appropriate actions when planned improvements are not achieved or sustained
  o Inclusion of data from external sources to determine if there is excessive variability or unacceptable levels of performance
  o Changes in PI activities to accommodate urgent events such as patient or resident health outcomes, high-volume, high-risk, or problem prone processes, adequacy of staffing and significant changes in the internal or external environment
  o Core measure implementation and process changes
  o Proactive activities for identifying and reducing unanticipated adverse events and safety risks to patients or residents are being performed.

Rehabilitation Services
• Review and discuss:
  o Process for development and review of the plan of treatment
  o Role of inter-disciplinary team

Patient and Resident Rights
• Staff discussion and observation:
  o Patient or resident right to choice
  o Patient or resident involvement in care and treatment decisions
  o Effective resident communication
  o Hand off communications between shifts and departments
  o Education within the confines of patient or resident needs, physical and cognitive challenges, culture and language diversity
  o Use of restraint and seclusion
  o Process when a patient or resident refuses care
• Patient or resident and family understanding of:
  o Rights, including advanced directives and end of life decisions
  o Process to register a complaint
  o Patient and resident safety and personal / health information privacy

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

Point of Care Lab Testing Tracer
• During an individual tracer, identify a patient or resident who is undergoing point of care lab testing by the organization’s staff. (Note: Patients or residents who are self testing are exempt from CLIA regulations). Trace the organization’s process by:
  o Reviewing documentation elements in the patient or resident record (quantitative result and acceptable range)
  o 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 point of care testing quality control plan, including responsibilities
    ▪ Validation that the organization completed quality control testing for the patient’s or resident’s waived tests you are tracing
      • Organizations are no longer required to perform quality control checks on each day of testing. Organizations are now required to perform quality control checks per manufacturers’ instructions.
    ▪ Follow up process when results are obtained
  o Drilling down as indicated by:
    ▪ Identifying and interviewing the waived testing director and / or supervisor – director name found on the CLIA waiver
    ▪ Reviewing quality control plan and other planning documents, e.g. policies and protocols (reference standard for detailed needs)
  o Evaluating personnel files for the presence of staff education and competency for each type of test being traced
  o Reviewing additional data and trace where the data flows and its use in organizational performance improvement
  o Instrument maintenance
Program Specific -- Individual (Patient or Resident) Dementia Tracer Activity
Applies to: Nursing Care Center Accreditation

Duration
60 – 120 minutes

Participants
One surveyor

Organization:
Staff and leaders who have been involved in the patient’s or resident’s care, treatment, or services.

Objectives
1. To evaluate the organization’s compliance with standards as they relate to the care, treatment and services provided for the patient or resident with dementia
2. To learn how the organization supports the quality of life for the patient or resident with dementia through direct and indirect observation and interviews
3. To identify processes and possibly system issues contributing to a lack of effective dementia care

Before
Select residents from the CMS 802 form that trigger on the quality indicators of Cognitive Impairment, Behavior Symptoms, and Psychoactive Medications.

During
Incorporate the following into individual resident tracers:

Assessment
- Explore the evidence-based cognitive and functional assessment tools used by the organization
- Explore the process for establishing a differential diagnosis. Explore that the evaluation is conducted by a qualified physician (neurologist, psychiatrist, or geriatrician, if available, or another physician qualified to establish the diagnosis)
- Explore that the initial history includes the following:
  - Recent changes in behavior or cognition
  - The patient’s or resident’s pre-dementia personality
  - Social patterns
  - Responses to stress and effective interventions
  - Patient or resident lifelong interests, preferences, and routines
  - Eating habits, food and beverage preferences
  - Religious, spiritual, and cultural customs
- Explore that the organization assesses for the following:
  - Behavioral expressions, including signs of potential delirium
  - Sensory capabilities
  - Swallowing abilities
  - Decision-making capacity
  - Sleep patterns
  - Weight loss patterns, if applicable
  - Depression screening
  - Wandering patterns, if applicable, and conditions under which wandering occurs
  - Elopement risk assessment
  - The reason(s) why antipsychotic medication has been prescribed
  - Physical function capabilities
  - Variances in physical and cognitive function based on time of day
  - Attention span during meals that may affect hydration and food consumption
  - Environmental factors that minimize distress

Memory Care is the term used to describe the care needed for patients or residents who have been diagnosed with memory-impacting conditions such as Alzheimer’s disease or dementia. The goal of the memory care requirements is to keep patients and residents with memory impairment engaged in their environment at the level of their cognitive capability. By doing so, the ability of these patients and residents to function at the highest level possible and to maintain that level for as long as possible is promoted.

Cognitive and functional assessment tool examples include the Confusion Assessment Method (CAM), The Clock Test, the Global Deterioration Scale (GDS), the Functional Activities Questionnaire (FAQ), the Montreal Cognitive Assessment (MoCA), and the Allan Cognitive Disability Scale.

A useful tool for assessing pain for patients and residents with dementia is the “Pain Assessment in Advanced Dementia (PAINAD) Scale.” It can be found on the American Medical Directors Association website at www.amda.com/publications/caring/may2004/painad.cfm.
A Note About Behaviors
Behaviors are an expression of unmet needs. Responding to behaviors with personalized approaches to patient and resident care fosters meaningful relationships between staff, patients, and residents. These meaningful relationships enable staff to know the patient's or resident's personal interests, preferences, and routines, which can minimize and even eliminate the need for psychotropic medication.

Note that psychotropic medications include:
- Antipsychotics
- Antidepressants
- Anxiolytics
- Sedatives/hypnotics

• Explore the validated non-verbal/non-cognitive pain assessment tool used by the organization

Care Planning
• Explore that the Interdisciplinary Team (IDT) discusses the following:
  - The presence of behavioral symptoms
  - Assessment of underlying causes of behavioral symptoms, including sudden and severe onset of confusion or delirium
  - Personalized approaches to behavioral expressions of unmet needs that minimize the use of psychotropic medications
  - Effectiveness of personalized approaches to care
  - Use of any psychotropic medications
  - Interventions to promote optimal physical function
• Review that the care plan includes the following (PC.01.03.01):
  - Personalized approaches to behavioral expressions of unmet needs that minimize the use of psychotropic medications
  - Flexibility for providing personal care based on the patient's or resident's sleep and wake patterns
  - Interventions to promote optimal physical function
  - Activities that promote the patient's or resident's quality of life
  - Nutrition and hydration needs
  - Environmental interventions that minimize distress

Psychotropic Medication Management
• Explore how the medical director monitors the use of psychotropic medications in order to minimize misuse or overuse (LD.01.06.01)
• Explore the process for the medication list review by the physician and consulting pharmacist. Explore if the review includes the following (MM.01.01.05):
  - Clinical indication for the antipsychotic medication
  - Necessity for ongoing use of the antipsychotic medication, based on the patient's or resident's potential to cause harm to self or others
  - Consideration of gradual dose reduction of the antipsychotic medication
  - Consideration of alternatives to antipsychotic medication use
• Explore that a qualified licensed independent practitioner conducts a behavioral health assessment at least quarterly for patients or residents on a psychotropic medication

Transitions of Care
• Explore the transition of care process (PC.02.02.01 and PC.04.02.01).
  Explore the following:
  - Process for receiving and sharing information (hand-off communication)
  - Explore if the following are provided at the time of transfer or discharge:
    - A complete list of medications
    - Successful communication techniques
    - Successful personalized anxiety-reducing interventions that may promote a feeling of safety

Family Involvement
• Explore how the family is included and involved in the following:
  - Resident assessment and care planning process
  - Decisions to be placed on antipsychotic medication
Other Dementia Care Resources:


*Bathing Without a Battle video www.bathingwithoutabattle.unc.edu

“Mouthcare Without a Battle” video http://www.mouthcarewithoutabattle.org

Dementia Care Practice
Recommendations for Assisted Living Residences and Nursing Homes
www.alz.org

CARES™ Dementia Basics™ program, the CARES® Dementia Advanced Care™ program, and Alzheimer’s Association essentiALZ® certification program found at www.alz.org/essentialz

- Developing personalized approached to address expressions of unmet needs.
- Explore what family education is provided. Explore that the education includes the following:
  - Dementia progression and related behavioral expressions of unmet needs
  - Communication techniques for the patient or resident with dementia
  - Personalized approaches to care for the patient or resident with dementia
  - Use of psychotropic medications, reason(s) for use, risks versus benefits, including potential side effects

Collaborative Approach to Care Delivery

- Explore how the organization involves the direct care staff in developing personalized approaches to address behavioral expressions of unmet needs
- Explore the information direct care staff communicate between shifts. Explore that the following are discussed:
  - Patients and residents with behavioral symptoms
  - Identification of potential underlying cause(s) of behavioral symptoms
  - Successful personalized approaches to care
  - Successful communication techniques
  - Emotional support provided to family
- Interview various staff regarding the elopement procedures

Mealtime Experience

- Observe the mealtime experience for the following: (PC.02.02.03)
  - Staff assisting patients and residents who require help eating
  - Staff give special attention to patients or residents with dementia who have either low attentiveness or wander away during a meal
  - Staff help minimize distraction and confusion during meal time

Social and Recreational Activities

- Observe that the activity program does the following: (PC.02.02.09)
  - Recognize the patient or resident with dementia as a mature adult
  - Encompass both small groups with similar cognitive levels and one-to-one opportunities
  - Match the patient’s or resident’s cognitive, sensory, and physical capabilities
  - Promote engagement in a manner that supports the patient’s or resident’s communication ability
  - Match the patient’s or resident’s past and current interests
  - Promote creative artistic expression
  - Meet the patient’s or resident’s spiritual or religious needs
  - Allow for flexibility based on the patient’s or resident’s sleep and wake patterns

Physical Environment

- Observe for the display of objects in the patient’s or resident’s personal space that reflect meaningful memories and religious, spiritual, or cultural traditions from his or her past
- Observe for visual cues or landmarks in the physical environment to assist with wayfinding
**Special Issue Resolution**

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

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

**Objective**

Further investigate and resolve any open issues from previous survey activity

**Before**

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

**During**

- Discuss with attendees issues identified during the course of the survey for which you would like further information.
- Review documentation pertinent to the issues identified during the survey, such as:
  - Policies and procedures
  - Additional patient or resident records, or components of records to confirm an individual tracer observation
  - Personnel or credentials files
  - 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 Session – End of Day

### 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 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.</td>
</tr>
<tr>
<td><strong>Organization:</strong></td>
<td>None</td>
</tr>
</tbody>
</table>

### 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
- Identify the priority focus areas for findings
- Think about and review connections between observations and systems. Plan the approach to survey activities for the next day.
- 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 tracers
• Review and verify the status of any outstanding requests for information
• Prepare for the Daily Briefing discussion with the organization, including sharing where observations of non-compliance have the potential to appear on the SAFER™ matrix

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

<table>
<thead>
<tr>
<th>Duration</th>
<th>30 - 45 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOTE: The briefing is not required on the first day of multi-day surveys; however, it is left to surveyor discretion to determine the need for a briefing at the conclusion of the first day</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants</th>
<th>All surveyors on site available to participate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization:</td>
<td>Governing body, Administrator and other leaders and staff invited to participate by the most senior leader</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other information</th>
<th>When multiple surveyors are on site, this session is conducted jointly. In such cases, team members may take turns presenting findings.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveyors who need to be at a different location at the time of the Daily Briefing session should make arrangements to join the discussion via conference call if possible.</td>
<td></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.

<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 summarize survey activities completed on the previous day. 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>Discuss what occurred to substantiate an observation as needed for organization understanding. Do not discuss in detail each survey activity, specific records, and discussions held with individuals during Individual Tracers.</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 Requirements for Improvement (RFIs) will be available only when all activities are complete and results are aggregated.</td>
</tr>
<tr>
<td>Answer questions and clarify your comments where requested.</td>
</tr>
<tr>
<td>Review the agenda for the day (including identifying Individual Tracer candidates). Make necessary adjustments to plans based on organization needs or the need for more intensive assessment of an issue.</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>

**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.

- At the last day Daily Briefing, remind the organization of any items they have promised and you are still awaiting. All items they want you to review or people they want you to interview to clarify observations and findings must be accomplished at the start of the Report Preparation session.
## Competence Assessment Session

### Includes Credentialing of Licensed Independent Practitioners

### Applies to: Nursing Care Center Accreditation

## Objectives

1. Learn more about the organization’s competence assessment process for staff, licensed independent practitioners, and other credentialed practitioners.
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. Learn more about the Medical Staff credentialing process.

## Duration

60 minutes

## Participants

One surveyor

### Organization:

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

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

### File review

While file review is not the primary focus of this session, you may want to use time in this session to confirm or verify process-related information through documentation in personnel or, as applicable, credentials files. You may also elect to review files as part of Individual Tracers or during the Special Issue Resolution session.

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

### Other information

In multi-program surveyors, 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

- 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.
    - Does the orientation include person-centered care content? (e.g., person-centered care practices, workplace practices, environmental changes)
  - Experience, education, and abilities assessments.
  - Ongoing education and training.
    - Does the orientation include person-centered care content (e.g., person-centered care practices,
review during Individual Tracer activity and reporting on their observations.

workplace practices, environmental changes [HR.01.05.03, EP 23])?

- How are staff and licensed independent practitioners oriented when new person-centered practices are introduced within the organization?

- Staff participate in annual education and training that aligns with current best practices in dementia care and includes the following (HR.01.05.03, EP 24):
  - Symptoms of dementia and its progression
  - How to recognize potential symptoms of delirium
  - Understanding how a patient's or resident's unmet needs are expressed through behaviors, such as wandering or exit seeking
  - Communication techniques for the patient or resident with dementia
  - Personalized approaches to behavioral expressions of unmet needs
  - Abuse prevention
  - Supporting the patient or resident through environmental cues and landmarks
  - Environmental measures that promote comfort including room temperature, lighting, and sound

- Competency assessment, maintenance, and improvement, including how the organization evaluates staff performance related to the delivery of person-centered care [HR.01.07.01, EP 6]

- Staff competencies include at least the following (HR.01.06.01, EP 25):
  - Communication techniques for the patient or resident with dementia
  - Effective personalized approaches to care for patients or residents with dementia

- 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.

- As you deem necessary, review the files of specific staff, licensed independent practitioners, and other credentialed practitioners.

- Antimicrobial Stewardship: Determine which staff and licensed independent practitioners were provided with antimicrobial resistance and antimicrobial stewardship education.

- Any evidence that staff were educated is acceptable.
  - Acceptable materials and methods of education are determined by the organization and should be based on acceptable practice. Examples can include: written
materials, presentations, online education, classes, manager’s minutes from staff meetings, conferences, annual education days, CEUs, etc.

- Antimicrobial Stewardship: Evidence of non-compliance;
  - There is no evidence that any staff or licensed independent practitioner have been educated or were provided information on antimicrobial resistance or antimicrobial stewardship.

