

All Accreditation Programs Survey Activity Guide

January 2022





**Survey Activity Guide
For Health Care Organizations
All Accreditation Programs**

January 2022

Issue Date: January 1, 2022

What's New for 2022

New or revised content for 2022 is identified by underlined text.

Changes effective: January 1, 2022

Ambulatory Health Care

- **Environment of Care and Emergency Management Session** – Updated
- **Orientation to the Organization, Individual Tracer Activity, System Tracer-Data Management, Leadership Session** – Added discussion topics to explore compliance with the new Performance Improvement standards and elements of performance.

Behavioral Health Care and Human Services

- **Orientation to the Organization, Individual Tracer Activity, System Tracer-Data Management, Leadership Session** – Added discussion topics to explore compliance with the new Performance Improvement standards and elements of performance.

Critical Access Hospital

- **Orientation to the Organization, Individual Tracer Activity, System Tracer – Data Management, Leadership Session** – Added discussion topics to explore compliance with the new Performance Improvement standards and elements of performance.
- **Individual Tracer, Competence Assessment Session** – Updated these activities to include discussion topics related to the new elements of performance related to workplace violence incorporated into Environment of Care, Human Resources and Leadership standards.
- **Appendix DD - Critical Access Hospital Life Safety and Environment of Care Document List and Review Tool** – Updated the list/tool to include NFPA references throughout. Updated to reflect the new EC water management standard EC.02.05.02 and EPs that take effect 1/1/2022. Also updated to include EC.02.01.01, new EP 17 requiring hospitals to conduct an annual worksite analysis related to its workplace violence prevention program.

Home Care

- **Orientation to the Organization, Individual Tracer Activity, System Tracer-Data Management, Leadership Session** – Added discussion topics to explore compliance with the new Performance Improvement standards and elements of performance.

Hospital

- **Orientation to the Organization, Individual Tracer Activity, System Tracer – Data Management, Leadership Session** – Added discussion topics to explore compliance with the new Performance Improvement standards and elements of performance.
- **Individual Tracer Activity, Competence Assessment** – Updated these activities to include discussion topics and evaluation guidance to support implementation of the new resuscitation requirements.
- **Individual Tracer, Competence Assessment Session** – Updated these activities to include discussion topics related to the new elements of performance related to workplace violence incorporated into Environment of Care, Human Resources and Leadership standards.
- **Appendix DD - Critical Access Hospital Life Safety and Environment of Care Document List and Review Tool** – Updated the list/tool to include NFPA references throughout. Updated

to reflect the new EC water management standard EC.02.05.02 and EPs that take effect 1/1/2022. Also updated to include EC.02.01.01, new EP 17 requiring hospitals to conduct an annual worksite analysis related to its workplace violence prevention program.

Laboratory

- **Orientation to the Organization, Tracer Activity** – Added discussion topics to explore compliance with the new Performance Improvement standards and elements of performance.

Nursing Care Centers

- **Orientation to the Organization, Individual Tracer Activity, Leadership and Data Use** – Added discussion topics to explore compliance with the new Performance Improvement standards and elements of performance.

How to Use this Guide

The Joint Commission's Survey Activity Guide is available on your organization's extranet site.

This guide contains:

- Information to help you prepare for survey
- An abstract of each survey activity that includes logistical needs, session objectives, an overview of the session, and suggested participants
- Sessions are listed in the general order that they are conducted.

A template agenda and a list of survey activities that occur during an onsite visit are posted to your organization's *Joint Commission Connect* extranet site in proximity to the time your application is received and reviewed. When the template agenda and survey activity list is available, please download and review the activities and think about the people you might like to have involved. The activity list includes a column in which you can record participant names or positions next to each of the sessions. Identifying key participants (and their phone numbers) for each session, including back-ups, is important. Consider including possible meeting locations and surveyor workspace in your planning documents. Reference the sessions in this Survey Activity Guide and learn more about what you can expect to occur during the activity.

The template agenda and activity list include suggested duration and scheduling guidelines for each of the activities. On the first day of survey, there will be an opportunity for you to collaborate with the surveyor in preparing an agenda for the visit that is considerate of your day-to-day operations.

