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## Who Is Eligible for Office-Based Surgery Accreditation?

Office practices that perform invasive procedures are eligible for accreditation under The Joint Commission's Office-Based Surgery Accreditation Program. Since beginning the accreditation program in January 2001, The Joint Commission has completed surveys of many different surgical specialties, including plastic surgery, oral surgery, podiatric surgery, endoscopy and orthopedics, to name a few.

Practices must meet **all** of the following criteria to be eligible for accreditation under the Office-Based Surgery (OBS) standards:

- The practice is comprised of four or fewer surgeons\* (physician, dentist or podiatrist) performing operative or invasive procedures. OBS practices, including multi-site practices, are limited to four or fewer licensed independent practitioners;
- The practice must be surgeon owned or operated, e.g., a professional services corporation, private physician office, or small group practice;
- Invasive procedures are provided to patients. (Practices only providing procedures such as excisions of skin lesions, moles, warts, and abscess drainage limited to the skin and subcutaneous tissue are not typically surveyed under OBS standards;) and
- Local anesthesia, minimal sedation, conscious sedation or general anesthesia is administered. (However, laser eye surgery using topical anesthesia does qualify.)

Office-based practices that render four or more patients incapable of self-preservation at the same time are required to meet the provisions of the *Life-Safety Code*<sup>®</sup>. Practices may work with The Joint Commission to identify equivalencies to meet these requirements.

Many different types of office-based surgical practices should consider this accreditation option, including oral/maxillofacial surgeons, podiatric surgeons, endoscopy practices, plastic surgery and dermatologic surgery practices, urology practices, orthopedic practices and laser surgery clinics.

A typical on-site survey lasts one day. Practices that have more than one office, and still meet all of the above criteria, require a multiple-day survey. If you have more than one office site under the same ownership that meets all of the above criteria, or if you're not sure if you would be eligible for this option, call (630) 792-5259.

\***Surgeon** includes physicians, dentists or podiatrists who meet the definition of a licensed independent practitioner (LIP). An LIP, as defined by The Joint Commission, is an individual permitted by law and by the practice to provide care, treatment and services without direction or supervision, within the scope of the individual's license.

## Office-Based Surgery (OBS) Standards Sampler

### Introduction

The *Comprehensive Accreditation Manual for Office-Based Surgery Practices (CAMOBS)* contains the set of standards that have been designed to evaluate OBS practices. The manual can also be used as a comprehensive self-assessment tool that you can use to prepare for a Joint Commission on-site survey.

To help familiarize you with the standards while you are in the early stages of exploring accreditation, The Joint Commission has prepared this resource, the *OBS Standards Sampler*. The *Standards Sampler* contains a few selected standards from each of nine standards chapters to illustrate the types of issues that accreditation involves.

As you review the *Standards Sampler*, please note the components structure of each standard.

### **Understanding the Standard, Element of Performance, and Scoring**

To help you navigate the standards, it may be helpful to think of the parts this way:

- The **standard** is the “goal.”
- The **rationale** explains why it’s important to achieve this goal.
- The **elements of performance** identify the step(s) needed to achieve this goal.

These parts are defined as follows:

**Standard** A statement that defines the performance expectations and/or structures or processes that must be in place in order for a practice to provide safe, high-quality care, treatment, and services. A practice is either “compliant” or “not compliant” with a standard.

Accreditation decisions are based on simple counts of the standards that are determined to be “not compliant.” Standards are identified by number (eg. PC.1.10).

**Rationale** A statement that provides background, justification, or additional information about a standard. A standard’s rationale is not scored. In some instances, the rationale for a standard is self-evident. Therefore, not every standard has a written rationale.

**Elements of performance (EPs)** The specific performance expectations and/or structures or processes that must be in place in order for a practice to provide safe, high-quality care, treatment, and services. The scoring of EP compliance determines a practice’s overall compliance with a standard. EP’s are evaluated on the following scale:

- |           |                         |
|-----------|-------------------------|
| <b>0</b>  | Insufficient compliance |
| <b>1</b>  | Partial compliance      |
| <b>2</b>  | Satisfactory compliance |
| <b>NA</b> | Not applicable          |

## **Scoring**

There are three categories of Elements of Performance:

### **Category A**

These EPs relate to the presence or absence of the requirement(s) and are scored either yes (2) or no (0).

### **Category B**

Category B EPs are scored in two steps:

1. If your practice *does not meet* the requirement(s), the EP is scored 0; there is no need to address the principles of good process design (see below.)
2. If your practice *does meet* the requirement(s), but there is concern about the quality or comprehensiveness of the effort, then the qualitative aspects of the EP are addressed:
  - Consistent with your practice's mission, values, and goals
  - Meets the needs of patients
  - Reflects the use of currently accepted practices (doing the right thing, using resources responsibly, using practice guidelines)
  - Incorporates current safety information and knowledge such as sentinel event data and National Patient Safety Goals
  - Incorporates relevant performance improvement results

### **Category C**

Category C EPs are scored 0, 1, or 2 based on the number of times your practice does not meet the EP. These EPs are frequency based and require totaling the number of occurrences (that is, results of performance or non-performance) related to a particular EP. Each event discovered by a surveyor(s) will be counted as a separate occurrence.