After

- Verify through review of a sample of employee health files any documentation that staff has undergone required health screenings.
- Do not review human resource records or medical staff records for antimicrobial stewardship.
- Summarize strengths and potential risk points in the organization’s competency assessment process.
- Consider the observations relative to systems issues.
- Share with other team members issues that need to be further explored in subsequent Tracers.
# Environment of Care and Emergency Management Session

**Applies to:** Nursing Care Center accreditation program

<table>
<thead>
<tr>
<th><strong>Duration - Variable</strong></th>
<th><strong>Objective</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>60-120 minutes</td>
<td>Assess the organization’s degree of compliance with relevant standards and identify vulnerabilities and strengths in the organization’s environment of care and emergency management processes.</td>
</tr>
</tbody>
</table>

**Participants**

One surveyor

Organization: Individuals able to address issues related to the environment of care and emergency management in all areas within the organization
- Safety management coordinator
- Security management coordinator
- Facility manager(s)
- Responsible person for emergency management activities
- Building utility systems manager
- IT Representative, if available
- Responsible person for medical/laboratory maintenance
- EC or safety team leader
- Organizational leadership

**Before**

Review the following documents.

- Annual evaluations of the Environment of Care (EC) management plans (EC.04.01.03)
- Review the organization’s performance from emergency management drill activity. Drills are required for addressing the emergency management requirements of standard EM.03.01.03.
- Review any changes to the Emergency Operations Plan based on the organization’s evaluation of exercises and responses to actual events.
- Review the organization's performance from fire drills and fire response activity
- Review EC-related issues observed and discovered in previous survey activities (including those made by other survey team members, when applicable). Analyze the data collected on survey up to this point and identify strengths and patterns of weakness in management processes related to EC-risks to review with the organization.
  - Management processes include:
    - Plan
    - Teach
    - Implement
    - Respond
    - Monitor
    - Improve
  - EC-risks include:
    - Safety
    - Security
    - Hazardous materials and wastes
    - Emergency management
    - Fire safety
    - Medical/Laboratory equipment
    - Utilities
    - Construction

**During**

**Environment of Care and Emergency Management Discussion**

Engage attendees in discussion about environment of care risks that have been addressed in each of the management processes

- PLAN – What specific risks related to its environment of care have been identified by the organization
- TEACH – How roles/responsibilities of staff/volunteers have been communicated by the organization.
• IMPLEMENT – What procedures and controls (both human and physical components) the organization has implemented to minimize the impact of risk to residents, visitors, and staff.
• RESPOND – What procedures the organization implements to respond to an EC incident/failure. How, when, and to whom are EC problems, incidents, and/or failures reported within the organization.
• MONITOR – How the organization monitors EC performance (both human activities and physical components). What monitoring activities have taken place within the last 12 months
• IMPROVE – What environment of care issues are currently being analyzed. What actions have been taken as a result of EC monitoring activities

Review the organization’s performance in promoting culture transformation and person-centered care including:
• Identifying the environmental changes made in support of person-centered care
• Identifying how patients or residents, family members, and staff are involved in decision-making related to environmental changes.
• For patients or residents with dementia, the organization encourages the display of objects in the patient’s or resident’s personal space that reflect meaningful memories and religious, spiritual, or cultural traditions from his or her past (EC.02.06.01, EP 39)

Review the organization’s performance in providing an environment appropriate for the safety of patients and residents with dementia:
• The organization has written procedures to following in the event of a patient or resident elopement.
• The organization meets the needs of patients or residents with dementia by providing visual cues or landmarks in the physical environment to assist with wayfinding.

Review the organization’s performance in addressing the Emergency Management standards including:
• Identifying potential emergencies that may affect the need for their services or the ability to provide those services (sometimes referred to as a Hazard Vulnerability Analysis (HVA));
• Determining their response strategies (e.g., maintaining or expanding services, curtailing services, working with alternative care site, closing and reopening after emergency) and how the Emergency Operations Plan supports these strategies;
• Identifying its role in relation to the community’s, county’s or region’s emergency response plan (including relationships with other health care providers, linkage with the community’s incident command structure, etc.);
• Designing and performing exercises consistent with patient care and service plans defined in the Emergency Operations Plan. Exercise design should be demanding enough to surface weaknesses, gaps, or opportunities for improvement in the organization’s response effort.
• Making any necessary improvements to its Emergency Operations Plan based on critiques of emergency management drill and response to actual emergencies.

Risk, Detection and Response – Cyber Emergencies

• Discuss with leaders:
  o IT system integrity support for maintaining high reliability in care, treatment, or services.
  o IT participation in system risk identification and prioritization, and planning for system emergencies that might impact care, treatment, or services.
  o Updates received by leadership on cyber risk analysis or the state of cybersecurity, including who provides the updates and how frequently they are provided.
  o 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:
  o How IT is represented in or informs EM activities related to risk identification or development of the organization’s emergency management plan.
  o The organization’s emergency management planning related to information management, primary and back-up communications, and patient care and support.
  o How medical devices, care, treatment or service equipment, and care-related utilities (medical gas, electricity, water, etc) that are connected to the internet are protected from unauthorized access, catastrophic failure, or malicious attack.
  o Staff training, drills or exercises that support effective response and recovery relative to cyber emergencies that impact care, treatment, or service.

After

• Consider the relationship of your observations to system level issues
• Follow-up during subsequent tracer activity to explore issues identified during this session (see Individual Tracer Addendum)
**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><strong>Planning</strong></td>
</tr>
<tr>
<td><strong>Planning</strong></td>
</tr>
<tr>
<td><strong>COMMUNICATION</strong></td>
</tr>
<tr>
<td><strong>Communication Systems</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Communication with physicians</strong></td>
</tr>
<tr>
<td><strong>Communication via social media</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Communication via Media - national and international</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
- Decides (in advance to the extent possible) the type of circumstances and conditions under which media can be allowed access to patients/residents for interviews with patient/resident consent; organization can then aid patients/residents or family members in the interaction with local, national, or international media.

**INFECTIONOUS DISEASE**

**Emerging infectious diseases: training and exercises**
Exercises should not just repeat the same scenarios if there is a new threat in the environment; the organization should update its preparation for new threats or risks where needed (for example, in terms of mitigation, community planning, use of social media, etc.)

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

**RESPONSE**

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

**SECURITY**

**Security during Community Threat/Attack/Unrest**
Health care organizations can work in advance with public safety providers when there are known or perceived safety risks; and should be prepared to be proactive and nimble when the unexpected happens. During a bomb attack in one community that resulted in multiple casualties and involvement of local, state, and federal authorities:

- When all vehicles were ordered to stay off the streets and trains/buses ceased operations, it was difficult for health care staff to get to work. Health care organizations can contact local authorities in advance to discuss ways to facilitate access of essential staff to their organizations during a community disaster (identification cards, transport, escort, etc.)

- Security forces had a different understanding of what it meant to lock down a facility than did staff and physicians in the hospitals - what was lock down at some hospitals was just limited access in others. Hospitals should work with other health care facilities and local law enforcement (especially if served by overlapping authorities, such as campus and city police, or city police and county sheriff) to coordinate procedures and terminology essential in emergency response.

**STAFF**

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

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

PATIENT CARE

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

UTILITIES

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

EXERCISES

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

HEALTH CARE PARTNERS

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

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

Health care partners - utilities
Organizations can consider how ambulatory providers can partner with inpatient settings to share information, maintain situational awareness, and support response. Following a contamination of the community water supply, the local ambulatory dialysis company:

- mobilized its biomedical engineer, and maintained contact with its regional director and the command center at its affiliated hospital throughout the incident.
- through its national contract, acquired a 6000 gallon tanker truck within 4 hours, rigged up a distribution center, and worked with hospital building engineers and local fire department to provide for proper pressurization to operate hospital equipment and services until community water services were restored.
- kept in touch with the CDC and the EPA in an attempt to identify the specific contaminant. Because clear information was not available and it was difficult to measure the contaminant in the field, they worked with a competitor dialysis provider to share information, sampled water at the hospital, and contracted with an independent laboratory.
- improved its preparedness going forward by mapping the water sources for each of its sites; and including review of the EM plan as a standing agenda item in its monthly meetings with its affiliated hospitals.

Health Care Partners – infectious disease outbreak

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

Evacuation

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/residents 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
- impact of long recovery on ancillary/offsite/support departments that were peripherally impacted
Life Safety Code® Building Assessment
Applies to: Nursing Care Center accreditation programs

Duration
15-30 minutes

Participants
One surveyor

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

Objectives
1. Evaluate the effectiveness of the organization’s processes for maintaining life safety equipment and related building systems.
2. Determine the organization’s degree of compliance with relevant below-the-ceiling LSC requirements.
3. Evaluate the effectiveness of the organization’s processes for identifying and resolving LSC problems.
4. Educate attendees on potential actions to take to address any identified LSC vulnerabilities.

Before
- Inform your organizational contact that you will need 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 Statement of Conditions History Audit Trail for evidence of equivalencies that have been granted.

During
Conduct a brief, focused Building Tour to assess only life safety equipment and systems not visited during patient or resident tracers including:
- Main fire alarm panel to verify that it is functional, and no trouble lights exist
- Fire pump to verify that it is functional and weekly “churn” tests are performed
- Linen/trash chute discharge rooms (if any)
- Emergency Generator – functional, problems, 20 to 40 day tests
- Consider the relationship of your observations to system level issues.
- Verify that any granted equivalency conditions align with the information submitted by the organization as reflected in the History Audit Trail section of the SOC.
- Conclude the session by summarizing identified strengths and weaknesses in managing Life Safety Code compliance.

After
During patient or resident tracer activity, assess compliance in managing and maintaining:
- Fire-rated doors to stairs and hazardous rooms – positive latching, automatic closing, acceptable gaps
- Cross corridor smoke barrier doors – automatic closing devices, acceptable gaps
- Corridors and exits free from clutter,
- Emergency egress/exit lighting
• Life safety compliance with any locking of doors used for occupant egress
• Portable fire extinguishers – monthly inspections, types
• Kitchen automatic extinguishment systems above cook tops – when activated shuts off fuel source and alarms the fire panel; K type portable fire extinguisher nearby
• Clearance of 18” below sprinkler heads (especially problematic in storage rooms with shelving)
• Any chute inlet doors – latching, automatic closing devices
• Prohibiting combustible decorations (i.e., those typically used during the holidays)
• Soiled linen and trash receptacles are less than 32 gallons unless placed in hazardous rooms
• 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

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

The “Observed, but Corrected On-Site” provision impacts only a limited number of requirements in the Life Safety (LS) chapter, focusing on “operational type” deficiencies. Required repair and/or replacement deficiencies may be corrected while the LSC Specialist 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. The following examples will help you determine when and when not to apply the provision. If you have any questions on applying this provision, contact SIG for further guidance. Situations in which the “Observed, but Corrected On-Site” provision APPLIES:

• Gap in ceiling tile that is repositioned
• 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

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

• Door problems (e.g., improper fire rating, latching and automatic closer problems)
• Non-functioning fire alarm
• Missing smoke detector
• Missing handrail in stairwell
Program Specific Tracer – Staffing
Applies to: Nursing Care Center accreditation program

Duration
Variable – approximately 60 minutes

Participants
All surveyors on site

Organization:
At the direction of the surveyor(s):
- CNAs, as applicable
- Agency staff
- Non-nursing Ancillary Staff
- Administrator
- Other leaders
- Family Council Members, if available (may be telephonic)

Rationale:
Staffing in Nursing Care Centers is a major issue. The industry is fraught with reimbursement issues that prevent them from paying much more than minimum wage. The work is difficult. As a result, the industry is competing against higher paying entry level positions in retail and other markets. In addition to high turnover of CNAs, administrative turnover is quite high with approximately 80% turnover from one accreditation survey to the next. This tracer focuses on the communications and coordination that occurs to curtail turnover and retain staff when an organization has experienced either staff or administrative turnover.

Objectives
1. To evaluate actions taken by the organization during turnover to ensure positive outcomes to patient or resident care.
2. To identify processes and possibly system issues contributing to negative patient or resident outcomes in light of staff or administrative turnover.

Targeted Tracer
- When the organization’s ICM Profile data (general program and organization specific risk areas) point to Staffing. (S)
- When administrative turnover has occurred since the last full survey. (A)

Before
The focus of this tracer is to look for breaks in continuity of care and operational processes in the presence of staff and/or administrative turnover.

- Inform the organization, in advance, that a staffing tracer will be conducted.
- Based upon available data identify a unit or units that potentially have experienced negative performance that could be associated with turnover. These units could:
  - High turnover rates
  - Negative MDS outcomes in pressure ulcers, incontinence, falls, dehydration etc.
  - High number of complaints
- Identify 2 – 4 patients or residents with negative MDS outcomes

During Individual Tracer Activity
- Target the identified units and residents
- Conduct individual interviews with at least 4 representatives from the most predominant discipline group that had major turnover, e.g. CNAs – select a cross representation of new and seasoned staff and, when in use, agency staff caring for residents with and without negative outcomes. Inquire about:
  - processes pertaining to the care of patients or residents to prevent
  - negative outcomes (reference MDS) (S)
  - barriers to those processes (S)
  - knowledge of resident, including likes and dislikes, and care needs (S)
  - perceptions of issues leading to turnover (S)
  - staff communications at the time of the turnover (S/A)
  - recruitment and hiring practices (S)
  - orientation and training (S)
  - changes in policy, procedure, vision, expectations (S/A)

During the System Tracer for Data Management

S = Staffing
A = Administrative turnover since last full survey
Conduct interviews with leadership, e.g. Director of Nursing, MDS Coordinator. (S/A) Discuss their knowledge regarding:

- MDS outcomes
- follow up actions taken
- monitoring of those actions

Conducting additional tracer activity for Staffing

Conduct individual interviews with at least two patients or residents/family members (family interviews can be conducted telephonically)

Ask questions about:

- their care, or the care of their loved one, to prevent reference MDS negative outcomes (S)
- perceived barriers to that care (S)
- perceptions of caregiving (S)
- patient or resident communications at the time of administrative or staff turnover (S/A)
- staff knowledge of the patient or resident, patient or resident likes and dislikes and care needs (S)
- changes in the provision of care in the past cite the period of time when turnover occurred (S/A)

Conduct individual interviews with leadership, e.g. governing body member, Administrator, Director of Nursing. (Interview with a governing body member may be telephonic.) Discuss their knowledge regarding:

- MDS outcomes (S/A)
- Association of negative outcomes with staffing issues (S/A)
- follow up actions taken (S/A)
- monitoring of those actions (S/A)
- organization communications about changes in mission, vision, process, etc. (S/A)
- methods used to stabilize or prevent turnover (S/A)

If validation is necessary to support findings or further define issues, request and review additional documents, such as:

- staffing plans (S)
- staff variance reports from the affected time frames (S)
- meeting minutes where recruitment and retention issues were discussed (S)
- meeting minutes demonstrating corrective actions, where needed (S)
- meeting minutes demonstrating changes in or support for the mission, values, processes, etc (A)

At the next daily briefing or issue resolution time, summarize strengths and potential risk points in staffing.

After

- Review competency and credentials files as part of the Competency Session (S/A)
- Consider the relationship of your observations to system level issues
- Discuss system level issues at the leadership session.
- Discuss findings with the organization at the conclusion of the tracer activity and/or at the next daily briefing.