Please Note: Not all the activities described in this guide are included in the activity list or on the agenda template. Many of the accreditation program-specific activities are designed to take place during individual tracer activity. Surveyors will incorporate these into the onsite survey when they are applicable to your organization.

For **complex organizations** (being surveyed under more than one accreditation manual or for more than one service under one accreditation manual), you will receive an activity list and agenda template for each of the programs being surveyed (e.g., hospital, home care, long term care). Include an organization contact name and phone number for each program, as well as, names or positions and phone numbers of activity participants from all of the programs on these activity lists. Identify when it would be most effective to conduct an activity with all programs present (e.g., Leadership, Daily Briefing, and System Tracer--Data Management) and suggest this to the surveyors when they arrive.

For multiple services being surveyed under a single accreditation program, be sure to include contact names and phone numbers from all your organization's services. For example, Home Care might have the following services: Home Health, Hospice, Personal Care /Support Services, Home Medical Equipment, or Pharmacy.

Finally, please recognize that this Survey Activity Guide is created for small and large organizations. Some organizations will have one surveyor while others will have multiple surveyors. If you have any questions about the number of surveyors who will arrive at your site, please contact your Account Executive. If you are unsure of your Account Executive's name or phone number, call the Joint Commission switchboard operator at 630-792-3007 for assistance.

Health Care Organization Survey Activity Guide (SAG)

<p>Key: The following abbreviations are used throughout this Guide to identify specific accreditation programs and the survey activities applicable to the program.</p> <ul style="list-style-type: none"> • All – All programs (All accreditation programs listed below) • AHC – Ambulatory Health Care (surveyed from the Comprehensive Accreditation Manual for Ambulatory Health Care and not the Hospital Accreditation Manual) • BHC – Behavioral Health Care and Human Services • CAH – Critical Access Hospitals • HAP – Hospital • LAB – Laboratory • NCC – Nursing Care Centers • OBS – Office-Based Surgery • OME – Home Care - Home Health, Home Infusion Therapy, Pharmacy, Hospice • HME – Home Medical Equipment
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1- Only applies to Federal Bureau of Primary Health Care programs

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1- Applies to the following types of programs: Addictions, Children & Youth, Developmental Disabilities, Foster/Therapeutic Foster Care, Group Homes, Mental Health, and Residential Treatment

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1- Does not apply to Critical Access Hospitals

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1 -- Applies to Post-Acute Care Optional Certification surveys ONLY

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- 1- Only applies to Home Medical Equipment (HME) programs
 - 2- Applies to the following programs: Home Health/Personal Care, HME, and hospice
 - 3- Only applies to Medicare Certified Home Health
 - 4- Only applies to Inpatient Hospice programs

Preparing for Surveyor Arrival

Overview

The surveyors arrive unannounced or with short notice for most surveys. Please consult the program accreditation manual, “The Accreditation Process chapter”, “Unannounced Surveys” section, for more information about exceptions to the unannounced survey process. Changes to these exceptions may occur at any time and are published in the Joint Commission newsletter *Perspectives*.

***All CMS deemed surveys or surveys conducted for CMS recognition are unannounced.**

Comments received from staff in accredited organizations indicate that a planned approach for the surveyor’s arrival allows them to feel calmer and more synchronized with the survey. Whether the surveyor arrival is announced or unannounced, the first hour of the surveyor’s day is devoted to planning for your survey activities. This planning requires review of specific documents provided by your organization which can be found on the Document Lists for each accreditation program in the pages that follow. If these documents are not available when the surveyors arrive, they immediately begin to evaluate the care, treatment, or services provided to one of your patients/residents/individuals served through an individual tracer.