Once you have evaluated and scored each EP for a particular standard, simple rules apply to determine your compliance with the standard itself:

- Your practice is not in compliance (that is, "not compliant") with the standard if any EP is scored 0
- Otherwise, your practice is in compliance with a standard if 65% or more of its EPs are scored 2

Please share these examples of OBS standards with your staff. You'll likely see that much of what is required for accreditation is already in place at your practice.

The full text for all these standards can be found in the *CAMOBS*.

Joint Commission Resources, a Joint Commission affiliate, publishes the standards manual. You can order this publication on the web at [www.jcrinc.net](http://www.jcrinc.net) or by phone with JCR's Customer Service Center at (877) 223-6866.

You may also take advantage of a complimentary Joint Commission resource - the Standards Interpretation Unit - which can answer specific standards-based questions for your setting. The phone number is (630) 792-5900; you can also access a web-based question submission form at [www.jointcommission.org](http://www.jointcommission.org).

For more information about accrediting your OBS practice, contact The Joint Commission's Business Development unit at (630) 792-5286.

## **PRACTICE ETHICS AND PATIENT RIGHTS AND RESPONSIBILITIES (RI)**

### **OVERVIEW**

A practice has an ethical responsibility to the patients and community it serves. To fulfill this responsibility, ethical care, treatment, and service practices and ethical business practices must go hand in hand. Furthermore, the practice provides care, treatment, and services within its scope, stated mission and philosophy, and applicable law and regulation.

The practice's system of ethics supports honest and appropriate interactions with patients. The system of ethics also includes patients whenever possible in decisions about their care, treatment, and services, including ethical issues.

### **PRACTICE ETHICS**

**Standard RI.2.60** Patients receive adequate information about the person(s) responsible for the delivery of their care, treatment, and services.

#### **Elements of Performance for RI.2.60**

**1-2.** Not applicable.

- C 3.** The patient (and family, as appropriate) are given information about the following:
- The licensed independent practitioner(s) responsible for the procedure
  - The licensed independent practitioner or staff member primarily responsible for the sedation and anesthesia
  - Others authorizing or performing procedures and treatment.
- C 4.** At the time of initial consultation, before any surgical procedure or service is performed, the patient receives disclosure information about the licensed independent practitioner's licensure and relevant education, training, and experience in performing the planned procedure.  
**Note:** *This information can be provided in any written format that the practice chooses.*
- C 5.** The licensed independent practitioner described in the disclosure information is the licensed independent practitioner that performs the procedure.
- C 6.** The disclosure information also includes the qualifications of the licensed independent practitioner or clinical staff who will administer and monitor anesthesia during the procedure.
- C 7.** The patient signs an acknowledgement that he or she has received the disclosure information.
- C 8.** Each patient has the right to be informed of any educational activities related to care and can refuse to participate in any such activity without that refusal compromising usual care.

**Standard RI.2.100** The practice respects the patient's right to and need for effective communication.

**Elements of Performance for RI.2.100**

**1-3.** Not applicable.

**C 4.** The practice addresses the needs of those with vision, speech, hearing, language, and cognitive impairments.

**Standard RI.2.120** The practice addresses the resolution of complaints from patients and their families.

**Elements of Performance for RI.2.120**

**C 1.** The practice informs patients, families, and staff about the complaint resolution process.

**C 2.** The practice receives, reviews, and, when possible, resolves complaints from patients and their families.

**Standard RI.2.130** The practice respects the needs of patients for confidentiality, privacy, and security.

**Elements of Performance for RI.2.130**

**C 1.** The practice protects confidentiality of information about patients.

**C 2.** The practice respects the privacy of patients.

**3.** Not applicable.

**C 4.** The practice provides for the safety and security of patients and their property.

**5-20.** Not applicable.

**A 21.** The practice addresses the needs of those with physical and visual impairments for physical access to the facility.

## **PROVISION OF CARE, TREATMENT AND SERVICES (PC)**

### **OVERVIEW**

The goal of surgical and invasive procedures, sedation, anesthesia, and recovery activities in an office-based surgery practice is to provide for effective, appropriate, and individualized care and procedures that respond to the patient's specific needs. Before any procedure, the practice assesses the patient as an appropriate candidate for an office-based procedure. Sedation and anesthesia assessment and any necessary examinations and diagnostic testing occur, and the patient is informed about risks, benefits, alternatives, and informed consent. The surgeon gives final approval for the planned sedation or anesthesia and the invasive or surgical procedure based on these assessments. Assessment occurs throughout the pre-, peri-, and post-procedure phases, addressing not only physical and functional status, but also physiological and cognitive status as relates to the use of sedation and anesthesia. Surgeons perform the surgical and invasive procedures. The administration and monitoring of sedation or anesthesia is performed by a qualified licensed independent practitioner (LIP) or by qualified clinical staff under the supervision of an LIP. Discharge planning in the office-based surgery practice addresses appropriate referrals, transfers, and follow-up. The practice maintains timely and accurate documentation of all phases of care to support treatment and performance improvement.

### **PLANNING CARE, TREATMENT, AND SERVICES**

**Standard PC.2.130** The practice respects the needs of patients for confidentiality, privacy, security.

#### **Elements of Performance for PC.2.130**

- C 1.** The practice protects confidentiality of information about patients.
- C 2.** The practice respects the privacy of patients.
  - 3.** Not applicable.
- C 4.** The practice provides for the safety and security of patients and their property.
- 5-20.** Not applicable.
- A 21.** The practice addresses the needs of those with physical and visual impairments for physical access to the facility.