Identified issues create opportunities for drilling down into organizational response and processes. For example, if the organization had negative variances in staffing levels for one floor, the surveyor should drill down to find out how the organization addressed their unplanned variance. Did they hold admissions? Did they reassign duties to other staff? Surveyors can request clinical records or floor specific data from the time period in question to look for evidence of understaffing, e.g. missed treatments, restraint use, pressure ulcers etc.
## Leadership and Data Use Session

**Applies to:** Nursing Care Center accreditation program

<table>
<thead>
<tr>
<th>Duration</th>
<th>90 minutes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Participants</th>
<th>One surveyor (at minimum). All surveyors available to participate should do so.</th>
</tr>
</thead>
</table>

**Organization:**

**Leaders with responsibility and accountability for design, planning, organizational processes, and data management.**

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 Administrator)
- Senior organization leaders (Administrator, COO, CNO, CFO, CIO, VP for Clinical Services, Director of Patient Services or Branch Manager)
- Other organization leaders (Director of Human Resources, MDS Coordinator and Performance Improvement).

*The following are the fundamental principles of performance improvement:

- **Planning - Selection of measures:** Understand the organization’s planning process for data use including how your organization identifies and prioritizes measures.
- **Data collection:** Understand the organization’s methodology for ensuring that all data is collected as planned.
- **Data Aggregation and Analysis:** Understand the organization’s processes for turning data into useful information.
- **Data use:** Understand how the organization uses the information obtained from data analysis.

<table>
<thead>
<tr>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
</tr>
<tr>
<td>To explore where the organization is on the journey to high reliability</td>
</tr>
<tr>
<td>To understand and assess the organization’s performance improvement process</td>
</tr>
</tbody>
</table>

**Before**

Thoughtful planning is pivotal to the success of this activity and the utility of on-site survey analysis.

- Reflect upon survey observations and potential requirements for improvement.
- Identify the system(s) that you believe helped to contribute to those survey observations. Systems addressed by standards in the Leadership chapter include:
  - Using data
  - Planning
  - Communicating
  - Changing performance
  - Staffing
- Review performance improvement data and prepare to explore with leaders how they use data in decision making.
- Inform the organization about who should attend as active participants
- The antimicrobial stewardship standard, MM.09.01.01, is an affirmative observation standard, and requires field staff to always survey this standard.
- Review documents that supports leadership making antimicrobial stewardship an organizational priority. **Examples may include:** accountability documents, budget plans, infection prevention plans, strategic plans and performance improvement plans
- Ask the organization to provide a document that describes how it uses the CDCs The Core Elements of Antibiotic Stewardship for Nursing Homes
- Ask the organization to provide examples of antimicrobial stewardship protocols (e.g. policies, procedures or order sets)

**During**

To the extent possible, begin the discussion based on a positive observations from the survey. This could include a successful performance improvement initiative, the introduction of a new service, or a well-run department or unit. Explore the reasons for this success related to high reliability concepts: Leadership commitment, safety culture, robust process improvement, involvement of physicians and other clinicians, etc.
Applicable System Performance Standards in the Leadership chapter
- Using data LD.03.02.01
- Planning LD.03.03.01
- Communicating LD.03.04.01
- Changing Performance LD.03.05.01
- Staffing LD.03.06.01

Culture Transformation and Person-Centered Care Resources:
- Pioneer Network http://www.pioneernetwork.net/Providers/ProviderTools
- Eden Alternative http://www.edenalt.org/
- Planetree http://planetree.org/
- Picker Institute http://pickerinstitute.org/
- Action Pact http://actionpact.com/
- Artifact Tool http://www.artifactsofculturechange.org/ACCTool/

Consistent staffing assignments refer to the same caregiver caring for the same patient or resident almost every time they are on duty. Consistent staffing assignments help build staff’s personal knowledge on ways to provide the best care while cultivating meaningful and engaging relationships with patients and residents.

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
- Struggles to maintain compliance with a National Patient Safety Goal.

Discuss 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, review selected components of the high reliability organization characteristics such as:
- Leaders efforts to achieve the characteristics of a high reliability organization—flexibility, agility, ability to sustain effective performance
- Ask for examples of progress being made and what characteristics they are struggling to achieve and maintain
- Ask leaders about internal systems and how they do or do not support their efforts to be a high reliability organization.
- Determine the medical director’s involvement in evaluating systems performance in the organization.
- Explore the organization’s adoption of performance improvement fundamental principles* for the following topics:
  - MDS outcomes
  - Medication monitoring through data:
  - Errors
  - Adverse events
  - Utilization
  - Infection prevention and control, collection and use of surveillance data
  - Risk assessment/management activities National Patient Safety Goals— including monitoring of CDC or WHO hand hygiene compliance
  - Monitoring performance of contracted services
  - Monitoring staff compliance with employee health screening requirements
  - The quality of person-centered care being provided to residents. (PI.01.01.01, EP16)
  - Monitoring of psychotropic medications, including antipsychotics (PI.01.01.01, EP 45)Staffing (RN, LPN, CNA) to meet the needs of patients or residents with dementia based on (HR.01.01.01, EP 26):
    - Patient or resident personal care needs
    - The varying cognitive levels of the patient or resident population served
    - The level of supervision needed to maintain patient or resident safety
- The organization provides consistent staffing for nursing (RN, LPN, CNA) assignments in order to meet the individualized needs of patients or residents with dementia (HR.01.01.01, EP 27)
- Ask the organization how they would educate patients who were being discharged on antimicrobials
- Ask the organization to describe the antimicrobial stewardship team
- Ask the organization about its antimicrobial stewardship protocols
- Determine what type of data the organization is collecting on its antimicrobial stewardship data. Note: data may be basic or complex depending on the type of hospital and the duration of their antimicrobial stewardship program. Examples can include an antibiogram, prescribing practices, use of protocols etc.
- Determine any antimicrobial stewardship improvement opportunities identified by the organization.
- Determine if actions resulted in improvements. Note: For some organizations that have sound antimicrobial stewardship data with no opportunities for improvement, EP 8 may be non-applicable

**Antimicrobial Stewardship: Evidence of non-Compliance:**
- No evidence of a multidisciplinary team.
- No evidence of review and use of the CDCs The Core Elements of Antibiotic Stewardship for Nursing Homes.
- No evidence of antimicrobials stewardship protocols.
- No evidence of collecting any type of antimicrobial stewardship data.
- No evidence of reporting antimicrobial stewardship data within the organization.
- For organizations with an opportunity(s) for improvement, they are unable to demonstrate that improvement actions have been taken

- Ask leaders about the culture transformation planning process (LD.03.01.02, EP1, EP2, EP3) including:
  - How do leaders engage staff in the planning process?
  - How are residents, family members, and staff involved in organizational meetings to share ideas and opinions? (e.g., use of learning circles, focus groups),
  - How do leaders evaluate culture transformation progress? (e.g., does the organization use the Artifact tool? How often is a cultural assessment conducted?)
  - Explore how leaders support care of patients and residents with dementia (IM.03.01.01, EP 5)
  - Does the organization use dementia-related resources and tools to plan dementia programming and services?
  - Ask leaders about the influenza vaccination program for staff and licensed independent practitioners. Seek specifics about:
    - The infection control plan such as: Does it include a goal of improving influenza vaccination rates with a focus on reaching the 90% target in 2020
  - The education provided to staff and licensed independent practitioners about, the influenza vaccine, non-vaccine control and prevention measures and the diagnosis, transmission, and impact of influenza
• Organization offering of influenza vaccinations on-site or facilitation of off-site vaccinations

• The organization has a written description of the methodology used to determine influenza vaccination rates for licensed independent practitioners and staff

• The organization's process for evaluating licensed independent practitioner and staff reasons for declining the influenza vaccination

• Improvement in rates of vaccination

• Dissemination of influenza vaccination rate data throughout the organization

• Conclude by asking attendees if they have any questions and if there is anything else they would like to add or discuss.

After

• Follow up on any identified issues or remaining topics during subsequent survey activity

• Consider the relationship of your observations to system level issues

• Seek clarification from leaders on any open issues.
Tips for Exploring Leadership Roles and Responsibilities

These suggestions may be helpful in conducting the leadership session when survey findings do not suggest patterns to be explored. However, it can be a useful tool for conducting the session even when there are patterns and trends to discuss.

Use the session to explore leadership’s responsibility for creating and maintaining the organization’s systems, infrastructure, key processes that contribute to quality and safety of care, treatment, and services.

Introduction (Example)

“Up to this point, we have traced the patient or resident care your staff provides and at the direct provision of care level, your staff is doing a good job in meeting the standards, with a few exceptions. What we would like to do now is to spend time with you and discuss how you approach important processes and evaluate their performance. We would like to explore the infrastructure you’ve created; the strategies, programs, policies and procedures you have set into motion which enable your staff to provide quality care.” (Note: If patterns of non-compliance exist, this introduction would need adjustment.)

The issues below can serve as a framework for discussion with leaders on various topics such as the five issues identified here for example.

- 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
- Comprehensiveness of the system/process
- Person-centered quality and safety criteria and expectations for the system/process
- Responsibility for monitoring effectiveness of implementation of changes
- Adaptability/flexibility and change as appropriate
- Evaluation of the effectiveness of the five systems

Discussion topics you might consider exploring include the leaders’ role in:

Changing Performance

- Ability to adapt or change in response to changes in the environment or with priorities
- Use of proactive risk assessment
- Use of data in improvements
- Organization-wide involvement in improvement activities
- How change is managed—proactively, not reactively

Planning

- Focus on safety—is it evident in planning
- Infrastructure creation (including planning for planning)
- New or revised processes and services
- Designing/building-in safety in the physical environment and organizational processes to increase safety/minimize risk
- People involved in planning
- Information used in planning

Communicating

- Creating formal and informal channels of communication
- Effectiveness/timeliness of communication (top-down/bottom-up)
- Interaction between key leadership elements: Administration, Governance, Medical Staff, Nursing
- Effective transmission of new knowledge, policies, procedures, cautionary alerts
- Effectiveness/timeliness in transmitting and disseminating urgent/critical information
- Reporting safety issues
- Effectiveness of communicating patient information between shifts, staff, licensed independent practitioners, etc.

Using Data

- Vision/definition of data use needs
- Resources available
- Role of data in planning, improvement, change, etc.
- Management of data—timeliness, accuracy, display, etc.
- Sharing of data
- Use of data in decision-making

Support for Effective Staffing (People)

- Establishing the right mix, skills, number of staff
- Management of factors impacting staffing (resource availability, services offered, labor issues, etc.)
- Management solutions to constraints (expanded job descriptions, contracting, resource sharing, collaborative ventures)
- Existence of team approaches
- Staff involvement on safety
Tips for Exploring Data Use

Successful data use is based on the organization’s adoption of performance improvement fundamental principles. Therefore discussion during this session should focus on:

1. Planning
2. Collecting
3. Aggregation and Analysis and
4. Use of data.

Planning – understand the organization’s planning process for data use including how the organization identifies and prioritizes measures.

- 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 resident 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.

- 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.

Collection - understand the organization’s methodology for ensuring that all data is collected as planned.

- There are technical issues associated with data collection, such as sample sizes, biases, etc. Sampling Criteria
  - For a population size of 30 or fewer ADC, sample 100% of the applicable medical records
  - For a population size of 31 to 100 ADC, sample 30 medical records
  - For a population size of 101 to 500 ADC, sample 50 medical records
  - For a population size of more than 500 ADC, sample 70 medical records

- Engage in a facilitated discussion centered on simple issues, such as data sources being used (e.g., billing data, satisfaction surveys, record abstraction, observation) and whether the needed data are available.

Aggregation and Analysis - understand the organization’s processes for turning data into useful information.

- Reinforce the importance of displaying data so that patterns and the effect of interventions can be readily identified.

- 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.

Use of Data - understand how the organization uses the information obtained from data analysis. 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 changes or interventions are successful and that the success is maintained.
Report Preparation
Applies to: All accreditation programs

<table>
<thead>
<tr>
<th>Duration</th>
<th>60 – 90 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>All surveyors on site</td>
</tr>
</tbody>
</table>

**Changes in Scoring and Reporting**
– Effective January 1, 2017
- Elements of performance no longer categorized as A or C
- All observations of non-compliance are documented
- Direct and indirect EP categories eliminated
- No OFIs in the accreditation report
- All observations of noncompliance require follow-up in the form of a 60-day ESC
- MOS are no longer required
- RFIs will be displayed in the 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).

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

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

**During**
- Document any additional observations you made. Follow the Documenting your Observations section of the SAG found in Appendix B. Pay particular attention to the reconciliation process.
- Remove any observations that the organization is able to clarify.
- Revise your documentation of observations that were observed, but the organization has corrected while you are onsite. Choose “Observed in survey activity but corrected onsite pending acceptable Evidence of Standards Compliance from the “Observed in” drop down list when entering an observation. Survey tech will insert the selected phrase before the observation text. Organizations should still be reminded during the exit conference that the observed and corrected onsite finding(s) will remain in the final report and will require an ESC.
  - Observations that are appropriately documented as “Observed, but Corrected On-Site” have the following characteristics:
    - The deficiencies are easily corrected and do not pose a significant threat to patient safety
    - The correction should not require any organizational planning or forethought
How will this affect my review?

- 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.

- The practice is correct but the policy needed amending to coincide with the practice, so the policy was amended
- Corrections to a form that was missing an element or piece of information and the change would not impact the process

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

- Confirm that observations are complete and fully justified.
- Update the survey report with any changes prior to the Exit Conference.

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

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

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

After

• Notify the organization’s contact that the report is available on their extranet site for review and printing.

• Make arrangements with the organization to print and copy the report for:
  - The organization (copy the number requested by the CEO)
  - Each survey team member present.

• Notify the CEO when you are ready for the CEO Exit Briefing and determine the meeting location.

• Submit the report using WST within 24 hours of event completion
## Exit Briefing
**Applies to:** All accreditation programs

### Duration
15 minutes

### Participants
All surveyors on site

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

### Guidelines
The Summary of Survey Findings Report is organized by chapter
- Each survey team member could take a turn reviewing all of the findings grouped under a particular standards chapter.
- Alternatively, surveyors could take turns by accreditation program presenting the findings pertinent to their program within a chapter.

### 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

**Duration**
30 minutes

**Participants**
All surveyors on site

Organization:
Leadership and staff invited to participate by the CEO

**Guidelines**

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

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

**Objectives**

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

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

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

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

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

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

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

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

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

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

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

After

• Submit the report using WST within 24 hours of event completion
Introduction to Post-Acute Care Certification

Post-Acute Care is a program or service that provides goal-directed, time-limited, medically complex care or rehabilitative services to patients who have typically been recently hospitalized. The goal of post-acute care is to help transition the patient from an acute care setting to a lower level of care setting or a return to their home. Examples of post-acute care include post-operative care, orthopedic or cardiac rehabilitation, respiratory care, and wound care.

Key concepts in the provision of these services include:

- Leadership accountability – Leaders assign responsibility for establishing and monitoring post-acute care.
- Staff knowledge and competency – Staff have the required qualifications, skills, training, and education to assess and manage specific rehabilitation and advanced care conditions and procedures.
- Transitions of care – Staff provide for the timely and accurate transfer of information during admission, transfer, and discharge
- Provision of care for the high acuity patient or resident – Staff collaboratively assess, plan, communicate, and use clinical practice guidelines as a systematic approach to rendering and optimizing care for the higher acuity patient or resident.