Preparing for Survey

Prepare a plan for staff to follow when surveyors arrive. The plan should include:

- Greeting surveyors: Identify the staff usually at the main entrance of your organization. Tell them about The Joint Commission and educate them about what to do upon the arrival of surveyors. Explain the importance of verifying any surveyor’s identity by viewing their Joint Commission identification badge. This badge is a picture ID.
- Who to notify upon their arrival: Identify leaders and staff who must be notified when surveyors arrive. Create a list of names, phone numbers, or cell phone numbers. Also, include the individual who will be the surveyor’s “contact person” during the survey. Identify alternate individuals in the event that leaders and staff are unavailable.
- A location for surveyors: Ask surveyors to wait in the lobby until an organization contact person is available. Surveyors will need a location that they will call their “base” throughout the survey. This location should have a desk or table, electrical outlet, phone access, **and internet access**.
- Validation of survey: Identify who will be responsible for the validation of the survey and the identity of surveyors. Identify the steps to be taken for this process. (See Surveyor Arrival Session for these steps.)
- Readiness Guide and Accreditation Program-specific Document Lists: The Guide is created for you to use as a planning tool and can be included with your survey plan. The document list portion of the Readiness Guide now appears as six separate lists specific to each accreditation program. Your organization should be prepared to have documents available for each program for which you are seeking accreditation. These documents should be given to surveyors as soon as your organization validates their identity. **If this information is not immediately available for surveyors at the Surveyor Preliminary Planning Session, they will begin the survey with an individual tracer.**
- Identifying who will serve as escorts for the surveyors.
- Identifying who will assist the surveyors with review of electronic records of care, if applicable to your organization; surveyors may ask to print some components of the record in order to facilitate tracer activity and subsequent record review.
- Identifying your organization’s expectations for the on-site survey and who will share these with the survey team.

Note: When a situation is identified that could be a threat to health and safety, surveyors contact the Joint Commission administrative team. The Joint Commission either sends a different surveyor to investigate the issue or the surveyor on site will be assigned to conduct the investigation. Investigations include interviews, observation of care, treatment and service delivery and document review. Your cooperation is an important part of this process. Surveyors collaborate with the Joint Commission administrative team and outcomes will be communicated to your organization when a determination is reached.

Readiness Guide

Actions to take when surveyor arrives	Responsible Staff	Comments:
Greet surveyor(s)		
Verify identity		Look at picture ID to ensure they are from the Joint Commission
Ask them to wait		Location:
Validate authenticity of survey		Contact: _____ (this individual has a user ID and password to access the organization's Joint Commission extranet site) Phone number: _____

Note: Please download the entire Survey Activity Guide for additional information on how to prepare for survey

Document Lists and Survey Activity Lists for each accreditation program appear on the pages that follow. These lists are intended for use with the Survey Activity Guide.

Survey Planning and Readiness Notes:

1. Please review the Program-Specific Survey Activity List to assist you in preparing for your survey. The list includes the potential survey activities that can occur on an accreditation survey, including the suggested duration, and suggested timing for these activities. This information will allow your organization to begin identifying participants that need to be involved in the survey. The activity list includes a column for your organization to use for recording participant names, possible meeting locations, times that could conflict with participant availability, or any other notes.
2. If more than one of your programs is being surveyed by The Joint Commission at the same time, please consider the following in your survey readiness plans:
 - Making available as many of the materials noted on the applicable program-specific document list at the organization's primary location for the Surveyor Arrival and Preliminary Planning Session. (Note: This does not apply to the Laboratory) Program.
 - Arrangements to have a staff representative from each applicable program available in-person or by phone for the Opening Conference and Orientation to the Organization session.

Please work with your surveyor(s) to confirm the best day and time for specific survey activities to take place.

Contact your Account Executive with any questions related to this information

Ambulatory Care Accreditation Program Office-Based Surgery Accreditation Program Document List

As an Ambulatory Care or Office-Based Surgery organization, you will need the following information and documents available for the surveyor to begin reviewing during the Preliminary Planning activity with continued review throughout the survey.

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

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

For Ambulatory Surgery Center (ASC) Deemed Status surveys:

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

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

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

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

For Bureau of Primary Health Care (BPHC) surveys:

- List of Board of Directors membership, including the user/patient/consumer status, occupational/areas of expertise, geographic location, and special population representation
- Board minutes (past 12 months on all surveys); annual Uniform Data System (UDS) report
- Most recent BPHC Notice of Grant Award (with any conditions or management assessment items)

- Items from most recent BPHC Grant Application: Health Care Plan, Scope of Services; Overall Summary (if available)
- Health Center's bylaws, strategic plan, and needs assessment

Please note that this is not intended to be a comprehensive list of documentation that may be requested during the survey. Surveyors may need to see additional documents throughout the survey to further explore or validate observations or discussions with staff.