**Standard PC.4.10** Development of a plan for care, treatment, and services is individualized and appropriate to the patient's needs, strengths, limitations, and goals.

#### **Rationale for PC.4.10**

Treatment is effective, efficient, individualized, and appropriate. Each phase of care--assessment, administration of sedation or anesthesia, surgical/invasive procedure, recovery, and discharge--identifies and responds to each patient's needs, expectations, characteristics, age, and severity of disease, condition, or impairment.

### **Elements of Performance for PC.4.10**

**B 1.** Care, treatment, and services and planned to ensure that they are individualized to the patient's needs.

## **STANDARDS FOR OPERATIVE OR OTHER HIGH-RISK PROCEDURES AND/OR THE ADMINISTRATION OF MODERATE OR DEEP SEDATION OR ANESTHESIA**

**Standard PC.13.30** Patients are monitored during the procedure and/or administration of moderate or deep sedation or anesthesia.

### **Rationale for PC.13.30**

Physiological monitoring is often the only reliable source of assessment information for patients who have lost consciousness or who undergo sedation or anesthesia. The patient's physiological status is measured and assessed throughout sedation or anesthesia to ensure appropriate physiological support. Monitoring methods depend on the patient's preprocedure status, sedation or anesthesia choice, and complexity of the procedure.

### **Elements of Performance for PC.13.30**

- 1.** Not applicable.
- C 2.** The procedure and/or the administration of moderate and/or deep sedation or anesthesia for each patient is documented in the medical record.
- A 3.** Heart rate and oxygenation are continuously monitored by pulse oximetry.
- A 4.** Respiratory frequency and adequacy of pulmonary ventilation are continually monitored.
- A 5.** Blood pressure is measured at regular intervals.
- A 6.** EKG is monitored in patients with significant cardiovascular disease or when dysrhythmias are anticipated or detected.

## **MEDICATION MANAGEMENT (MM)**

### **OVERVIEW**

The clinical services needed to support office-based surgery may be provided on a contract basis. The following standards address both the direct provision of the clinical services as well as clinical services provided through contract.

Medications are essential to patient care; however, their use and handling entail certain risks. The following standards identify risk points and offer a system for managing them. Medical evaluation of past and current drug treatments is conducted when medications are used. Treatment efficacy, the impact on current functioning and side effects are considered, including evaluations from the patient, family, or caregivers. These standards address the following components of medication management:

- Availability
- Prescribing and ordering
- Preparation and dispensing
- Administration
- Monitoring of effect

### **STORAGE**

**Standard MM.2.30** Emergency medications and/or supplies, if any, are consistently available, controlled, and secured.

#### **Elements of Performance for MM.2.30**

**1-3.** Not applicable.

**A 4.** Emergency medications are sealed or stored in containers (for example, crash carts, tackle boxes, emergency drug kits, closed bags that are clearly labeled, and so forth ) in such a way that staff can readily determine that the contents are complete and have not expired.

**5-8.** Not applicable.

**A 9.** Emergency medications are available, controlled, and secure in the procedure areas.

## **PREPARING AND DISPENSING**

**Standard MM.4.70** Medications dispensed by the practice are retrieved when recalled or discontinued by the manufacturer or the Food and Drug Administration for safety reasons.

**Note:** *This standard is applicable to all practices that dispense medications, including those practices that dispense sample medications.*

### **Elements of Performance for MM.4.70**

**1-3.** Not applicable.

**B 4.** The practice has procedures for retrieving and safely disposing of recalled medications including the following:

- Identifying each patient who is receiving or has received recalled medications
- Identifying the source of the medication
- Providing for the retrieval and safe disposal of medications subject to recall
- Providing for external reporting of medication product defects

## **ADMINISTRATION**

**Standard MM.5.10** Medications are safely and accurately administered.

### **Elements of Performance for MM.5.10**

**B 1.** Policies and procedures address health care staff who are allowed to administer medications, with or without supervision, consistent with law or regulation and practice policy.

Before administering a medication, the licensed independent practitioner or qualified individual administering the medication does the following (EPs 2-4):

- C 2.** Verifies that the medication selected for administration is the correct one based on the medication order and product label.
- C 3.** Verifies that the medication is stable based on visual examination for particulates or discoloration and that the medication has not expired.
- C 4.** Verifies that there is no contraindication for administering the medication.

**5-14.** Not applicable.

**A 15.** Medications are administered by or under the supervision of appropriately licensed staff consistent with law, regulation, and practice procedures.

## **SURVEILLANCE, PREVENTION AND CONTROL OF INFECTIONS (IC)**

### **OVERVIEW**

Infections can be acquired within any care, treatment, and service setting, and be transferred between settings or brought in from the community. Therefore, prevention of health care-associated infections (HAIs) represents one of the major safety initiatives that a practice can undertake.

The goal of an effective infection control (IC) program is to reduce the risk of acquisition and transmission of HAIs. To achieve this goal, office-based surgery practices must do the following:

1. The practice incorporates its infection program as a major component of its safety and performance improvement programs.
2. The practice performs an ongoing assessment to identify its risks for the acquisition and transmission of infectious agents.
3. The practice effectively conducts surveillance, collects data, and interprets the data.
4. The practice effectively implements infection prevention and control processes.
5. The practice educates and collaborates with leaders across the practice to effectively participate in the design and implementation of the IC program.
6. The practice integrates its efforts with health care and community leaders to the extent practicable, recognizing that infection prevention and control is a communitywide effort.
7. The practice plans for responding to infections that may potentially overwhelm its resources.