See the following pages for guidance on evaluating Post-Acute Care programs within an accredited Nursing Care Center.
Evaluation Guide for Optional Post-Acute Care Certification

Applies to: Nursing Care Centers who comply with all foundational requirements for accreditation and are seeking this optional certification

<table>
<thead>
<tr>
<th>Tracer Selection</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients receiving post acute care, treatment, and services</td>
<td>1. To assess the organization’s provision of post-acute care services.</td>
</tr>
<tr>
<td>Resources:</td>
<td>2. To evaluate the degree of compliance with standards and elements of performance as they relate to the provision of post-acute care services.</td>
</tr>
<tr>
<td></td>
<td>3. To provide informational and educational opportunities to health care organizations, regarding the post-acute care certification.</td>
</tr>
<tr>
<td>Improving Care Transitions Between The Nursing Facility and The Acute –Care Hospital Settings (AMDA, 2010) <a href="http://www.amda.com/governance/whitepapers/H10.pdf">http://www.amda.com/governance/whitepapers/H10.pdf</a></td>
<td>The evaluation of these processes is to be incorporated into the following survey activity sessions:</td>
</tr>
<tr>
<td>Sub-acute Care <a href="http://geriatrics.uthscsa.edu/tools/Subacute_SNF_Care.pdf">http://geriatrics.uthscsa.edu/tools/Subacute_SNF_Care.pdf</a></td>
<td>• Orientation to the Organization</td>
</tr>
<tr>
<td>Care Coordination for People With Chronic Conditions <a href="http://www.partnershipforsolutions.org/DMS/files/Care_coordination.pdf">http://www.partnershipforsolutions.org/DMS/files/Care_coordination.pdf</a></td>
<td>• Individual Resident Tracers</td>
</tr>
<tr>
<td>MDS OBRA Assessment Scheduling Tool <a href="https://www.qtso.com/download/mds/MDSSchedTool2012_MDS_3_0_20100910.pdf">https://www.qtso.com/download/mds/MDSSchedTool2012_MDS_3_0_20100910.pdf</a></td>
<td>• Transition of Care Session (<em>New – see activity description later in this guide</em>)</td>
</tr>
<tr>
<td></td>
<td>• Competence Assessment / Credentialing Session</td>
</tr>
<tr>
<td></td>
<td>• Environment of Care Session</td>
</tr>
</tbody>
</table>

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

- **Profile of Post-Acute Services:**
  - Types of post-acute services (stroke, post op wound care, orthopedic rehab)
  - Average length of stay and census
  - Services provided in distinct unit or throughout the organization

- **Leadership:**
  - Post-acute care leadership structure.
  - Who coordinates the provision of post-acute care services with staff, patients, and/or family? (PC.02.02.02, EP1)

- **Staffing:**
  - Are contract services utilized for meeting post acute care needs (LD.04.03.09)?

**Individual Tracer Activity**

- **Assessment of the post-acute patient** – Explore if:
  - Medical history and physical are performed/updated within 24 hours prior to or 48 hours after admission (PC.01.02.03, EP18 and EP19)
  - Within one hour after admission – assess to determine immediate care for use in developing the interim plan of care (PC.01.02.03, EP20)
  - Within eight hours after admission – assess for pain, fall risk, skin condition, assistance needed in activities of daily living, and risk for re-hospitalization (PC.01.02.03, EP20)
Interdisciplinary team members collaborate and share information when conducting assessments and reassessments. (PC.01.02.01, EP40)

Aside from changes in the patient’s condition, plan of care, and scheduled evaluation, is the resident also reassessed based on factors that hinder the achievement of desired outcomes (PC.01.02.03, EP24)

Assessment and reassessments information is used to identify the patient’s ability to perform self-managed tasks (PC.01.02.01, EP39)

Pain
- Assessments include location, duration, type, intensity, exacerbating factors, alleviating factors, previous treatment and responses, and any barriers that may prevent effective treatment (PC.01.02.07, EP6)
- Family input if patient is unable to verbalize or convey presence of pain (PC.01.02.07, EP7)
- Measures are taken to prevent or reduce pain before a treatment or procedure; use of non-pharmacological interventions (PC.01.02.07, EP8)

Responding to Changes in Patient’s Condition
- Process for recognizing and responding to changes in a patient’s condition as soon as it appears to be worsening (PC.02.01.19, EP1 and EP3)
- Written criteria for determining early warning signs of deterioration in a patient’s condition and when to seek additional assistance (PC.02.01.19, EP2)
- Patient and/or family awareness of process (PC.02.01.19, EP4)

Procedure for managing critical results of tests and diagnostic procedures (PC.01.02.15, EP8 and EP9)

Provision of Care – Explore if:

Staffing
- Registered nurse on duty 24 hours a day, 7 days a week (HR.01.01.01, EP24)
- Factors considered when planning clinical staffing (patient’s acuity, complexity of tasks, staff experience and expertise, and layout of the facility) (HR.01.01.01, EP25)
- Staff involvement in identifying learning needs (HR.01.05.03, EP21)

Post-Acute Coordinator
- A qualified person is designated (PC.02.02.02, EP1 and EP2), that makes sure:
- Assessments are completed on time
- Patient's needs are supported in a person-centered manner in order to meet self managed care goals
• Discharge planning occurs from admission to discharge
• Educational resources are provided to the patient and/or family about the patient’s disease process(es)

  o Attending Physicians and on-call Licensed Independent Practitioners:
    • Available 24 hours a day, seven days a week (PC.02.01.05, EP29)
    • Written plan if unreachable to receive communication regarding a change in a resident’s condition (PC.02.01.05, EP30)

  o Plan of Care
    • Any Advance Directives are Incorporated of (PC.01.03.01, EP14)
    • Interim plan of care is updated until the comprehensive plan is developed (PC.01.03.01, EP46)
    • Patient and/or family involvement in developing the plan of care (PC.01.03.01, EP47)
    • Regular review of the patient’s progress towards goal attainment by the interdisciplinary team (PC.02.01.05, EP27)
    • Ongoing discussion with the patient and/or family (current status, outcomes, barriers to achieving goals, alternative interventions to facilitate achieving goals) (PC.02.01.05, EP28)

  o Clinical Practice Guidelines,
    • Used when available (LD.04.04.09, EP1)
    • Management and evaluation of implementation of CPG’s (LD.04.04.09, EP3)
    • Review and approval of the CPG’s (LD.04.04.09, EP4)
    • Monitoring and reviewing for effectiveness of CPGs (LD.04.04.09, EP5)
    • Use of protocols when clinical practice guidelines are not available. Are they using established protocols or did they develop their own? (LD.04.04.09, EP6)

  o Resuscitation Equipment and supplies
    • Available for staff use based on the needs of the population served (e.g., a crash cart, oxygen, automated external defibrillator, and weight-based equipment). (PC.02.01.09, EP9)

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

• Qualifications of clinical staff match the needs of the post-acute patients
• Staff involvement in identifying their learning needs relevant to post-acute care (HR.01.05.03, EP21). Is the education and training reflective of the educational needs assessment identified by staff?
• Staff education and training in identifying early warning signs of a change in patient’s condition and how to respond to a decline in condition. Ask for documentation. (HR.01.05.03, EP22)
- Annual assessment of staff competency assessment (HR.01.06.01, EP24)

**Environment of Care Session** - Explore:
- How the organization’s environment meets the needs of the post-acute population for safety and suitability, such as special chairs, equipment piped oxygen, ventilation, and electrical systems (EC.02.06.01)
- Handling of patient waste or additional hazards associated with the post-acute care population (i.e., dialysis, blood products) (EC.02.02.01)
- What the organization does when medical equipment fails (EC.02.04.01, EP6)
Post Acute Certification -- Transitions of Care Session

Applies to: Nursing Care Centers who comply with all foundational requirements for accreditation and are seeking the Post-Acute Care optional certification

Duration: 60 minutes

Participants: Joint Commission Surveyor

Organization: Staff and leaders who are involved in the patient admission and discharge process (e.g. as applicable, Post-Acute Care coordinator, discharge planner, social worker, case manager, clinical liaison).

Tracer Selection Patients receiving post-acute care, treatment, and services.

Resources:
- Care Coordination for People With Chronic Conditions http://www.partnershipforsolutions.org/DMS/files/Care_coordination.pdf

Objectives
1. To learn about and evaluate the effectiveness of the organization’s processes related to transitions of care of the post-acute care patient
2. To help the organization identify opportunities for process improvement

Before
- Review transitions of care related issues observed and discovered in previous survey activity and determine areas to explore in more depth at this session.
- Ask the organization to have a few patient records available for this activity including:
  - 1-2 patients who have recently been admitted, preferably from different settings, e.g., different hospitals
  - 1-2 patients that are nearing discharge, preferably to different settings, e.g., to home, another NCC or SNF, assisted living
  - 1-2 patients that have recently been discharged, preferably to different settings, e.g., to home, another NCC or SNF, assisted living
  - 1-2 patients that were readmitted to the hospital

During
- Ask the organization’s team that is assembled for this activity to orient you to the admission, discharge and post discharge processes followed for post-acute care patients.
- Suggest that they walk you through each of the processes based on the experience of the patients whose records they have brought along. Use the following discussion items to prompt the team to cover the standards content.

  Related to Admission
  - Explore the admission process – Procedures followed to determine if a prospective patient is eligible for admission; staff involved in decision-making process (PC.01.01.01, EP 24)
  - Determine the sources of patient referrals to the organization’s post-acute care services
  - Identify any guidance the organization provides to referral sources on information that is needed to accept the patient
  - Ask staff to describe how information about prospective patients is obtained and by who
  - Ask staff about any challenges related to: Communication of information between care settings, receipt of patient test results from transferring organizations, and physician coordination of care. Determine if and how these challenges have been addressed and if they are resolved.

  Related to Discharge
o Inquire about the information made available in the discharge instructions

o Ask how the team and staff determine that the patient and family understand what is necessary to continue the patient's progress in the next setting

o Determine what types of instructions are provided as a matter of routine and what would be patient or diagnosis-specific, for example:
  - Diet and fluid intake
  - Safety considerations
  - Recommended exercises and other activities
  - Life style changes
  - Access to resources in the community
  - Follow-up appointments
  - Recognition of indications of a worsening condition and how to respond
  - Adherence to the plan of care to prevent readmission across care settings (for example, hospital, skilled nursing facility, rehabilitation facility, home care) (PC.04.01.05, EP15)

o Determine how the organization facilitates the transfer of important information to other service providers (PC.04.02.01, EP7)

- Related to Post-Discharge

  o Discuss the organization’s processes for follow-up communication with the patient and/or family

  o Determine when this follow-up is initiated and the frequency (PC.04.02.02, EP1) Note: The organization may consider the clinical condition of the patient at discharge when determining the frequency.

  o Ask the team what is covered during the organization's post-discharge communication with the patient and/or family. Determine if it includes such topics as: (PC.04.02.02, EP1)
    - The patient’s degree of compliance with discharge instructions (e.g., filling prescriptions and taking medications as prescribed, keeping follow-up appointments with physicians)
    - The patient’s current condition and ability to function
    - The opportunities for improvement related to their stay
    - Whether equipment/services, as indicated at discharge, were provided

- Related to Monitoring Performance

  o Determine what data the organization collects relative to post-acute care patient transitions (PI.01.01.01, EP42)

  o Determine if and how the organization incorporates data from the post discharge follow-up calls into performance improvement efforts (PI.01.01.01, EP43)

  o Ask the team if they can identify any improvements that have been made based on the data that they are collecting on post-acute care patient transitions of care

  o Explore the process, including the volume of and frequency with which the medical director reviews admissions, transfers and discharges; ask the organization to describe the scope of this evaluation and how the results are used (e.g., policy changes,
physician and staff education, better communication with
transferring and receiving organizations) (LD.01.06.01, EP6)

After
Use scheduled tracer time following this activity to focus in on the topic of
transitions of care with a number of patients to validate what you learned
about these processes. Select patients to trace, that will allow you to explore
the admission, discharge and post discharge processes in more depth. Note:
Consider selecting one or two of the patients that the team walked you
through for the purposes of interviewing the patient/family or patient care
staff.

During Tracer Activity

Related to Admission
• Conduct of medication reconciliation (NPSG.03.06.01)
• Provider hand-off -- explore the availability of advance information to
ensure timely availability of needed medications, equipment, and
accommodations (e.g., for patients with infection control issues or with
other special needs) at the time of transfer

Related to Discharge
• Observe or look for documented evidence that appropriate transfer
information (e.g. clinical, psychosocial) is communicated to the receiving
organization during discharge from the organization (PC.04.01.01)
• Medication reconciliation in preparation for discharge (NPSG.03.06.01)
• Provider hand-off -- explore the organization’s provision of advance
information to any receiving provider to ensure timely availability of
medications, equipment, and accommodations
• Physician communication
• Inquire about the information made available in the discharge
instructions. Listen and look for the name and contact information of the
health care provider(s) responsible for the patient’s care after discharge
or transfer (PC.04.01.05, EP15)
• Listen and look for evidence that the patient and family has
demonstrated an understanding of:
  o Medications the patient should be taking when he or she leaves the
organization’s care and how to manage those medications safely
and effectively (See also NPSG.03.06.01, EPs 4 and 5)
  o Diet and fluid intake
  o Safety considerations
  o Recommended exercises and other activities
  o Life style changes
  o Access to resources in the community
  o Follow-up appointments
  o Recognition of indications of a worsening condition and how to
respond
  o Adherence to the plan of care to prevent readmission across care
settings (for example, hospital, skilled nursing facility, rehabilitation
facility, home care) (PC.04.01.05, EP16)
• Ask staff about any challenges related to: Communication of information
between care settings, receipt of patient test results from transferring
organizations, and physician coordination of care. Ask if there has been
any action to address the challenges.
• Determine staff awareness of who is responsible for communicating or discussing the patient's discharge plan with the family and relevant practitioners across different care settings (PC.04.01.01, EP27)

• Interview the patient and/or family to determine their knowledge, understanding, and expectations regarding the post-acute plan of care, discharge plans etc.

• Interview the patient and/or family, if applicable about their inclusion in the discharge planning process. (PC.04.01.01, EP27)
Introduction to Memory Care Certification

Memory Care is the term used to describe the care needed for patients or residents who have been diagnosed with memory-impacting conditions such as Alzheimer’s disease or dementia. Memory care certification will provide organizations with the structure needed to enrich the lives of patients or residents with memory impairment by focusing on activity programming, the physical environment, and alternatives to medication use for managing behaviors. The goal of the memory care requirements is to keep patients and residents with memory impairment engaged in their environment at the level of their cognitive capability. By doing so, the ability of these patients and residents to function at the highest level possible and to maintain that level for as long as possible is promoted.

Key concepts in the provision of memory care include:

- Care coordination – Staff collaboratively assess, plan, and provide care that is consistent with current advances in dementia care practices.
- Staff knowledge and competency – Staff have the qualifications, skills, training, and education to assess and provide care for a patient or resident population with memory impairment.
- Activity programming based on abilities – Staff provide activities that match the patient’s or resident’s cognitive ability, memory, attention span, language, reasoning ability, and physical function.
- Behavior management – Emphasis is placed on the use of non-pharmacological interventions as an alternative to antipsychotic medication use.
- Safe and supportive physical environment – Staff modify the physical environment to promote safety and minimize confusion and overstimulation.