Ambulatory Care and Office-Based Surgery Accreditation Survey Activity List

Activity Name	Suggested Duration of Activity	Suggested Scheduling of Activity	Key Organization Participants (Refer to Survey Activity Guide for more info.)
Surveyor Arrival and Preliminary Planning	30-60 minutes	1 st day, upon arrival	
Opening Conference	15 minutes	1 st day, as early as possible	
Orientation to Organization	30-60 minutes	1 st day, as early as possible	
Individual Tracer	60-120 minutes	Individual Tracer activity occurs throughout the survey; the number of individuals who surveyors trace varies by organization	
Lunch	30 minutes	At a time negotiated with the organization	
Issue Resolution OR Surveyor Planning / Team Meeting	30 minutes	End of each day except last; can be scheduled at other times as necessary	
Daily Briefing	15-30 minutes	Start of each survey day except the first day; can be scheduled at other times as necessary	
Competence Assessment and Credentialing & Privileging	30-60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Environment of Care and Emergency Management	45-90 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
System Tracer – Data Management	30-90 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization. If this is the only system tracer taking place during survey, the topics of Infection Control and Medication Management will be covered in this discussion.	
Leadership	60 minutes	Towards the middle or end of survey at a time negotiated with the organization	
Surveyor Report Preparation	60-120 minutes	Last day of survey	
CEO Exit Briefing	15 minutes	Last day of survey	
Organization Exit Conference	30 minutes	Last day, final activity of survey	
Note: The following activities may be incorporated into the survey agenda as noted under the Suggested Scheduling of Activity column.			
Life Safety Code Building Assessment	45-90 minutes	Occurs on all Ambulatory Surgery Center surveys, both deemed status and non-deemed status, to evaluate compliance with the Ambulatory Health Care Occupancies chapters of the Life Safety Code® NFPA 101-2012 and Health	

Ambulatory Care and Office-Based Surgery Accreditation Survey Activity List... continued

Activity Name	Suggested Duration of Activity	Suggested Scheduling of Activity	Key Organization Participants (Refer to Survey Activity Guide for more info.)
		Care Facilities Code NFPA 99-2012. Also occurs on surveys where four or more individuals are simultaneously rendered incapable of self-preservation	
Program Specific Tracer – Continuity of Care	60-120 minutes	This focused tracer occurs during time designated for Individual Tracer Activity.	
System Tracer – Infection Control	30-60 minutes	After some individual tracer activity has occurred; topic may be covered during the Data Management system tracer depending on the length of survey	
System Tracer – Medication Management	30-60 minutes	After some individual tracer activity has occurred; topic may be covered during the Data Management system tracer depending on the length of survey	
Bureau of Primary Health Care Surveys only -- Governance Discussion	45-60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Bureau of Primary Health Care Surveys only – Clinical Leadership & Staff Discussion	60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	

Behavioral Health Care and Human Services Accreditation Program Document List

As an organization accredited under the Accreditation Manual for Behavioral Health Care and Human Services, you will need the following information and documents available for the surveyor to begin reviewing during the Preliminary Planning activity with continued review throughout the survey.

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

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

For organizations that elect the Behavioral Health Home (BHH) Certification option

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

Please note that this is not intended to be a comprehensive list of documentation that may be requested during the survey. The surveyor(s) may need to see additional documents throughout the survey to further explore or validate observations or discussions with staff.