A program with aims of such broad scope and depth requires the direct involvement of practice leaders. Only with the ongoing attention and direction of the practice's leadership can the appropriate scope of the IC program be determined and adequately resourced.

The standards in this chapter, which focus on development and implementation of plans to prevent and control infections, are supported by standards in other chapters, such as "Management of the Environment of Care," "Management of Human Resources," "Improving Practice Performance," and "Leadership," to produce a comprehensive approach to IC.

## **THE IC PROGRAM AND ITS COMPONENTS**

**Standard IC.2.10** The infection control program identifies risks for the acquisition and transmission of infectious agents on an ongoing basis.

### **Rationale for IC.2.10**

A practice's risks of infection will vary based on the practice's geographic location, the community environment, the types of programs/services provided, and the characteristics and behaviors of the population served. As these risks change over time—sometimes rapidly—risk assessment must be an ongoing process.

### **Elements of Performance for IC.2.10**

- B 1.** The practice identifies risks for the transmission and acquisition of infectious agents throughout the practice based on the following factors:
- The program/services provided, and the characteristics of the population served
  - The results of the analysis of the practice's infection prevention and control data
  - The care, treatment, and services provided
- A 2.** The risk analysis is formally reviewed at least annually and whenever significant changes occur in any of the above factors.
- B 3.** Surveillance activities, including data collection and analysis, are used to identify infection prevention and control risks pertaining to the following:
- Patients
  - Licensed independent practitioners staff, and student/trainees
  - And as warranted, visitors

## **STRUCTURE AND RESOURCES FOR THE IC PROGRAM**

**Standard IC.7.10** The infection control program is managed effectively.

### **Rationale for IC.7.10**

The IC program requires management by an individual (or individuals) with knowledge that is appropriate to the risks identified by the practice, as well as knowledge of the analysis of infection risks, principles of infection prevention and control, and data analysis. The individual gathering data for the infection control program does not have to be the person analyzing the data and managing the program. The individual may be employed by the practice, or the practice may contract with this individual. The number of individuals and their qualifications are based on the practice's size, complexity, and needs.

### **Elements of Performance for IC.7.10**

- A 1.** The practice assigns responsibility for managing IC program activities to one or more individuals whose number, competency, and skill mix are determined by the goals and objectives of the IC activities.

- B 2.** Qualifications of the individual(s) responsible for managing the IC program are determined by the risks entailed in the care, treatment, and services provided; the practice's patient population(s); and the complexity of the activities that will be carried out.
- Note:** *Qualifications may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control in the prevention and control of infections.)*
- B 3.** This individual(s) coordinates all infection prevention and control activities within the practice.
- B 4.** This individual(s) facilitates ongoing monitoring of the effectiveness of prevention and/or control activities and interventions.

## **IMPROVING PRACTICE PERFORMANCE (PI)**

### **OVERVIEW**

Performance improvement (PI) is a continuous process. It involves measuring the functioning of important processes and services, and, when indicated, identifying changes that enhance performance. These changes are incorporated into new or existing work processes, products or services, and performance is monitored to ensure that the improvements are sustained.

Performance improvement focuses on outcomes of care, treatment, and services. Leaders establish a planned, systematic, and practice-wide approach(es) to performance improvement. They set priorities for performance improvement and ensure that the disciplines representing the scope of care, treatment, and services across the practice work collaboratively to plan and implement improvement activities. The leaders' responsibilities are described in the "Practice Leadership" chapter (standards LD.4.10 through LD.4.70) of the *CAMOBS* manual.

An important aspect of improving practice performance is effectively reducing factors that contribute to unanticipated adverse events and/or outcomes. Unanticipated adverse events and/or outcomes may be caused by poorly designed systems, system failures, or errors. Reducing unanticipated adverse events and/or unanticipated outcomes requires an environment in which patients, their families, and practice staff and leaders can identify and manage actual and potential risks to safety. Such an environment encourages the following:

- Recognizing and acknowledging risks and unanticipated adverse events
- Initiating actions to reduce these risks and unanticipated adverse events
- Reporting internally on risk reduction initiatives and their effectiveness
- Focusing on processes and systems
- Minimizing individual blame or retribution for involvement in an unanticipated adverse event
- Investigating factors that contribute to unanticipated adverse events and sharing that acquired knowledge both internally and with other practices

The leaders are responsible for fostering such an environment through their personal example and by supporting effective responses to actual occurrences of unanticipated adverse events; and integration of safety priorities into the design and redesign of all relevant practice processes, functions, and services.

This chapter focuses on the following fundamental components of performance improvement:

- Measuring performance through data collection
- Assessing current performance
- Improving performance

**Standard PI.1.10** The practice collects data to monitor its performance.

**Rationale for PI.1.10**

Data help determine performance improvement priorities. The data collected for high priority and required areas are used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, or sustain improvement. Data collection helps identify specific areas that require further study. These areas are determined by considering the information provided by the data about process stability, risks, and sentinel events, and priorities set by the leaders. Data may come from internal sources such as staff or external sources such as patients, referral sources, and so on. In addition, the practice identifies those areas needing improvement and identifies desired changes. Performance measures are used to determine whether the changes result in desired outcomes. The practice identifies the frequency and detail of data collection.