Key areas that distinguish the memory care optional certification requirements from the accreditation requirements include the following:

- The role of the coordinator
- Staff education and training
- Activity programming
- Features of the physical environment
Evaluation Guide for Optional Memory Care Certification

Applies to: Nursing Care Centers who comply with all foundational requirements for accreditation and are seeking this optional certification

**Tracer Selection**
Patients or residents with dementia who are receiving memory care, treatment, and services in a distinct unit or in the general nursing home setting

**Resources:**
- “Bathing Without a Battle” video: [www.bathingwithoutabattle.unc.edu](http://www.bathingwithoutabattle.unc.edu)
- “Mouthcare Without a Battle” video: [http://www.mouthcarewithoutabattle.org](http://www.mouthcarewithoutabattle.org)
- Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes: [www.alz.org](http://www.alz.org)
- CARES™ Dementia Basics™ program, the CARES® Dementia Advanced Care™ program, and Alzheimer’s Association essentiALZ® certification program found at [www.alz.org/essentialz](http://www.alz.org/essentialz)

Cognitive and functional assessment tool examples include the Confusion Assessment Method (CAM), The Clock Test, the Global Deterioration Scale (GDS), the Functional Activities Questionnaire (FAQ), the Montreal Cognitive Assessment (MoCA), and the Allan Cognitive Disability Scale

**Objectives**
1. To assess the organization’s provision of memory care services.
2. To evaluate the degree of compliance with standards and elements of performance as they relate to the provision of memory care services.
3. To provide informational and educational opportunities to health care organizations, regarding the memory care certification services

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

- Orientation to the Organization
- Individual Resident Tracers
- Leadership Session
- Competence Assessment / Credentialing Session
- Environment of Care Session

**Before**
- Select residents from the CMS 802 form that trigger on the quality indicators of Cognitive Impairment, Behavior Symptoms, and Psychoactive Medications.
- Select residents from the organization’s distinct dementia care unit (if applicable) as well as from the general population.

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

- Profile of memory care services:
  - Number of patients or residents with dementia
  - Varying cognitive levels or stages of dementia
  - Services provided in distinct specialized memory care unit or throughout the organization

**Incorporate the following into Individual Resident Tracers**
Placement of patient or resident with dementia – Explore if:

- When placing patients or residents with dementia in a distinct and secured memory care unit or area, does the organization require:
  - The patient or resident to have a dementia diagnosis?
  - That the patient or resident will benefit from a specialized distinct environment? (PC.02.01.01, EP 3)

**Mealtime Experience** – Observe and explore if:

- The organization engages patients and residents with dementia in the mealtime experience by creating opportunities for them to assist with the mealtime process, according to their abilities. Examples may include having the patient or resident help plan the menu or set the table. (PC 02.02.03, EP 23)
dementia is the “Pain Assessment in Advanced Dementia (PAINAD) Scale.” It can be found on the American Medical Directors Association website at www.amda.com/publications/caring/may2004/painad.cfm.

- The organization promotes a social environment during mealtime by seating patients and residents with dementia according to similar abilities or common interests. (PC.02.02.03, EP 23)

- The organization serves food to patients and residents with dementia in a manner that offers visual contrast between the plate, food, and place setting. (PC.02.02.03, EP 25)

Social and recreational activities – Observe and explore if:

- The organization provides interactive, technology-based activity programming for patients and residents with dementia, according to their abilities, that stimulates cognition and adapts to each patient’s or resident’s unique abilities and interests. (PC.02.02.09, EP 5)

- The organization documents the life story of patients and residents with dementia to create opportunities for meaningful engagement that includes major life events, important people, lifelong occupation, hobbies, interests, favorite music, favorite foods, cultural practices, spiritual practices, and other activities of enjoyment. (PC.02.02.09, EP 6)

- The organization provides opportunities for patients and residents with dementia to go on outings on a routine basis if it is determined that the patient or resident can benefit from the activity without posing a safety risk to self or others. (PC.02.02.09, EP 7)

- The organization provides opportunities for family of patients or residents with dementia to be involved in activity programs. (PC.02.02.09, EP 8)

- The organization provides intergenerational programs for patients or residents with dementia. (PC.02.02.09, EP 9)

- The organization provides physical activities patients or residents with dementia, such as dance or exercise. Note: Physical activity that involves balance and coordination may ultimately decrease the need for an assistive device and reduce the risk of falls. (PC.02.02.09, EP 10).

Family Support – Explore if:

- The organization provides a support group for family members of patients or residents with dementia that meets at a frequency determined by the organization. (PC.02.03.01, EP 29)

Leadership Session - from observations gathered during Individual Tracer activity, engage attendees in discussion of the following topics:

- Who coordinates the provision of dementia care services for patients or residents? Does the coordinator do the following?
  - Coordinates patient and resident activities
  - Monitors staff performance regarding personalized approaches to address behaviors
  - Monitors staff performance regarding communication techniques
  - Fosters an authentic learning environment through coaching and modeling of effective dementia care practices
  - Coordinates internal resources and provides information on how to access external resources in response to family support needs
  - Communicates the dementia program’s quality and safety needs to leadership
- Participates in the evaluation of cognitive devices and equipment to support the care and treatment of patients or residents with dementia (PC.02.02.02, EP 3 and 4)

- How does the organization remain current with changes in dementia care? What affiliation do they have with a national organization that specializes in dementia care? Note: An affiliation(s) can be formal or informal. Examples include the Alzheimer’s Association and the Pioneer Network (IM.03.01.01, EP 6)

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

- How did the organization determine that the coordinator was qualified for the position? Is the coordinator experienced and trained in dementia care? (PC.02.02.02, EP 3).

- Does staff participate in annual education and training that aligns with current best practices in dementia care? Does the education and training include the following?
  - Team building
  - Creating a therapeutic environment
  - Assessing and addressing pain
  - Palliative care for advanced dementia (HR.01.05.03, EP 26)

**Environment of Care / Emergency Management Session** - from observations gathered during Individual Tracer activity and the building tour, engage attendees in discussion of the following topics:

- Does the organization provide an environment in which noises that may over-stimulate or distress patients and residents with dementia are minimized? (EC.02.06.01, EP 40)

- Does the organization minimize overstimulation and distress for patients or residents with dementia by providing an environment that minimizes confusing visual stimuli? Note: Examples of visual stimuli that may cause confusion include lighting that creates shadows or glare; furnishings with busy patterns; lack of color contrast with walls, tables, and floor surfaces. (EC.02.06.01, EP 41)

- Does the organization provide access to outdoor space(s) for patients or residents with dementia? Does the space have the following characteristics?
  - Safety and security
  - Monitoring by staff
  - Seating for patients and residents
  - Pleasant stimulation such as flowers, birds, and sunlight (EC.02.06.01, EP 42)

- Does the organization provide an environment for walking and exploring that is free of obstruction and barriers that may cause falls? (EC.02.06.01, EP 43)

- If the organization uses overhead paging, is it only used for emergencies? (EC.02.06.01, EP 44)

- Does the organization create interest points in the physical environment that encourage visual or tactile stimulation for patients or residents with dementia? Note: Examples of interest points include a fish tank, a colorful tapestry, or objects with varying textures and shapes. (EC.02.06.01, EP 45)
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
1. 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
2. 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.

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

Definitions
The Joint Commission defines Immediate Threat to Health or Safety as “a threat that represents immediate risk and has or may potentially have serious adverse effects on the health or safety of the patient, resident, or individual served.”

Call Central Office Number: 800-965-5888

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

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

Surveyors identifying a potential threat:

- Communicate to the survey team leader the information and your plan to contact SIG or the Field Director On-Call.
- Include the team leader on the phone call to SIG or the Field Director On-Call.

**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 an observation at APR.09.04.01 to explain that an Immediate Threat was declared and the reasons for it, and document the risk mitigation strategy implemented by the organization until the deficiency can be resolved.
  - The PDA 01 decision rule will be triggered with the scoring of the APR.
  - Any other observations at other standards and NPSGs that are related to or support the Immediate Threat should have “This is related to the Immediate Threat” added to the start of the observations. Observations must be labeled this way as the organization will NOT be allowed to submit clarifying information for those RFIs.
  - The survey report must also include documentation of the risk mitigation strategy implemented by the organization until the deficiency can be resolved.
  - Enter surveyor comments regarding anything else not in the RFIs that would be helpful, like the organization’s reaction, response, etc.
  - The organization is very likely to appeal the PDA so the more precise the survey report is, the better.

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

Documenting Observations

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

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

Create Measurable/Observable Observations

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

The following always apply. The written observation should:

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

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

Example:

HAP EM.02.02.01 The Emergency Operations Plan describes the following:

EP 1 How staff will be notified that emergency response procedures have been initiated.

Weak: “The organization’s EOP lacked critical elements.”

Solid: “The organization’s Emergency Operations Plan lacked the process by which staff would be notified if an emergency occurred and response procedures were to be enacted. When asked about the plan’s missing element, the Chief Operating Officer concurred that the process of contacting staff when emergency response procedures were initiated was missing from the plan.”

Document Staff Title

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

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

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

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

If the deficiency identified is inherent in the observation statement, then a statement of evidence is not necessary because the observation contains the evidence.
For example:
Solid: “In the record reviewed in the Intensive Outpatient Program, the plan of care did not identify how the family participated in the care, treatment, or services of the client. Additionally, no refusal from the client or clinical contraindication for family involvement was noted within the record as confirmed by the primary clinician.”

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

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

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

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

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

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

All elements of dates (except year) for dates directly related to an individual, including:
- birth date,
- admission date,
- discharge date,
- date of death; and
- all ages over 89 and all elements of dates (including year) indicative of such age

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

The following examples demonstrate the use of dates:

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

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

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

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

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

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

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

**NOTE:** The timeframe (e.g. days, hours) demonstrating the deficiency was easily identified without using PHI.
There are certain standards where a timeframe is necessary because of the TJC standard requirement or because the standard suggests it is required based on organization policy, the law, or regulation. This does not mean a date is necessary to document the finding.

Examples are:

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

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

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

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

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

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

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

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

Examples are:

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

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

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

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

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

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

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

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

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

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

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

**Documenting PHI in WST**

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

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

   ![Records Section](image)

   - **View Only:** EHC
   - **Search By:** Standard
   - **Search Text:**
   - **Find**

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

   ![Add New Record](image)
3. Back on the Itinerary Home Page, select the Standard section:

<table>
<thead>
<tr>
<th>Itinerary</th>
<th>HCO Info</th>
<th>Tracers</th>
<th>Standard</th>
<th>OQPS</th>
<th>Records</th>
<th>CO Comments</th>
<th>Reports</th>
<th>Lock</th>
</tr>
</thead>
<tbody>
<tr>
<td>emed Status: No, Certification Option: No</td>
<td>Standard Selection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Search By:**  
- BHC

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

**Observation Text:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Examples are:

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

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

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

Document the Facts

Only use facts to communicate the reasons for the standard deficiency (no embellishment, inference, opinion, or peer review should be added to the citation).

Do not infer that certain facts exist if those facts were not actually observed. Similarly, do not draw conclusions about outcomes that were not actually observed. Do not include personal clinical opinion (peer review). Do not include positive comments to "soften" the impact of the observation.

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

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

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

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

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

- Who
- What
- When
- Where
- How

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

Nursing Care Center Surveyor Worksheet

<table>
<thead>
<tr>
<th>Tracer Selection Criteria</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you survey at least one patient or resident in the category, as applicable?</td>
<td>Clinical Services</td>
</tr>
<tr>
<td></td>
<td>Patient or resident taking a high risk medication</td>
</tr>
<tr>
<td></td>
<td>Patient or resident with an infection</td>
</tr>
<tr>
<td></td>
<td>Patient or resident being discharged</td>
</tr>
<tr>
<td></td>
<td>Patient or resident undergoing waived testing</td>
</tr>
<tr>
<td></td>
<td>Patient or resident experiencing pain</td>
</tr>
<tr>
<td></td>
<td>Patient or resident with a wound</td>
</tr>
<tr>
<td></td>
<td>Patient or resident receiving IV therapy</td>
</tr>
<tr>
<td></td>
<td>Patient or resident with a dementia diagnosis</td>
</tr>
<tr>
<td></td>
<td>Patient or resident with more complex situations and more contact with various parts of the organization to assess continuity of care issues (e.g., respiratory, dialysis)</td>
</tr>
<tr>
<td></td>
<td>Patient or resident that crosses programs (e.g., a patient or resident admitted from or discharged to another level of care, such as home care, ambulatory care or the hospital)</td>
</tr>
<tr>
<td></td>
<td>Patient or resident that covers multiple additional criteria</td>
</tr>
</tbody>
</table>

For organizations electing the Post-Acute Care Certification option, select these additional tracers:

- Patient who has recently been admitted, preferably from a different setting, e.g., different hospital
- Patient who is nearing discharge, preferably to a different setting, e.g., to home, another NCC or SNF, assisted living
- Patient who has recently been discharged, preferably to a different setting, e.g., to home, another NCC or SNF, assisted living
- Patient who was readmitted to the hospital
- Patient who has experienced a significant change in condition

For organizations electing the Memory Care Certification option, select these additional tracers

- Patient or resident with a dementia diagnosis who resides in the general nursing care center
- Patient or resident with a dementia diagnosis who resides in the nursing care center’s distinct, specialized unit or area (if applicable)

Did you see the following data during the survey?

1. Behavioral Management
2. Blood and Blood Product Use
3. Infection Prevention and Control
4. Medication Management
5. MDS / ORYX Data  
6. NPSG Data (hand hygiene monitoring) **Reminder:** All applicable NPSGs must be evaluated during the course of the survey  
7. Patient or resident perceptions of care, treatment and services (specific needs and expectations, how the organization meets these needs and expectations, how the organization can improve patient and resident safety, effectiveness of pain management, when applicable)  
8. Restraint Use  
9. Staff opinions and needs*  
10. Staff perceptions of risks to individuals and suggestions for improving patient and resident safety*  
11. Staff willingness to report unanticipated adverse outcomes*  
12. Staffing Effectiveness  
13. EC.04.01.03 Environment of care issues  
14. Other PI Activities (e.g. incident reports, complaints, adverse outcome reports)  

* Recommended, not required

### Nursing Care Center Survey Process Rules for Surveyor Planning

<table>
<thead>
<tr>
<th>Did you survey these…</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When multiple types of units exist, sample each type of unit during tracer activity (e.g., skilled, subacute, intermediate, ventilator, pediatric).</strong></td>
</tr>
<tr>
<td>Life Safety Code® building tour must be conducted for each freestanding building providing 24-hour patient or resident care. Exception is Medicare/Medicaid Certification based surveys (a.k.a. Long Term Care 2) do not require a Life Safety Code® building tour.</td>
</tr>
</tbody>
</table>
Appendix D – Team Leader Responsibilities

Applies to: All Accreditation programs

Primary Team Leader Expectations

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

The Primary Team Leader role is a survey-specific assignment.

Surveyors and reviewers assigned as Team Leaders fulfill the expectations outlined in this document.