Behavioral Health Care and Human Services Accreditation Survey Activity List

Activity Name	Suggested Duration of Activity	Suggested Scheduling of Activity	Key Organization Staff (Refer to Survey Activity Guide for more info.)
Surveyor Arrival and Preliminary Planning	30 minutes	1 st day, upon arrival	
Opening Conference	15 minutes	1 st day, as early as possible	
Orientation to Organization	45 minutes	1 st day, as early as possible	
Individual Tracer	60-120 minutes	Individual Tracer activity occurs throughout the survey; the number of individuals served that surveyors trace varies by organization. If travel is required to perform tracer activity it will be planned into this time.	
Lunch	30 minutes	At a time negotiated with the organization	
Issue Resolution OR Surveyor Planning / Team Meeting	30 minutes	End of each day except last; can be scheduled at other times as necessary	
Daily Briefing	30 minutes	Start of each survey day except the first day; can be scheduled at other times as necessary	
Competence Assessment	60 minutes	After some individual tracer activity has occurred	
Environment of Care and Emergency Management	60-90 minutes	After some individual tracer activity has occurred	
System Tracer – Data Management	60 minutes	After some individual tracer activity has occurred at a time negotiated with the organization. If this is the only system tracer taking place during survey, the topics of Infection Control and Medication Management will be covered in this discussion.	
Leadership	60 minutes	Towards the middle or end of survey at time negotiated with organization	
Report Preparation	60-90 minutes	Last day of survey	
CEO Exit Briefing	15 minutes	Last day of survey	
Interim Exit	30 minutes	Last activity on last day of survey on surveys occurring simultaneously with other program surveys, e.g., hospital	
Organization Exit Conference	30 minutes	Last day, final activity of survey	
Note: The following activities may be incorporated into the survey agenda as noted under the Suggested Scheduling of Activity column.			
Life Safety Code Building Assessment	60 minutes	Only takes place on surveys when the organization is subject to compliance with the Life Safety Code standards. See the Accreditation Manual	

Behavioral Health Care Accreditation Survey Activity List

...continued

Activity Name	Suggested Duration of Activity	Suggested Scheduling of Activity	Key Organization Staff (Refer to Survey Activity Guide for more info.)
		for Behavioral Health Care and Human Services, Life Safety chapter Overview, Applicability of the Standards section. If required, occurs at a time negotiated with organization	
Foster Parents Group Meeting	60 minutes	Only applicable to organizations providing Foster Care services. At a time negotiated with the organization	
Foster/Therapeutic Foster Family Home Visit	60-90 minutes	Only applicable to organizations providing Foster Care services. At a time negotiated with the organization	
System Tracer – Infection Control	60 minutes	After some individual tracer activity has occurred; topic may be covered during the Data Management system tracer depending on the length of survey	
System Tracer – Medication Management	60 minutes	Only occurs if the organization is responsible for any of the critical medication processes. Takes place after some individual tracer activity has occurred. Topic may be covered during the Data Management system tracer depending on the length of survey	

Hospital Accreditation Program

Critical Access Hospital Accreditation Program

Document List

As a Hospital, you will need the following information and documents available for the surveyor(s) to begin reviewing during the Preliminary Planning activity with continued review throughout the survey.

In addition to the documents noted below, please be prepared to provide the Life Safety Surveyor, upon arrival, the documents found on the Life Safety and Environment of Care Document List and Review Tool, which is located later in this Guide.

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

1. Hospital license
2. CLIA Certificates
3. Organization chart
4. Name of key contact person who can assist surveyors in planning tracer selection
5. A map of the organization, if available
6. List of all sites that are eligible for survey
7. List of sites where deep or moderate sedation is in use
8. List of sites where high-level disinfection and sterilization is in use
9. List of departments/units/ areas/programs/services within the organization, if applicable
10. List of patients that includes: Name, location, age, diagnosis, and length of stay, admit date, source of admission (ED, direct admit, transfer)
11. Lists of scheduled surgeries and special procedures, for example, cardiac catheterization, endoscopy lab, electroconvulsive therapy, caesarian sections, including location of procedure and time
12. List of unapproved abbreviations
13. List of all contracted services
14. Agreement with outside blood supplier *(Not applicable to Critical Access Hospitals unless they operate Rehab and Psych Distinct Part Units)*
15. Organ Procurement Organization agreement
16. Tissue and Eye Procurement Organization agreement
17. Organ, tissue and eye procurement policies
18. Performance improvement data from the past 12 months
19. Documentation of performance improvement projects being conducted, including the reasons for conducting the projects and the measurable progress achieved (this can be documentation in governing body minutes or other minutes)
20. Patient flow documentation: Dashboards and other reports reviewed by hospital leadership; documentation of any patient flow projects being conducted (including reasons for conducting the projects); internal throughput data collected by emergency department, inpatient units, diagnostic services, and support services such as patient transport and housekeeping
21. Analysis from a high risk process
22. Organ donation and procurement conversion rates *(Hospital only)*
23. Environment of Care data
24. Environment of Care Management Plans and annual evaluations
25. Environment of Care multidisciplinary team meeting minutes for the 12 months prior to survey
26. Hazard Vulnerability Analysis
27. Emergency Operations Plan (EOP) and documented review and update every two years, including communications plans
28. Continuity of operations, and succession and delegation of authority plans*
29. Documentation of completed/attempted contacts with local, state, tribal, regional, federal EM officials in organization's service area*