**Elements of Performance for PI.1.10**

**B 1.** The practice collects data for priorities identified by leaders.

**2.** Not applicable.

**B 3.** The practice collects data on the perceptions of care, treatment, and services of patients, including the following:

- Their specific needs and expectations
- How well the practice meets these needs and expectations

The practice collects data that measure the performance of each of the following potentially high-risk processes, when provided:

**A 4.** Medication management

**A 5.** Blood and blood product use

**6-10.** Not applicable.

**A 11.** Operative and other procedures that place patients at risk

**12-15.** Not applicable.

**B 16.** Relevant information developed from the following activities is integrated into performance improvement initiatives. This occurs in a way consistent with any practice policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law: infection control surveillance and reporting.

**17-26.** Not applicable.

- B 27.** The practice collects data that measures clinical outcomes, including the following:
- Adverse clinical events during procedures
  - Complications following procedures
  - Complications requiring transfer to an acute care facility
  - Unplanned, prolonged, or frequent extended stays in recovery
  - Procedures that, once begun, are stopped prematurely.
- B 28.** Data that the practice considers for collection to monitor performance include the following:
- Care or services provided to high-risk populations
  - Appropriateness of surgery and anesthesia.

**Standard PI.2.20** Undesirable patterns or trends in performance are analyzed.

**Elements of Performance for PI.2.20**

- B 1.** Analysis is performed when data comparisons indicate that levels of performance, patterns, or trends vary substantially from those expected.
- B 2.** Analysis occurs for those topics chosen by leaders as performance improvement priorities.
- 3-4.** Not applicable.

An analysis is performed for:

- A 5.** All serious adverse drug events, if applicable and as defined by the practice
- A 6.** All significant medication errors, if applicable and as defined by the practice
- A 7.** All major discrepancies between preoperative and postoperative (including pathologic) diagnoses
- A 8.** Adverse events or patterns of adverse events during moderate or deep sedation and anesthesia use.
- 9-11.** Not applicable.
- A 12.** An analysis is performed for the following: errors and omissions in patient assessment for surgery and anesthesia resulting in significant adverse clinical events.

## **PRACTICE LEADERSHIP (LD)**

### **OVERVIEW**

The goal of planning and directing practice services in an office-based surgery practice is to provide a framework of decision-making, accountability, and responsibility for delivering effective, efficient, and safe patient care services. Planning and directing practice services encompasses a broad range of activities which affect all areas of the practice and should involve a collaborative process among all staff. As such, these activities are represented throughout this manual, with reference to appropriate staff. However, those whom the practice defines as its leaders are accountable for decision-making in the following areas:

- **Planning and designing services.** Practice leaders provide a collaborative process to develop operational, strategic, and long-range plans; service design; resource allocation; and practice protocols and procedures.
- **Directing services.** Practice leaders provide practice, direction, and staffing for patient care and support services according to the scope of service offered, either directly or through delegated activities or contracted staff. Practice leaders communicate objectives and facilitate coordination of services.
- **Improving performance.** Practice leaders establish expectations, plans, and priorities and manage the performance improvement process, ensuring implementation of processes to measure, assess, and improve the performance of the practice's clinical and support services.

Office-based surgery practices to which this accreditation manual applies are owned or operated by surgeons. As such, the practice leadership is composed of surgeons and, as appropriate, other administrative and clinical staff.

**Standard LD.3.50** Services provided by consultation, contractual arrangements, or other agreements are provided safely and effectively.

**Rationale for LD.3.50**

The practice leaders may choose to provide some services through consultation, contractual arrangements, or other agreements, while retaining overall responsibility and authority for the level of safety and quality of the patient care provided. These services might include the following:

- Diagnostic radiology services
- Pathology and clinical laboratory services
- Pharmaceutical services
- Anesthesia services

**Elements of Performance for LD.3.50**

- A 1.** The leaders approve sources for the practice’s services that are provided by consultation, contractual arrangements, or other agreements.
- A 2.** The clinical leaders advise the practice’s leaders on the sources of clinical services to be provided by consultation, contractual arrangements, or other agreements.
- 3.** Not applicable.
- A 4.** The nature and scope of services provided by consultation, contractual arrangements, or other agreements are defined in writing.
- 5-6.** Not applicable.
- A 7.** The practice retains overall responsibility and authority for services furnished under a contract.
- A 8.** All reference and contract lab services meet the applicable federal regulations for clinical laboratories and maintain evidence of the same.

**Standard LD.4.40** The leaders ensure that an integrated patient safety program is implemented throughout the practice.

**Rationale for LD.4.40**

The leaders should work to foster a safe environment throughout the practice by integrating safety priorities into all relevant practice processes, functions, and services. In pursuit of this effort, a patient safety program can work to improve safety by reducing the risk of system or process failures. As part of its responsibility to communicate objectives and coordinate efforts to integrate patient care and support services throughout the practice and with contracted services, leadership takes the lead in developing, implementing, and overseeing a patient safety program.

The standard does not require the creation of new structures or “offices” in the practice; rather, the standard emphasizes the need to integrate all patient-safety activities, both existing and newly created, with the practice’s leadership identified as accountable for this integration.