In addition to duties outlined in the Surveyor and/or Reviewer Job Description, the Team Leader is expected to demonstrate leadership and provide guidance by:

- coordinating pre-survey and/or pre-review activities for the on-site team
- managing the on-site survey/review in order to achieve a thorough, credible and fair evaluation of the organization
- promoting positive communication and interpersonal interactions between team members and the organization to achieve a professional and valued on-site experience
- maintaining appropriate contact with central office to manage the quality of the on-site survey/review and the quality of the report of survey/review findings left on-site
- leading and coaching team members, as needed
- resolving interpersonal issues among the team that arise on-site

Primary Team Leader Responsibilities

Pre-Survey Responsibilities

Two weeks prior to the survey:

1. Review pre-survey information.
   a. If needed, place pre-survey phone call to TJC Account Exec. to gather information for the entire survey, not just for your primary program.
2. Share pre-survey information with the entire survey team via e-mail.
   a. Provide additional pre-survey information provided by the Account Rep to other team members, as needed.
   b. Assure that all team members have shared phone numbers, to assure effective communication.
   c. Choose the most appropriate agenda from Survey tech and modify as needed.
   d. Each program creates their own agenda, but assure that activities are coordinated across all programs as needed (System tracers, Interim exits, etc.)
   e. Communicate plan with the team and publish agenda in survey technology
3. Inform survey team of your travel arrangements.
   a. Encourage the team to stay at the same hotel.
   b. Encourage the team to share rental cars, when possible
   c. Check in with the survey team members the night before; and let them know you have arrived, and where they should meet the next morning.
   d. Confirm team members’ travel plans post survey, to assure that the last day of survey is not shortened.

On-Site Responsibilities

1. Assure a thorough and professional survey is conducted.
   a. Manage the survey process as outlined in the Surveyor Activity Guide
b. Manage the agenda in collaboration with the customer so survey activities are implemented effectively and professionally. Publish, modify and coordinate agendas, as needed.

c. Provide leadership and facilitate conflict resolution when needed to manage the survey; including facilitating a conference call with the customer and central office.

d. Utilize customer relationship management skills

2. Manage survey team member assignments
   a. Review agenda assignments with team members
   b. Assign responsibilities for system tracers with input from other team members
   c. Coordinate Survey Team Meetings
      i. Set up telephone conference calls for other program surveyors if required.
      ii. Facilitate the sharing of information and issues found during tracers with team members from all programs
      iii. Review the progress being made on observing and evaluating compliance with all applicable National Patient Safety Goals. Plan an approach for accomplishing the evaluation of any remaining NPSGs
   d. Facilitate discussions with team members to ensure EPs are scored accurately; that the language in the RFI is clear; and that documentation from all surveyors is included.
   e. Coordinate Report Preparation
      i. Assure all team members lock their findings
      ii. Facilitate team efforts to document observations at the most appropriate EP
      iii. Review to insure that similar observations from different surveyors are scored at same standard and/or element of performance
      iv. Confirm that observations are complete and fully justified.
      v. Update survey report with any changes prior to exit conference.
      vi. Submit survey findings within 24 hours.
   f. Oversee professionalism of survey team

3. Manage relationship with the organization
   a. Coordinate communication between organization staff and survey team;
   b. Lead problem-solving activities, when needed, to resolve issues of compliance
   c. Attend interim exit conferences
   d. Confirm that all organization documents have been returned at the close of each day and at the end of the survey/review.
   e. Share accreditation report with CEO prior to the exit conference

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

Responsibilities for Corporate and System Surveys
1. Educates team members about the organizations centralized and de-centralized functions
2. Keep notes across sites and programs.
   a. Record positive attributes within the organization, observed by the survey team through the course of the survey route
   b. Record leading practices within the organization, observed by the survey team through the course of the survey route
   c. Record trends that could be considered as leadership insights that did not translate into official survey report observations, (e.g. issues related to supervision, education, quality improvement, customer/patient satisfaction) that the leaders within the organization should be aware of relative to the overall performance of the corporation
3. Deliver summation conferences at the end of the corporate route.

Secondary Team Leader Role
The Secondary Team Leader role is utilized on a tailored survey when a secondary program has more than one surveyor assigned. The Primary Team Leader will be assigned from the primary program and is the main lead for the survey. The Secondary Team Leader is responsible for coordinating the activities of all surveyors for their specific program and serving as the point person to coordinate and communicate with the Primary Team Leader.

For example:

**Hospital (HAP) tailored survey with Home Health Care (OME) and Behavioral Health Care (BHC)**

3 - Hospital surveyors (HAP surveyor would be assigned as the Primary Team Leader)
1 - Behavioral Health Care surveyor
2 - Home Health Care surveyors (OME would have a Secondary Team Leader assigned)

**Ambulatory Health Care (AHC) tailored survey with Behavioral Health Care and Home Health Care**

2 - Ambulatory Health Care surveyors (AHC would be assigned as the Primary Team Leader)
2 - Behavioral Health Care surveyors (BHC would have a Secondary Team Leader assigned)
1 - Home Health Care surveyor

### Secondary Team Leader Expectations

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

The Secondary Team Leader role is a survey-specific assignment. Surveyors assigned as Secondary Team Leaders fulfill the expectations outlined in this document. In addition to duties outlined in the Surveyor and/or Reviewer Job Description, the Secondary Team Leader is expected to demonstrate leadership and provide guidance by:

- coordinating pre-survey and/or pre-review activities for the on-site program team members
- managing the on-site survey/review in order to achieve a thorough, credible and fair evaluation of the organization
- promoting positive communication and interpersonal interactions between program team members, Primary Team Leader and the organization to achieve a professional and valued on-site experience
- maintaining appropriate contact with central office to manage the quality of the on-site survey/review and the quality of the report of survey/review findings left on-site
- leading and coaching program team members, as needed
- in collaboration with the Primary Team Leader resolving interpersonal issues among the program team that arise on-site

### Secondary Team Leader Responsibilities

#### Pre-Survey Responsibilities

Two weeks prior to the survey:

1. Review pre-survey information.
   a. If needed, place pre-survey phone call to TJC Account Exec to gather information for your program.
2. Share pre-survey information with the program survey team via e-mail.
a. Provide additional pre-survey information provided by the Account Executive to other program team members and Primary Team Leader, as needed.
b. Assure that all program team members have shared phone numbers, to assure effective communication.
c. Choose the most appropriate program agenda from Survey tech and modify as needed
d. Collaborate with the Primary Team Leader to assure activities are coordinated across all programs as needed (System tracers, Interim exits, etc.)
e. Communicate plan with the program team members and publish agenda in survey technology

3. Inform the Primary Team Leader and program team members of your travel arrangements.
   a. Check in with the Primary Team Leader and your program survey team members the night before; and let them know you have arrived
   b. Confirm program team members’ travel plans post survey, to assure that the last day of survey is not shortened.

On-Site Responsibilities for Program and Collaboration with the Primary Team Leader
1. Assure a thorough and professional survey is conducted.
   a. Manage the survey process as outlined in the Surveyor Activity Guide
   b. Manage the agenda in collaboration with the Primary Team Leader and customer so survey activities are implemented effectively and professionally. Publish, modify and coordinate agendas, as needed.
   c. Collaborating with the Primary Team Leader, provide leadership and facilitate conflict resolution when needed to manage the survey; including facilitating a conference call with the customer and central office.
   d. Utilize customer relationship management skills

2. Manage program team member assignments
   a. Review agenda assignments with program team members and Primary Team Leader, as needed
   b. Assign responsibilities for system tracers with input from other program team members and in collaboration with the Primary Team Leader
   c. Coordinate Survey Team Meetings and participation of the program team members with the Primary Team Leader
      i. Facilitate the sharing of information and issues found during tracers with program team members and the Primary Team Leader as needed
      ii. Review the progress being made on observing and evaluating program compliance with all applicable National Patient Safety Goals. Plan an approach for accomplishing the evaluation of any remaining NPSGs
   d. Facilitate discussions with program team members to ensure EPs are scored accurately; that the language in the RFI is clear; and that documentation from all surveyors is included.
   e. Coordinate program Report Preparation
      i. Assure all program team members lock their findings
      ii. Facilitate program team efforts to document observations at the most appropriate EP
      iii. Review to insure that similar observations from different surveyors within your program are scored at same standard and/or element of performance
      iv. Confirm that observations are complete and fully justified.
      v. Update survey report with any changes prior to exit conference.
   f. Oversee professionalism of program survey team

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

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

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

1. Educates program team members about the organization’s centralized and 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 F – Handout for the Nursing Care Center

To access information about your survey, proceed to your Joint Commission extranet site by accessing www.jointcommission.org

- Click on ‘Log-in-Joint Commission Connect’ under the Action Center section
- Enter your login and password
- You will find the following information
  - Notification of scheduled Joint Commission event authorizing the presence of the surveyors for the unannounced survey
  - Surveyor(s) name, picture and biographical sketch
  - Scheduled survey dates

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

*Note: The 12-month reference in the following items is not applicable to initial surveys.*

- Organization Chart
- Contact person who will assist the surveyor during survey: Name and phone extension
- Map of your organization, if available
- List of sites where high-level disinfection and sterilization is in use, when applicable
- List of staff members on the interdisciplinary team, and when the team meets
- List of patients/residents discharged in the last 48 hours
- Facility Level Quality Measure Report, most current
- Resident Level Quality Measure Report (also known as CMS Form 802)
- Patient/resident treatment schedules
- Performance Improvement data from the past 12 months, including your proactive risk assessment
- Infection Control Plan, including risk assessment
- Environment of Care Plan
- Emergency management hazard vulnerability analysis (HVA)
- Emergency Operations Plan and evaluations of exercises and responses to actual emergencies
- Evaluations and results of the organization’s culture of person-centered care
- Antimicrobial Stewardship
  - Document describing how the organization is using the CDC’s The Core Elements of Antibiotic Stewardship for Nursing Homes
  - Organization approved antimicrobial stewardship protocols (e.g. policies, procedures, or order sets)
  - Antimicrobial stewardship data
  - Antimicrobial stewardship reports documenting improvement. *If the data supports that antimicrobial stewardship improvements are not necessary make sure the surveyor is informed of this.*

**For Nursing Care Centers that elect the Post-Acute Care Certification option**

The following additional documents will need to be available for the surveyor:

- List of patient or resident discharges within the past 30 days
- List of patients or residents readmitted to the hospital within the past 90 days

**For Nursing Care Centers that elect the Memory Care Certification option**

The following additional documents will need to be available for the surveyor:

- Performance Improvement data from the past 12 months related to psychotropic medication use
- Activity calendar for past 3 months
- Nurse staffing schedule (RN, LPN, CNA) for past 3 months
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 – Nursing Care Center 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, Orientation to Organization, and Brief Orientation Tour</td>
<td>30-60 minutes</td>
<td>1st day, as early as possible</td>
</tr>
<tr>
<td>Surveyor Planning Initial</td>
<td>30-60 minutes</td>
<td>1st day, as early as possible</td>
</tr>
<tr>
<td>Individual Tracer</td>
<td>60-120 minutes</td>
<td>Individual tracer activity occurs each day throughout the survey; the number of individuals that surveyors trace varies by organization</td>
</tr>
<tr>
<td>Lunch</td>
<td>30 minutes</td>
<td>At a time negotiated with the organization</td>
</tr>
<tr>
<td>Issue Resolution</td>
<td>30 minutes</td>
<td>End of each day except last; can be scheduled at other times as necessary</td>
</tr>
<tr>
<td>Team Meeting</td>
<td>30 minutes</td>
<td>Mid-day and/or end of each day except last</td>
</tr>
<tr>
<td>Daily Briefing</td>
<td>30-45 minutes</td>
<td>Start of each survey day except the first day; can be scheduled at other times as necessary</td>
</tr>
<tr>
<td>Competence Assessment &amp; Credentialing of Licensed Independent Practitioners</td>
<td>60 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization</td>
</tr>
<tr>
<td>Environment of Care and Emergency Management</td>
<td>60-90 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization</td>
</tr>
<tr>
<td>Life Safety Code Building Assessment</td>
<td>60-90 minutes</td>
<td>At a time negotiated with the organization</td>
</tr>
<tr>
<td>Leadership and Data Use (includes discussion of infection control, medication management and culture transformation)</td>
<td>90 minutes</td>
<td>Towards the middle or end of survey at a time negotiated with the organization</td>
</tr>
<tr>
<td>Report Preparation</td>
<td>60-90 minutes</td>
<td>Last day of survey</td>
</tr>
<tr>
<td>CEO Exit Briefing</td>
<td>15 minutes</td>
<td>Last day of survey</td>
</tr>
<tr>
<td>Organization Exit Conference</td>
<td>30 minutes</td>
<td>Last day, final activity of survey</td>
</tr>
<tr>
<td><strong>For organizations electing the Post-Acute Care Certification Option</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Acute Care Individual Tracer</td>
<td>60-120 minutes</td>
<td>Individual tracer activity that focuses on patients receiving rehabilitation and advanced care; occurs throughout the survey; the number of patients the surveyor traces varies by organization</td>
</tr>
<tr>
<td>Transitions of Care</td>
<td>60 minutes</td>
<td>Towards the middle or end of the survey 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>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>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).</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

### 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.

### Duration

Per itinerary; one day in most cases.

### Participants

**Joint Commission:** Surveyors

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

### What’s a Surveyor To Do If...

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

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

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

*Q:* What should you do if you discover other non-compliant performance while conducting
**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](http://www.jointcommission.org). Once there, select the link to access The Joint Commission Connect. They will need the user ID and password to sign-on. They should find the following information:

   a. Notification of scheduled Joint Commission event authorizing your presence
   
   b. Surveyor picture and biographical sketch

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

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

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

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

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

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

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

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

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

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

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

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

**What happens if the surveyor finds that the ....**

**...organization is not compliant with the same standards that resulted in an RFI during the last survey event?**

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

**Conducting the survey**

1. Arrive at the organization approximately 10 minutes prior to the designated start time. Note: hospital surveys begin at 8 AM. Other program surveys start when the organization opens as identified in the organization’s demographic data. |
2. Report to the reception area, security officer, information desk or administrative office upon arrival and introduce yourself and the purpose of your visit. |
3. Display and show the organization’s representative your Joint Commission identification badge. |
4. Ask the staff person, first encountered, to contact the administrative office or an organization leader to let them know of your arrival. You may be asked to wait in the lobby or in a different location, e.g. the administration office, a conference room, desk or table located in the organization.