Hospital & Critical Access Hospital Accreditation Document List

...continued

30. Emergency procedures training including initial, at least every two years, and with significant updates to policies and procedures*
31. Tracking system for sheltered and relocated patients*
32. Emergency Management policy and procedures*
33. Emergency management protocols for Transplant Services* (*Hospital only*)
34. Integrated EM system risk assessments, plan, and annual review*
35. Emergency management drill records and after action reports
36. Infection Control Plan
 - Annual risk assessment and Annual Review of the Program
 - Assessment-based, prioritized goals
37. Infection Control surveillance data from the past 12 months
38. Medical Staff Bylaws and Rules and Regulations
39. Medical Executive Committee meeting minutes
40. The organization's signed and dated agreement with the QIO; in the absence of an agreement with a QIO, the organization's Utilization Review plan (*Not applicable to Critical Access Hospitals unless they operate Rehab and Psych Distinct Part Units*)
41. Governing Body minutes for the last 12 months
42. Autopsy policy (*Not applicable to Critical Access Hospitals unless they operate Rehab and Psych Distinct Part Units*)
43. Blood transfusion policy
44. Complaint/grievance policy
45. Restraint and seclusion policy
46. Waived testing policy and quality control plan
47. ORYX data – (*required only for very small hospitals exempt from submitting this data through vendors*)
48. Available regulatory reports (CMS, State)
49. Medication management policy (*which defines what is a complete medication order and therapeutic duplication*)
50. Abuse and neglect policy for inpatient, and ambulatory sites, if applicable
51. Fall risk assessment and policy
52. Document describing how the organization is using the CDC's Core Elements of Hospital Antibiotic Stewardship Programs
53. Organization approved antimicrobial stewardship protocols (for example, policies, procedures, or order sets)
54. Antimicrobial stewardship data
55. Antimicrobial stewardship reports documenting improvement (Note: If the data supports that antimicrobial stewardship improvements are not needed make sure the surveyor is informed.)
56. Final Reports of Certification/Testing for all Primary Engineering Controls and Secondary Engineering Controls associated with Sterile Medication Compounding (including any documentation of remediation/retesting conducted based on reported results) (*Hospital only*)
57. Most recent culture of safety and quality evaluation data

*These documents are related to the CMS Emergency Management Final Rule and will need to be available for surveyor review on all Deemed Status Hospital surveys. Note: Document formats may vary, and many of the documents may be included in the Emergency Operations Plan.

Please note that this is not intended to be a comprehensive list of documentation that may be requested during the survey. Surveyors may ask, on an as needed basis, to see additional documents throughout the survey to further explore or validate observations or discussions with staff.