### **Elements of Performance for LD.4.40**

The patient safety program includes the following:

- A 1.** One or more qualified individuals or an interdisciplinary group assigned to manage the practicewide safety program.
- B 2.** Definition of the scope of the program's oversight, typically ranging from no-harm, frequently occurring "slips" to sentinel events with serious adverse outcomes.
- B 3.** Integration into and participation of all components of the practice into the practicewide program.
- B 4.** Procedures for immediately responding to system or process failures, including care, treatment, or services for the affected individual(s), containing risk to others, and preserving factual information for subsequent analysis.
- B 5.** Clear systems for internal and external reporting of information about system or process failures.
- B 6.** Defined responses to various types of unanticipated adverse events and processes for conducting proactive risk assessment/risk reduction activities.
- B 7.** Defined support systems\* for staff members who have been involved in a sentinel event.
- A 8.** Reports, at least annually, to the practice's governance or authority on system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

\*Support systems provide individuals with additional help and support, as well as additional resources through the human resources function or an employee assistance program. Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. Support systems also focus on the process rather than blaming the involved individuals.

## **MANAGEMENT OF THE ENVIRONMENT OF CARE (EC)**

### **OVERVIEW**

The goal of Management of the Environment of Care in an office-based surgery practice is to provide a safe, functional, and effective environment for patients, staff members, and others, which is crucial to providing patient care and achieving good outcomes. Achieving this goal depends on performing the following processes:

- Planning by the practice leadership for the space, equipment, and resources needed to support the services provided safely and effectively. Planning should be consistent with the practice's goals and priorities.
- Educating staff about the role of the environment in safely and effectively supporting patient care. The practice educates staff about the environment, including equipment use and the processes for promoting safety while reducing risk in the practice.
- Implementing actions to create and manage safely the practice's environment of care, including actions to identify opportunities to improve the status of the environment of care.

The "environment of care" is made up of three basic components: building(s), equipment, and people. Effective management of the environment of care includes using processes and activities to:

- Reduce and control environmental hazards and risks
- Prevent accidents and injuries
- Maintain safe conditions for patients, staff and others.

The standards in this chapter focus on how everyone in the practice participates in the activities that make the care environment safe and effective. Practices will carry out most of these functions directly, but in some cases will carry them out through their contractual or leasing relationships.

### **PLANNING AND IMPLEMENTATION ACTIVITIES**

**Standard EC.1.20** The practice maintains a safe environment.

#### **Elements of Performance for EC.1.20**

- B 1.** The practice conducts environmental tours to identify environmental deficiencies, hazards, and unsafe practices.
- C 2.** The practice conducts environmental tours at least every six months in all areas where individuals are served.
- C 3.** The practice conducts environmental tours at least annually in areas where patients are not served.

**Standard EC.6.10** The practice manages medical equipment risks.

**Elements of Performance for EC.6.10**

1. Not applicable.
- B 2.** The practice identifies and implements a process(es) for selecting and acquiring medical equipment.
- 3-4.** Not applicable.
- B 5.** The practice defines intervals for inspecting, testing, and maintaining appropriate equipment (that is, those pieces of equipment benefiting from scheduled activities to minimize the clinical and physical risks) that are based upon criteria such as manufacturers' recommendations, risk levels, and current practice experience.
- B 6.** The practice identifies and implements processes for monitoring and acting on equipment hazard notices and recalls.
- B 7.** The practice identifies and implements processes for monitoring and reporting incidents in which a medical device is suspected or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990.
- A 8.** The practice identifies and implements processes for emergency procedures that address the following:
  - What to do in the event of equipment disruption or failure
  - When and how to perform emergency clinical interventions when medical equipment fails
  - Availability of backup equipment
  - How to obtain repair services.
- A 9.** At a minimum, defined protocols and schedules for infection control in the procedure and recovery areas include the following:
  - Anesthetic apparatus is inspected and tested before each use by the practitioner who will administer the anesthetic. If found defective, the equipment is not used until the fault is repaired; repair of the equipment is documented.
  - Temperature control for sterilizers, refrigerators, and other machines is monitored.
  - A preventive maintenance schedule is established and maintained that includes periodic calibration, cleaning, and adjustment of all equipment, as appropriate.

**Standard EC. 6.20** Medical equipment is maintained, tested, and inspected.

**Rationale for EC.6.20**

The practice ensures performance and safety testing of all medical equipment that may pose a risk to patient safety or adversely impact the delivery of patient care.

### **Elements of Performance for EC.6.20**

- 1. Not applicable.
- A 2.** The practice documents performance and safety testing of all equipment before initial use.
- 3-4.** Not applicable.
- A 5.** The practice documents performance testing of all sterilizers used.
- 6-14.** Not applicable.
- C 15.** The practice ensures preventive maintenance and inspection of medical equipment according to a schedule based on manufacturers' recommendations, with timeframes modified by current practice experience.

**Standard EC.7.20** The practice provides an emergency electrical power source.

**Note:** *This standard applies only to office-based surgery practices using electrical life support equipment or whose patients are provided assisted mechanical ventilation or if the practice has blood, bone, and tissue storage units.*

### **Elements of Performance for EC.7.20**

- 1-4.** Not applicable.
- A 5.** Blood, bone, and tissue storage units
- 6-8.** Not applicable.
- A 9.** Medical air compressors
- A 10.** Medical and surgical vacuum systems
- 11-13.** Not applicable.
- A 14.** Operating rooms
- A 15.** Postoperative recovery rooms
- 16-17.** Not applicable.
- A 18.** An emergency backup power unit is available to provide at least 90 minutes of power to all life safety devices and resuscitative equipment when normal electricity is interrupted.