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

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

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

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

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

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

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

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

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

15. Transmit the report to the Central Office within 24 hours of the exit following existing survey technology procedures.
Appendix P -- Onsite Evidence of Standards Compliance (ESC), Preliminary Denial of Accreditation-Evidence of Standards Compliance (PDA–ESC) Survey

<table>
<thead>
<tr>
<th>Duration</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per itinerary; usually one day, but is dependent on the number and severity of RFIs</td>
<td>The Onsite Evidence of Standards Compliance (ESC), and Onsite Preliminary Denial of Accreditation Evidence of Standards Compliance (PDA – ESC) are conducted to validate that an organization</td>
</tr>
<tr>
<td>Participants</td>
<td></td>
</tr>
<tr>
<td>Usually one surveyor</td>
<td></td>
</tr>
<tr>
<td>Organization:</td>
<td>• Has implemented the corrective action documented in its ESC submission, and</td>
</tr>
<tr>
<td>• Survey coordinator</td>
<td>• Is demonstrating current compliance with the elements of performance addressed in the ESC.</td>
</tr>
<tr>
<td>• Senior leadership</td>
<td></td>
</tr>
<tr>
<td>• Staff throughout the organization</td>
<td></td>
</tr>
<tr>
<td>• Licensed independent practitioners</td>
<td></td>
</tr>
<tr>
<td>What triggers this type of survey?</td>
<td>Objectives</td>
</tr>
<tr>
<td>A surveyor, staff person in the Standards Interpretation Group (SIG) or an ACO Field Director can recommend that an onsite survey be conducted to validate ESC implementation when they believe that there may be</td>
<td>1. Review all ESC submissions for the assigned program to verify that the organization has implemented reported plans and corrected previously cited standards non-compliance.</td>
</tr>
<tr>
<td>1. Questions about the integrity/accuracy of an organization’s ESC submission, or</td>
<td>2. Determine if the organization has sustained compliance since implementing corrective action plans.</td>
</tr>
<tr>
<td>2. A concern about the significant nature of the findings from a survey.</td>
<td>3. The PDA-ESC survey will occur approximately 60 days after the last survey event. Due to the serious nature of the issues previously identified, a quick return is required to assure corrections have been successfully implemented.</td>
</tr>
<tr>
<td>Who approves the conduct of an Onsite ESC?</td>
<td>4. Provide coaching and mentoring to the organization on sustaining and improving performance in those areas addressed in its ESC.</td>
</tr>
<tr>
<td>All Onsite ESC surveys require authorization from the ACO Chief Operating Officer.</td>
<td>Pre-Survey Planning</td>
</tr>
<tr>
<td>PDA-ESC Events will occur for all organizations who have received a PDA02 decision, which means, The organization’s patients have been placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings.</td>
<td>1. Access the HCO information in the usual manner through your itinerary on the Surveyor Portal.</td>
</tr>
<tr>
<td>If there are ESCs for multiple programs, is the assigned surveyor expected to review ESCs for all programs?</td>
<td>• Scroll through your assignments to find the Onsite ESC or PDA–ESC event. Select the event by clicking on the Event ID.</td>
</tr>
<tr>
<td></td>
<td>• You will use survey technology to access all available TJC information related to the organization through the Quick Links option. Click on the Quick Links button in the lower right corner of the screen to view the menu of available information.</td>
</tr>
<tr>
<td></td>
<td>• Click on the ESC selection to display a list of submissions from the organization. This list is cumulative over time, so you may need to scroll down to find the organization submission that is related to your current assignment. Click on the applicable date to display the ESC. 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.</td>
</tr>
<tr>
<td></td>
<td>2. Review the ESC report related to the survey event for which you are performing the onsite ESC follow-up. These reports include</td>
</tr>
<tr>
<td></td>
<td>• Standard text,</td>
</tr>
<tr>
<td></td>
<td>• EP text and scoring category,</td>
</tr>
<tr>
<td></td>
<td>• Surveyor findings for non-compliant standards found during the last survey, and</td>
</tr>
<tr>
<td></td>
<td>• Organization provided narrative describing the corrective action taken to address the finding (who, what, when, and how).</td>
</tr>
</tbody>
</table>
No. Surveyor assignment to an Onsite ESC or PDA-ESC survey event is based on the program that needs the onsite validation. Surveyors will not evaluate ESCs for other programs.

Is there a minimum number of records that must be reviewed during any Onsite ESC survey?
There is no defined number of records to review during the Onsite ESC or PDA-ESC survey.

What if there are no patients available to trace at the time of the Onsite ESC or PDA-ESC survey?
Contact the Field Director on call for further guidance.

How far back should the surveyor look to confirm current compliance?
Refer to the ESC report to determine the implementation date of the organization’s corrections and use this as your guide.

3. Plan your strategy to evaluate the organization’s current compliance with the EPs addressed in the ESC. **You are surveying standards compliance first.** The quality and effectiveness of the ESC corrective action plan should be revealed through evaluating standards compliance.

4. **Do not contact the organization.** This is an unannounced event.

5. Determine if ESC implementation can be verified by performing the survey at the organization’s main site. If the Requirement for Improvement (RFI) resulted from observations and performance at other organization sites, plan out several approaches for how you can verify ESC implementation using distance evaluation methods such as remote tracer activities. Call your Field Director for additional guidance and planning assistance as needed.

- If sites are only a short distance from the main site, plan to travel to one or two sites. **Exception: The Laboratory surveyor must visit all sites relevant to the RFI.**
- If sites are a significant distance from the main site, consider using other evaluation options that the organization may be able to facilitate, such as: Accessing records of care for all sites via computer from the main site, remote sites use of email or fax to send a patient schedule for the day, reviewing universal policies and procedures and interviewing staff about implementation at remote sites, remote sites faxing or emailing documentation to the main site, site staff availability for phone interviews, sites arranging for patient phone interviews).
- Prepare to review these approaches with the organization upon your arrival and reach agreement on the best options.

6. Identify survey activities that will provide you with access to organization staff and documentation that will allow you to evaluate current compliance with each EP identified as being corrected in the ESC report. For example,

- Issues with orders, patient care or medical record content should be addressed through tracer activity. Conduct a number of tracers to evaluate current compliance.
- Issues related to medication management should prompt the selection of a patient to trace that allows the best view possible of medication processes addressed in the ESC.
- Issues related to collecting data would prompt evaluating the implementation of the process described in its ESC to facilitate this data collection (e.g., view the collection instrument, plans to administer the instrument, results desired, follow-up plan when results are not achieved, etc.). Reviewing the collected data is not required. Perhaps a 30-minute Data Management System Tracer with a targeted group of organization staff would reveal current compliance.
- Environment of care issues could require touring various building areas, so scheduling time for a Building Tour with appropriate staff is recommended.
- If the organization underwent a focused Medicare Deficiency survey to validate resolution of a Condition Level Deficiency (CLD) you will review the EP’s associated with the CLD again to assure sustained compliance.

7. The following guidance is offered regarding template agendas for Onsite ESC and PDA–ESC surveys.
Accreditation surveyors will select a one-day template agenda through survey technology and edit to reflect the activities you believe will help reveal the organization's ESC implementation.

Surveyors should be prepared to discuss the agenda with the organization at the Opening Conference and make adjustments to activities and timing as needed.

**Conducting the survey**

1. Arrive at the organization approximately 10 minutes prior to the designated start time. **Note:** Most surveys begin at 8 AM unless the organization opens at a later time as identified in the organization's e-application data.

2. Report to the reception area, security officer, information desk or administrative office upon arrival and introduce yourself and the purpose of your visit.

3. Display and show the organization's representative your Joint Commission identification badge.

4. Ask the staff person, first encountered, to contact the administrative office or an organization leader to let them know of your arrival. You may be asked to wait in the lobby or in a different location.

5. Direct the survey coordinator or administrative contact to access the Joint Commission's web page at [www.jointcommission.org](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.

<table>
<thead>
<tr>
<th>Duration</th>
<th>Pre-Survey Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per itinerary; one day in most cases.</td>
<td>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.</td>
</tr>
<tr>
<td>Unannounced Format</td>
<td>2. Review the e-app for information about the HCO, travel directions, hotel accommodations and other logistical information.</td>
</tr>
<tr>
<td>Participants</td>
<td>3. Speak with the Accreditation and Certification Operations account executive for additional details about the extension survey.</td>
</tr>
<tr>
<td>All surveyors on site.</td>
<td>4. If this is an extension survey for expanded capacity of existing services, review the previous accreditation report.</td>
</tr>
<tr>
<td>Organization: Survey Coordinator, Senior leadership</td>
<td>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.</td>
</tr>
</tbody>
</table>

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 and biographical sketch
   c. Extension survey agenda template
8. Allow the organization an opportunity to access the information on their extranet site.
9. Ask the organization to print the extension survey agenda from their extranet site.
10. Once the organization verifies the authorization ask if they have a space where you can get settled while they begin to gather needed information as well as people to participate in the first activities of the day.
11. If the organization is requiring extra time to gather some of the initial planning information and people for the first activities, ask to begin...
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.

**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.

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).

Note: A Limited, Temporary Accreditation decision is not recognized by CMS for Medicare certification purposes.
An initial, full accreditation survey must occur within six months of the successful achievement of Limited, Temporary Accreditation.

Procedures

Before

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

The survey agenda will include:

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

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

During

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

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

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

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

7. Begin the survey with the Opening Conference
   a. 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.
   b. Provide the organization with the draft agenda and determine if any adjustments are needed to activity timing; make revisions as necessary.
   c. Verify the date the organization plans to begin provision of care, treatment and services, or will be ready for a full, initial accreditation survey
   d. 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.**
   e. Activities are conducted similar to how they would be on a full survey, however, with no individual tracers.
   f. 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,
   g. Surveyors will interact with staff and focus on the design and knowledge of policies and procedures expected to support day-to-day operations.
   h. 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.
   i. 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 45- and 60-day submissions,

12. Remind the organization that they need to be ready for the full, initial survey within six (6) months.

13. Instruct the organization to direct any follow-up questions to the Account Executive.

After

Surveyors transmit the report to Central Office following existing WST procedures.
Appendix S – Intracycle Monitoring (ICM) Option 2 & 3 Surveys & Focused Standards Assessment (FSA) Tool

Applies to: All accreditation programs that are subject to the Focused Standards Assessment, except Office-Based Surgery.

### Duration
Variable

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

### ICM Option 2 Description
- Organization undergoes an on-site ICM survey. Survey length is determined by the organization and there is a fee to cover survey costs. Surveyors review and respond to HCO-identified risk areas and General topics for Discussion identified in the ICM Profile submission. **Organization receives a written report of survey activities.**
- Organization develops Plan of Action and measures of success, as applicable, to address areas of non-compliance found during on-site survey. Joint Commission works with organization to refine its Plan of Action and measures of success via an optional scheduled phone conference with Standards Interpretation Group.

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

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

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

### Onsite Survey Process

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

### ICM Template Agenda
ICM Option 2 & 3 surveys are educational in nature. The agenda is intentionally generic so that you may focus attention on the needs of the organization based on the ICM Profile, rather than on all activities. Remind the organization you will be following the Survey Activity Guides in conducting all onsite activities. The agenda template, which can be found under the FSA tab of the ICM Profile, includes the core activities of the first and last days of survey:
Instructions

Web-based Survey Tech FSA Instructions

1. Access your itinerary and then select appropriate event ID
2. Click on Quick Links button
3. Select ICM Option 2 or 3 Survey from the list of links
4. Enter your login/password
5. On the HCO’s Intracycle Monitoring Profile Dashboard page, in the center column, click the orange ‘Go to History’ button.
6. The ICM History page displays; select the appropriate historical ICM submission (GEN or LAB). The ICM Accreditation Status page displays. From the horizontal menu bar at the top click the Focused Standards Assessment (FSA) tab.
7. The ICM Focused Standards Assessment page displays. Click on Access the focused Standards Assessment Tool option.
8. The FSA History Page displays. Under the Historical Submissions section, Option Submitted column, click on the View button next to the appropriate FSA Event.
9. The FSA tool opens and displays the Standards/EPs tab.

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

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
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.”

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.

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 & Related Activities

✓ Circle Program: Nursing Care Center Accreditation
✓ Which Directed Risk Area: Infusion Services

Part I: Focused Evaluation Screening Checklist

Step A. Verify if infusion services are being provided? If yes, please describe: __________
__________________________________________________________________________________

Step B. During the opening conference request:
- IC data associated with infusion services
- Policies related to infusion management (i.e. consents, documentation req.)
- Competencies and/or orientation for infusion management
- Infusion equipment management logs
- Protocols related to infusion services (i.e. NPSG07.04.01, emergency response)
- Contracts associated with infusion services (i.e. Rx)
- Relevant PI data

Notes:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Step C. Use the standard individual tracer process to address the Focused Evaluation topic.

a) Select a patient or resident that is receiving infusion services:
__________________________________________________________________________________

b) Attempt to observe an infusion being initiated or discontinued: __________________________
__________________________________________________________________________________

c) Interview a staff member that provides infusion services or the clinical educator: __________

d) Interview a patient or resident that is receiving infusion services ________________________
__________________________________________________________________________________

Step D. Evaluate the documentation for a patient or resident receiving infusion services?

- Is it consistent with policy requirements?
- Does the documentation policy demonstrate a lack of safe documentation design?
- Is the documentation accurate and reflect the patient’s or resident’s customized needs?
- Does the documentation demonstrate their required coordination of care?
__________________________________________________________________________________
Step E. Review an HR file for a clinician involved in infusion services:

a) Review at least one file, but attempt more if time permits.

b) Evaluate if orientation and/or competencies were completed per org requirements.

______________________________________________________________________________________
______________________________________________________________________________________

Step F. As part of the Leadership Session, evaluate: what information related to the Focused Evaluation topic needs to be covered and discussed with the organizational leaders?

- Management of PI data associated with infusion services
- Contract monitoring
- Management of adverse incidents or unexpected outcomes

______________________________________________________________________________________
______________________________________________________________________________________

Step H. If initial review indicates compliance – STOP. No need to pursue further review. In Web-based Survey Technology, check off Focused Evaluation performed.

Part II: Focused Evaluation Activities Conducted

If the severity and/or frequency of issues identified through the Focused Evaluation Screening Checklist in Part I above drives the need for further exploration, then conduct the Focused Evaluation activities for that topic using the SAG tool.
Appendix U – Guide for Evaluation of Management of IV Therapy Services in Nursing Care Centers

Focuses on IV Therapy administered through central venous catheters, PICC Lines and peripheral IV Lines. Excludes dialysis.

Applies to: Nursing Care Centers that provide IV Therapy Services

Use this guide to enhance your evaluation of an organization’s processes related to the provision of IV Therapy Services. Information in this guide is intended to be used during existing survey activities, and not during an independent survey activity.

Objectives

4. Assess and determine the degree of compliance with established guidelines and standards and elements of performance related to the provision of IV Therapy Services.

5. Increase the organization’s awareness of any identified risks related to the provision of IV Therapy Services.

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

- Orientation to the Organization
- Surveyor Planning Session
- Individual Tracer Activity
- Leadership and Data Use Session
- Competence Assessment / Credentialing Session
- Environment of Care Session

Orientation to the Organization

- Ask about the types of IV Therapy delivery methods utilized: Central, PICC, midlines, and peripheral IV Lines
- Inquire about any contract services related to infusion services

Surveyor Planning Session

- Review organization IV Therapy Policies
- Review contracts

Individual Resident Tracers

- Inquire about the roles and responsibilities of staff and licensed independent practitioners providing IV Therapy services.
- Explore staff knowledge base of risk factors such as infection, phlebitis, catheter malposition, thrombus formation, leakage and catheter breakage, infiltration and extravasation and vein inflammation.
- Inquire about the transfer of information from the hospital related to PICC insertion (description)
- Identify staff who are allowed to insert and/or remove PICC lines
- Identify staff who are allowed to change dressings and IV tubing
- Ask for the organization’s process for evaluating all central venous catheters
- Ask about staff orientation and ongoing competency assessment.
- Ask the resident/family about education about the purpose of the catheter.