## **MANAGEMENT OF HUMAN RESOURCES (HR)**

### **OVERVIEW**

The goal of staff development, training, and competence activities in an office-based surgery practice is to identify and provide the right number of competent staff to meet the needs of patients served by the practice. The practice leaders facilitate the following activities:

- **Planning.** The planning process defines the qualifications, competencies, and staffing necessary to provide for the practice's existing and new procedures, techniques, and services.
- **Providing competent staff.** Such staffing is achieved either through traditional employer/employee arrangements or contractual arrangements with other entities.
- **Assessing, maintaining, and improving staff competence.** Ongoing, periodic competence assessment evaluates staff members' continuing abilities to perform throughout their association with the practice.
- **Promoting self-development and learning.** Staff are encouraged to pursue ongoing professional development goals and provide feedback about the work environment.

### **PLANNING**

**Standard HR.1.10** The practice provides an adequate number and mix of staff and licensed independent practitioners consistent with the practice's staffing plan.

#### **Rationale for HR.1.10**

A practice's ability to meet patients' needs with safe and effective care depends in part on attracting and retaining adequate numbers and types of qualified, competent staff.

#### **Elements of Performance for HR.1.10**

- B 1.** The practice has an adequate number and mix of staff and licensed independent practitioners to meet the care, treatment, and service needs of the patients.

### **ORIENTATION, TRAINING, AND EDUCATION**

**Standard HR.2.20** Staff and licensed independent practitioners, as appropriate, can describe or demonstrate their roles and responsibilities relative to safety.

#### **Elements of Performance for HR.2.20**

Staff and licensed independent practitioners, as appropriate, can describe or demonstrate the following:

- C 1.** Risks within the practice's environment
- C 2.** Actions to eliminate, minimize, or report risks
- C 3.** Procedures to follow in the event of an incident
- C 4.** Reporting processes for common problems, failures, and user errors

## **CREDENTIALING AND PRIVILEGING**

**Standard HR.4.10** There is a process for ensuring the competence of all practitioners permitted by law and the practice to practice independently.

### **Elements of Performance for HR.4.10**

**1-5.** Not applicable.

**A 6.** At the time of initial granting of privileges, the practice verifies, by viewing a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport), that the individual being granted (privileges) is the same individual identified in the credentialing documents.

**A 7.** The credentialing process requires that the practice does the following:

- Verifies in writing current licensure, from the primary source at the time of hire
- Verifies in writing training (required by the practice to perform the privileges) from the primary source at the time of hire.
- Verifies in writing current competence from the primary source at time of initial granting of privileges
- Obtains a statement from the applicant at the time of initial granting, renewal, or revision of clinical privileges that no health problems exist that could affect his or her ability to perform the privileges requested.\*

**Note 1:** *Verification of current licensure with the primary source through a secure electronic communication or by telephone is acceptable, if this verification is documented. For additional information, see "primary source verification" in the CAMOBS Glossary.*

**Note 2:** *An external organization (for example, a credentials verification organization [CVO] or a Joint Commission-accredited health care organization functioning as a CVO) may be used to collect credentialing information. Both of these organizations must meet the CVO guidelines listed in the Glossary section of the accreditation manual.*

**Note 3:** *A primary source of verified information may designate to an agency the role of communicating credentials information. The delegated agency then becomes acceptable to be used as a primary source.*

**A 8.** All licensed independent practitioners who provide patient care possess a license, certification, or registration as required by law and regulation.

**9-11.** Not applicable.

**B 12.** The practice is responsible for reviewing the competence assessment process every two years or whenever the practice's scope changes or new procedures are introduced.

**B 13.** Policies and procedures address the following:

- The individuals subject to them
- Lines of administrative authority and oversight
- The scope of the office-based surgery practice, including all invasive and surgical procedures and services offered
- Standards of practice, clinical pathways, clinical practice guidelines, or protocols followed by the practice (the standards of practice and so forth may be incorporated by reference)

- A process to verify individual surgeon and licensed independent practitioner credentials
- The criteria employed by the practice to determine individual surgeon and licensed independent practitioner competence to perform a specific procedure, sedation, or anesthesia service
- The mechanisms for ongoing evaluation of an individual surgeon's or licensed independent practitioner's competence to perform a specific procedure or service
- Surgeon and licensed independent practitioner involvement in developing performance expectations and conducting competence assessments of clinical and office staff subject to job descriptions.

**C 14.** Each surgeon's and licensed independent practitioner's credentials file contains sufficient documentation to show that the criteria have been verified and evaluated.

**B 15.** The credentials verification and assessment processes are periodically reviewed for effectiveness.

**A 16.** The practice obtains the following information and includes it in the credentials file: evidence of a current, unrestricted Drug Enforcement Administration registration and any history of revocation.

**A 17.** The practice obtains the following information and includes it in the credentials file: board certification, current recertification, or eligibility.

**Standard HR.4.20** Individuals permitted by law and the practice to practice independently are granted privileges.

#### **Elements of Performance for HR.4.20**

**B 1.** Based on the scope of services provided, the practice establishes criteria for each privilege. These criteria include the following:

- Current licensure and/or certification as appropriate, verified with the primary source
- Successful completion of training specific to each requested privilege, verified with primary source
- Peer and/or faculty recommendation
- Evidence of the ability to perform the requested privilege

**B 2.** Before granting privileges, the clinical leadership evaluates the following:

- Challenges to any licensure or registration
- Voluntary and involuntary relinquishment of any license or registration
- Voluntary and involuntary termination of medical staff membership at another organization
- Voluntary and involuntary limitation, reduction, or loss of clinical privileges
- Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
- Documentation as to the applicant's health status

**A 3.** The practice queries the National Practitioner Data Bank at the time of initial granting of privileges, as well as at least every two years thereafter, for information on physicians and dentists granted privileges.

- C 4.** Privileges for licensed independent practitioners are granted according to practice policy and based on the licensed independent practitioner's current credentials and competence, as well as the population(s) served and the types of care, treatment, and services provided in the practice.

Practices offering services of licensed independent practitioners through a telemedical link for either direct care or interpretive services must also meet the following requirements (EPs 5-17):

**5-16.** Not applicable

- A 17.** The practice has a clearly defined procedure for the processing of applications for the granting, renewal, or revision of clinical privileges.

The process for awarding privileges also includes the following (EPs 18-20):

- C 18.** Completed applications for privileges are acted on within the time period specified by the practice.
- C 19.** Information regarding each practitioner's scope of privileges is updated as changes in clinical privileges for each practitioner are made.
- C 20.** Decisions on granting of privileges must consider criteria that are directly related to the quality of health care, treatment, and services. If privileging criteria are used that are unrelated to quality of care, treatment, and services or professional competence, evidence exists that the impact of resulting decisions on the quality of care, treatment, and services is evaluated.
- A 21.** The practice queries the National Practitioner Data Bank at the time of renewal of privileges, and when a new privilege(s) is requested.
- B 22.** Before granting privileges, designated clinical leaders\* evaluate the following:
- Challenges to any licensure or registration
  - Voluntary and involuntary relinquishment of any license or registration
  - Voluntary and involuntary termination of medical staff membership
  - Voluntary and involuntary limitation, reduction, or loss of clinical privileges
  - Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
  - Documentation as to the applicant's health status
  - Relevant practitioner-specific data are compared to aggregate data, when available
  - Morbidity and mortality data, when available

\*Clinical leaders chosen to evaluate credentialing and privileging information should, whenever possible, represent disciplines and expertise consistent with the privileges being sought.

**Standard HR.4.60** Individual surgeons' and licensed independent practitioners' credentials information that is subject to change is reverified at least every two years and reevaluated in the event of a change in services, an unexpected adverse outcome, or a sentinel event.

**Rationale for HR.4.60**

Certain credentials information, such as the location and dates of completed medical education, residency, and internship, remain constant and do not need to be reverified. Other credentials information, such as active licensure to practice in a particular state, may change over time.

**Elements of Performance for HR.4.60**

- A 1.** No more than two years may elapse between verification and reverification of individual surgeon's and licensed independent practitioner's credentials information that is subject to change.
  
- B 2.** If there is a change in the surgical, invasive, sedation, or anesthesia procedures, services, or techniques offered, or if an unexpected or adverse outcome or sentinel event occurs, the practice reviews its credentialing and self-assessment processes and information to ensure that clinical qualifications and skill are appropriate to the procedure or service involved.

## **MANAGEMENT OF INFORMATION (IM)**

### **OVERVIEW**

The goal of information management in an office-based surgery practice is to obtain, manage, and use information to improve patient outcomes and practice performance. Effective management of information involves the following:

- Providing timely and easy access to necessary clinical and procedural information
- Maintaining the accuracy of clinical, administrative, and procedural information
- Balancing the requirements of security and ease of access
- Using aggregate and comparative data to identify and pursue opportunities for improvement

While efficiency can be improved by computerization and other technologies, the principles of good information management apply to paper-based or electronic methods. These standards are designed to be equally compatible with noncomputerized systems and evolving technologies.

### **CONFIDENTIALITY AND SECURITY**

**Standard IM.2.10** Information privacy and confidentiality are maintained.

#### **Elements of Performance for IM.2.10**

**A 1.** The practice has a policy for addressing the privacy and confidentiality of information that is based on and consistent with law or regulation.

### **PATIENT-SPECIFIC INFORMATION**

**Standard IM.6.10** The practice has a complete and accurate medical record for individuals assessed or treated.

#### **Elements of Performance for IM.6.10**

**A 1.** Only authorized individuals make entries in the medical record.

**A 2.** The practice defines which entries made by nonindependent practitioners require countersigning consistent with law or regulation.

**3.** Not applicable.

**C 4-5.** Medical record entries are dated; the author identified and, when necessary according to law or regulation or practice policy, is authenticated, either by written signature, electronic signature, or computer key or rubber stamping the following:

- The history and physical examination
- Operative reports
- Follow-up or discharge orders

**C 6.** The medical record contains sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers.

- 7-8.** Not applicable.
- A 9.** The practice defines a complete record and the time frame within which the record completed after discharge.
- 10-13.** Not applicable.
- B 14.** The retention time of medical record information is determined by the practice based on law and regulation, and on its use for patient care, treatment, and services; legal, research, and operational purposes; and educational activities.
- 15-26.** Not applicable.
- B 27.** Medical records (electronic or hard copy) are periodically reviewed, as defined by the practice, to determine if they are completed on a timely basis and if required data are present, accurate, authenticated, and legible.