Data Use Session/Medication Management/Infection Control

- Ask what safety and quality data is being collected and monitored related to IV Therapy, for example, medication errors, IV site infections, etc.

Competence Assessment / Credentialing Session

- Ask how contracted or in-house staff is deemed competent to insert, maintain, remove central, PICC, midlines and/or peripheral IV lines.
- Review orientation and competency records

Patient Tracer Selection

When selecting residents to trace include patients that are receiving IV Therapy services.

Organization Participants

Suggested individuals to speak with during survey activities include:

- Leadership staff
- Staff and licensed independent practitioners providing IV Therapy services.
- Resident/family

Documentation

1. Review any contracts and organization policies related to management of IV Therapy services including those related to staffing and equipment maintenance and the organizations performance expectations in the contracts.
2. Review applicable equipment maintenance and QC logs.
3. Review HR files for staff qualifications, content addressed in staff orientation, and evidence of on-going training.
4. Review credentialing and privileging files as needed.

Resources:
• Review primary source licensure of staff as applicable

**Environment of Care Session**

• Review preventative maintenance equipment logs for IV pumps.
• Review methods and storage of clean and dirty equipment
## PICC Line Tracer Data Collection Tool

**Unit** __________ | **Infusion Services**
--- | ---
**Patient #** _________________ | ▪ Staff qualified

**Admit Date:** ______________________ |
▪ Dressing change as ordered
**Diagnosis:** _______________________ |
▪ Evaluation documented per policy

**Date of Insertion:** ________________ |
▪ Competency of staff
**Where** __________________________ |

**By Who:** __________________________ |
▪ If there is a contract - Review credentials, licensure/certification, staff competency and oversight by organization
**Date of Orders:** ___________ LIP ____________ |

**Nurse:** __________________________ |

**PICC Assessment Completed:** _____________ |

**Monitoring Required** ______________ |

**Dressing Change orders** ____ |

**Flushing orders** __________ |

**Type of Med ordered for patient:** ______________ |

**Patient education provided:** **Y or N** |

**Is patient being monitored?** _____________ |

**How often?** __________________________ |

**By Who:** __________________________ |

**Has patient been reassessed?** __________ |

**How often?** __________________________ |

---

### Observation at Medication administration

Does the patient’s med. reflect orders? **Y or N**

Is patient aware of special meds/Tx? ________________

Flushing? |

Dressing change? |

Monitoring site?

Compliant with Hand Hygiene Guidelines

---

### Environment

▪ Review most recent CDC regs – org implemented as recommended?

▪ Evaluate the medication preparation areas

▪ Observe the equipment cleaning and maintenance

▪ Observe equip. & medication storage areas – expiration dates

▪ Safety precautions being observed

---

### Leadership

▪ Qualified by experience/training

▪ Responsible for daily management

---

### Clinical

▪ Explore processes for tracking orders

▪ Observe dressing change, including evaluation

▪ Observe hand hygiene

▪ Infection-control practices minimize infections

▪ Written policies **Y or N**

▪ Contracts per organization.

▪ Written competencies

▪ Orientation education.

▪ On-going education.

---

### Staff

▪ Orientation, training and education received

▪ Staff complying with infection & safety practices

---

### Notes:
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:
EC.01.01.01, EP 1
EM.01.01.01, EP 6
EM.02.01.01, EP 4
EM.02.02.01, EP 14
EM.02.02.11, EP 2, 8
IM.01.01.01
IM.01.01.03
IM.02.01.01
IM.02.01.03
IM.02.02.01
IM.02.02.03
RC.01.01.01
RC.01.02.01, EP 1, 5
RC.01.03.01
RC.01.04.01
RI.01.01.01, EP 7

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

- Orientation and training that staff and practitioners received on accessing data needed to provide patient care
- Availability of data to staff and practitioners—timeliness of entries, accuracy of entries, access to and timeliness of data from other systems (e.g., laboratory, radiology, pharmacy)
- Troublesome features of computer systems; "work-arounds" that staff and practitioners may employ to accomplish their tasks in a more efficient manner
- Features of computer systems that allow efficiency, but that can compromise data accuracy and integrity – clinical information systems not synchronized, posing risk that current version of clinical information cannot be viewed from all systems; "cutting and pasting" of data from one part of an electronic health record to another without determining it is the latest information or if it needs editing to reflect the current patient condition
- Procedures followed by staff and practitioners when help with automated systems is needed; responsiveness of the support system
- Procedures followed by staff and practitioners when automated systems are interrupted and patient health information is not available via routine sources and means
- Security and access permissions processes that staff and practitioners must follow, including password protections
- Staff and practitioner processes for suggesting changes and improvements to current health information technology systems
- Staff and practitioner processes for requesting aggregate data for purposes of ongoing performance improvement

Observations and responses to these questions can help inform the surveyor(s) about additional areas to explore and can identify issues that may warrant a more in-depth evaluation of processes.

Issues that may indicate the need to conduct a more In depth evaluation of information management include:

- Patient data and health information is not easily and readily accessible to staff and practitioners
- There is a pattern of staff and practitioner difficulty locating patient data and information
- Staff and practitioners report that patient health data and information is not available in time to influence patient care, treatment and services
- Staff and practitioner reports of discontent with the existing systems for contributing to and accessing patient health data and information
- Staff and practitioner reports of difficulty viewing the patient's episode of care in its entirety
- Health information technology and medical record policies not based on available, nationally recognized guidelines
- Observations and reports of health information privacy breaches
- Staff and practitioners do not have an awareness of hospital standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.
- Observations reveal concerns for the security and integrity of patient health information – such as inaccurate data resulting from access to health records from multiple systems that are not
updated or refreshed simultaneously; or from “cutting and pasting” data from one area of a record into another without regard for selecting accurate content (such as the latest laboratory results)

- Staff and practitioners are unable to obtain data and information for performance improvement initiatives

**To perform a more in-depth evaluation of information management systems and processes:**

- Interview staff responsible for health information management or health records about the records maintenance systems and processes
- Visit the information systems department and interview staff that support the clinical end-users; ask if calls for assistance are being tracked and trended to identify problematic systems for end-users
- Interview those individuals responsible for staff orientation, training and ongoing education on use of the data and information systems in day-to-day patient care
- Ask to see results of patient health data and information audits for completeness and accuracy; ask if audits include reviewing and comparing contents of documentation that is available through multiple systems or for cutting and pasting from one area of a record (e.g., lab results) into another (e.g., progress notes); ask about actions taken to address undesirable audit results
- Ask to see logs or reports that track information systems (computer) down-time, scheduled and unscheduled
- Review policies and procedures for checking the integrity of data and information
- Review procedures related to protections from risks due to spam, phishing, weak passwords, viruses or malware in USBs, and potential points of intrusion such as the following:
  - Email
  - Phone calls
  - Internet/web sites
  - Wi-fi
  - Public access spaces (meeting rooms, waiting rooms, cafeteria)
- Review organization emergency management plans to determine if and how health information management is addressed in terms of
  - potential risks to care, treatment, or 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 Z – Office of Quality and Patient Safety Survey Activity

**Applies to:** All accreditation programs

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

## Participants
Joint Commission: Surveyors

Organization: Survey coordinator, senior leadership, others

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

### What's a Surveyor To Do If...

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

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

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

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

**Objectives**

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

## Before

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

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

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

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

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

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

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

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

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

10. Be cautious and use discretion if printing any materials related to the OQPS incident. Do not leave these items visible and unattended in any location. Do not bring hard copies of any of the above noted items into
Q: What should you do if you discover non-compliant performance while conducting the OQPS For Cause Survey?

A: The surveyor records all observations and findings related to any standard or EP found non-compliant, whether or not they are related to the incident.

the organization. The organization is not told the specifics of the complaint to ensure the complainant’s confidentiality. See the attachment to this section for sample scripting to assist you in discussing the purpose for your visit.

Conducting an OQPS For-Cause Survey

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

2. Report to the reception area, security officer, information desk, administrative office or area that TJC leadership has directed upon arrival and:
   a. Provide your name and the purpose for your visit.
   b. Display your Joint Commission identification badge.
   c. Ask to speak with the survey coordinator, by name. If the coordinator is unavailable, ask to speak with an administrator or the most senior leader available. See the attachment to this section for sample scripting to assist you in discussing the purpose for your visit.

3. Direct the survey coordinator or administrative contact to access the Joint Commission’s web page at www.jointcommission.org. 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 enter state whether the OQPS incident has been substantiated or not substantiated. Do not write any narrative notes.

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

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

Post Survey Process

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

Exploring an OQPS Incident During a Full-Survey Event

When TJC leadership has determined an OQPS incident will be evaluated during a full survey or other type of scheduled survey event:
A Field Director will be designated as your contact person for all pre-survey planning and strategizing related to the survey event. Their name will be noted on the GSAP.

The team leader and team members will have access to the OQPS incident report under the OQPS tab in WST. To view the details of the incident report you must click on the blue highlighted Gold Sheet link in the lower right corner of the OQPS Incident screen.

The Field Director on-call will still remain your primary contact to assist with any needs or concerns during the on-site visit.

Before

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

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

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

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

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

During

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

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

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

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

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

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

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

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

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

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

12. Inform the organization that the Central Office will need to review the report and that the final report will be available on their extranet site within ten calendar days.
Appendix Z – Attachment: Scripts for OQPS Survey Activity

Suggested Comments during Opening Session with Leadership (related to an OQPS Incident being the trigger of a For-cause (OQPS) Survey or related to an OQPS Incident being a component of a Full or other type Survey)

The guiding principle is to be as transparent as possible, while still to be thoughtful in not inadvertently disclosing either the complainant, or even, the nature of the complainant, i.e. “an employee,” or “a physician.” The HCO should be made aware, at the onset, of the nature of the allegation. It may be easiest to use standards areas, or focus areas, as well as clinical service categories, such as Medication Management in the PICU, or OPPE/FPPE processes for non-physician LIPs, etc. Here are some examples:

**For a for-cause (OQPS) survey:** “Information representing a possible patient safety issue has come in to The Joint Commission’s Office of Quality and Patient Safety. It has been analyzed thoroughly, and reviewed by Joint Commission leadership, who has asked that we spend some time with you today evaluating systems and processes related to the patient safety issue. The main focus of our assessment will start in the NICU, related to Infection Control processes, although we may look at other areas throughout the day.”

**For a ‘feed to full survey’:** “We want for you to know that during this full survey, we also will be evaluating information which has come into The Joint Commission’s Office of Quality and Patient Safety. This information, which represents a possible patient safety issue, has been analyzed thoroughly and reviewed by Joint Commission leadership. They have asked that during the course of your full survey, we evaluate the systems and processes related to the patient safety concern. The area of focus in the information is the process for Competency Assessment in the critical care area. As you know, looking into your competency assessment processes is a customary part of a full survey, so this will be incorporated into our time with you.

**For a Pull-Full Forward, with an OQPS Incident attached- if asked why the survey has come early:** “As you know, the full survey can come anytime within a 18-36 month window. While we’ll be conducting a full survey, we want to share with you that The Joint Commission’s Office of Quality and Patient Safety has received information about a potential patient safety issue. This has been analyzed thoroughly and reviewed by Joint Commission leadership who has asked that we evaluate the systems and processes involved in the patient safety issue as a component of our full survey. The area of focus in what we received has to do with the credentialing and privileging processes particularly in the surgical service line. As you know, a customary part of a full survey includes a review of these processes, so we will incorporate this into our survey day.”

**If it is a media article,** its okay to say: “We know you’ve had some press coverage recently, and along with related information, this has been analyzed thoroughly and reviewed by leadership, who has asked that we spend some time reviewing this issue. We will focus, at least initially, on the cleaning, disinfection and sterilization processes related to endoscopy, and we’d like to begin there now.”

**If it has to do with a government agency report,** we can say: “We know you’ve had some recent visits from your State Agency [or CMS]. These reports came in to The Joint Commission’s Office of Quality and Patient Safety and have been analyzed thoroughly there. Joint Commission leadership has reviewed the information and asked that we review some of the follow up actions which have been undertaken since that CMS visit. The main area of our evaluation is restraint practices in your geropsych unit.”

**If there is a written organizational response attached to the OQPS Incident:** “We understand that you’ve been working with The Joint Commission’s Office of Quality and Patient Safety on a patient
safety issue which came into that Office. Your response was thoroughly reviewed by Joint Commission leadership who has asked that we spend some time looking at that area during survey. The focus of our assessment will be in the ED, and how care, security and communication practices work in that environment, particularly with boarded patients."
# Appendix CC – Immediate Threat to Health or Safety Abatement Survey

**Applies to:** All accreditation and certification programs

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>When a surveyor identifies an Immediate Threat to Health or Safety during an on-site event, The Joint Commission conducts a follow-up survey within 23 days.</td>
<td>1. To evaluate the organization’s follow-up actions in response to an identified Immediate Threat to Health or Safety.</td>
</tr>
<tr>
<td><strong>Duration</strong></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:
   - Previous Requirements for Improvement and findings that led to the Immediate Threat to Health and Safety determination
   - Available ESC submissions
   - Organization’s application

2. Review the application for accreditation to locate information about the organization, travel directions, hotel accommodations, and other logistical information. Make note of the survey coordinator name and phone number.

3. **Do not contact the organization.** Call the Joint Commission Account Executive or Field Director On-Call with any questions.

4. Review the last survey report (Previous Recommendations under Quick Links).

5. Identify survey activities that would evaluate the element(s) of performance previously found out of compliance. The primary focus of this follow-up survey is on the area(s) identified as posing a serious threat to public or patient health or safety. However, if additional areas of non-compliance are discovered during the follow-up survey, document the additional observations in survey technology.

6. Plan for the on-site visit. While not required, consider selecting an agenda template from those available in WST that closely matches the survey length and complement for the assigned event. Revise the template to reflect activities that will allow for evaluation of the non-compliant standards related to the immediate threat. The agenda can include individual tracers, system tracers, building tours and review of documents.

7. One to two days before the scheduled survey date, access the organization’s extranet site and check the last survey report for any Central Office updates.

## Conducting the Survey

8. Arrive at the organization no earlier than 10 minutes before the designated start time for the unannounced survey. If the survey includes multiple surveyors, all surveyors should enter the organization together.
9. Report to the reception area, security officer, information desk or administrative office upon arrival and:
   a. Provide your name and the purpose for your visit.
   b. Display your Joint Commission identification badge.
   c. Ask to speak with the survey coordinator, by name. If the coordinator is unavailable, ask to speak with an administrator or the most senior leader available.
   d. Clearly explain the purpose of the survey to the organization.

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

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

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

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

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

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

16. If activities are completed in less than 8-hours, the surveyor should enter a note in the CO Comments tab indicating their time of departure from the organization and notify the FD on Call.

17. At the conclusion of the survey, provide organization leadership with the evaluation results, focusing on the abatement of the immediate threat to health or safety.
   a. Explain that follow-up questions should be directed to the organization’s Account Executive.
b. Indicate that you will not be posting a preliminary report to the HCO's extranet site for this on-site survey.

c. Indicate that Joint Commission Central Office will review the findings and will then post a final report to the organization's extranet site indicating the results of this event.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Surveyor Education
630-792-5757
(Barbara Buturusis)