Hospital & Critical Access Hospital Accreditation Survey Activity List

Survey Activity Name	Suggested Duration of Activity	Suggested Scheduling of Activity	Organization Participants (Refer to Survey Activity Guide for more info.)
Surveyor Arrival and Preliminary Planning	30-60 minutes	1 st day, upon arrival	
Opening Conference and Orientation to the Organization	30-60 minutes	1 st day, as early as possible	
Individual Tracer	60-120 minutes	Individual Tracer activity occurs each day throughout the survey; the number of individuals that surveyors trace varies by organization. If travel is required to perform tracer activity (e.g., to an outpatient setting), it will be planned into this time.	
Lunch	30 minutes	At a time negotiated with the organization	
Issue Resolution OR Surveyor Planning / Team Meeting	30 minutes	End of each day except last; can be scheduled at other times as necessary	
Daily Briefing	30-45 minutes	Start of each survey day except the first day; can be scheduled at other times as necessary	
Competence Assessment	30-60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Medical Staff Credentialing & Privileging	60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Emergency Management	60-90 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
System Tracer – Data Management	60 -90 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization. If this is the only system tracer taking place during survey, the topics of Infection Control and Medication Management will be covered in this discussion.	
Leadership	60 minutes	Towards the middle or end of survey at a time negotiated with the organization	
Report Preparation	60-120 minutes	Last day of survey	
CEO Exit Briefing	15-30 minutes	Last day of survey	
Organization Exit Conference	30-45 minutes	Last day, final activity of survey	
Note: The following activities may be incorporated into the survey agenda as noted under the Suggested Scheduling of Activity column.			
System Tracer – Infection Control	60 minutes	Occurs on surveys greater than three days in duration. After some individual tracer activity has occurred; at a time negotiated with the organization.	
System Tracer – Medication Management	60 minutes	Occurs on surveys greater than three days in duration. After some individual tracer activity has occurred; at a time negotiated with the organization.	

Hospital & Critical Access Hospital Accreditation Survey Activity List

...continued

Survey Activity Name	Suggested Duration of Activity	Suggested Scheduling of Activity	Organization Participants (Refer to Survey Activity Guide for more info.)
Interim Exit – w/ early departing surveyors & Org.	30 minutes	At the end of any day another program surveyor or Life Safety Code surveyor is departing from the survey in advance of the team	
Life Safety Code® Survey Activity			
Life Safety Code Surveyor Arrival and Preliminary Planning Session	30 minutes	LSCS survey 1 st day, early	
Facility Orientation / Maintenance Document Review	60-120 minutes	At a time negotiated with the organization	
Life Safety Code® Building Assessment	2 - 5 hours per day	At a time negotiated with the organization	
Lunch	30 minutes	At a time negotiated with the organization	
Emergency Management (Critical Access Hospital ONLY)	60-90 minutes	At a time negotiated with the organization	
Report Preparation	60 minutes	Towards the end of last day of survey	
Interim Exit	30 minutes	Last activity on last day of survey	

Laboratory Accreditation Program

Document List

As a Laboratory, you will need the following information and documents available for the surveyor to begin reviewing upon arrival and throughout the survey.

Note: The 24-month reference in the following items is not applicable to initial surveys, except for proficiency data. For initial surveys, a minimum of 4 months of data must be available for review.

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.

Organization Information:

- Name of key contact person who can assist surveyors in planning tracer selections
- An organizational chart and map of the facility

Regulatory Review:

- CLIA Certificates, Specialties and Subspecialties, State Licenses
- A list of specialties and subspecialties performed by the laboratory, a list of tests performed (for example, the test menu) and major instruments used by the laboratory service, including all other ancillary and point-of-care sites performing laboratory tests
- Form CMS-209 to be completed by the laboratory onsite (please refer to the CMS website to obtain the form)
- Documentation of reporting SARS-CoV-2 test results

Proficiency Testing:

- Proficiency data by CLIA number for the past 24 months (required for initial and resurveys) including all investigations, worksheets, and attestations, the last 6 events.
- A list of tests that do not use proficiency testing for accuracy and precision for verification
- Results of alternative performance verifications

Process Improvement, Infection Control and EOC:

- Performance Improvement Data for the past 24 months
- Results of periodic laboratory environment inspections from the safety committee or safety officer and manifests for disposal of hazardous waste
- Emergency Operations Plan, and evaluations of exercises and responses to actual emergencies
- Errors/accidents/nonconformances/complaints
- Internal and external audits/assessments, PI monitors
- Most recent culture of safety and quality evaluation data

Credentials, HR File Review and Competency Assessments:

- Laboratory Director(s) credential file and contract
- Personnel licenses or certification if required by the state or the policy of the organization
- List of all testing personnel qualifications, hire date, training & competency records for the past 24 months
- Proof of highest level of education for testing personnel

IQCP:

- IQCP documentation for all applicable test systems
 - Risk Assessment
 - Quality Control Plan
 - Quality Assessment
- Implementation date
- Documentation of review of Quality Control Plan

- In cases where IQCP was discontinued, risk assessment documentation for the past 24 months

General Laboratory Documentation:

- Ability to retrieve testing records for patients who have had laboratory tests or other services for the past 24 months
- Correlations and Calibration Verifications for the past two years for all test systems
- A list of new instruments and new tests that have been implemented in the past two years and their validation studies
- Temperature charts
- QC records including EQC and attempts at IQCP
 - Include daily quality control with dates and times performed as well as peer data
- List of critical equipment/supplies and maintenance records
- Policies, processes, and procedures
- The normal patient prothrombin time mean for your current lot of thromboplastin reagent
- The international sensitivity index (ISI) value specific to the lot of thromboplastin reagent in use.

Miscellaneous:

State of California Surveys: Using the **Surveyor Checklist to Unique Requirements of California Department of Public Health**, laboratories should review and ensure compliance to specific state regulations that apply to their facility (the form is available on the organizations secure Joint Commission *Connect* extranet site under the Survey Process tab, Laboratory Tools)

Laboratory Accreditation Survey Activity List

Activity Name	Suggested Duration of Activity	Suggested Scheduling of Activity	Key Organization Participants (Refer to Survey Activity Guide for more info.)
Opening Conference	15-30 minutes	1 st day, as early as possible	
Orientation to Organization	30-45 minutes	1 st day, as early as possible	
Regulatory Review	30-45 minutes	1 st day; must occur before or just after Surveyor Planning Session	
Proficiency Testing Validation/Performance Improvement Data Review	90-180 minutes	1 st day, must occur immediately after Regulatory Review	
Lunch	30 minutes	At a time negotiated with the organization	
Tracer Activity	60-120 minutes	Tracer activity occurs throughout the survey; the amount of tracer activity varies by organization	
Environment of Care and Emergency Management	45-90 minutes	Organization and surveyor determine if these topics will be covered during tracer activity, in a scheduled meeting, or a combination of the two	
Issue Resolution OR Surveyor Planning / Team Meeting	30 minutes	End of each day except last; can be scheduled at other times as necessary	
Daily Briefing	15-30 minutes	Start of each survey day except the first day; can be scheduled at other times as necessary	
Human Resources and Competence Assessment	60-120 minutes	After completion of most tracer activity. Some topics may be explored, and some record review may occur during Tracer Activity; additional record review takes place at scheduled time	
Report Preparation	60-120 minutes	Last day of survey	
CEO Exit Briefing	15 minutes	Last day of survey	
Organization Exit Conference	30 minutes	Last day, final activity of survey	

NOTE: Regulatory review may be extended for laboratories performing IQCP to provide adequate time for document review

Nursing Care Center (NCC) Accreditation Program Document List

As a Nursing Care Center, you will need the following information and documents available for the surveyor to begin reviewing during the Preliminary Planning activity with continued review throughout the 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 (for example, policies, procedures, or order sets)
 - Antimicrobial stewardship data
 - Antimicrobial stewardship reports documenting improvement (If the data supports that antimicrobial stewardship improvements are not needed make sure the surveyor is informed.)
- Most recent culture of safety and quality evaluation data

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.

Nursing Care Center Accreditation Survey Activity List

Activity Name	Suggested Duration of Activity	Suggested Scheduling of Activity	Key Organization Participants (Refer to Survey Activity Guide for more information)
Surveyor Arrival and Preliminary Planning	30-60 minutes	1 st day, upon arrival	
Opening Conference, Orientation to Organization and Brief Orientation Tour	30-60 minutes	1 st day, as early as possible	
Individual Tracer	60-120 minutes	Individual tracer activity occurs each day throughout the survey; the number of individuals that surveyors trace varies by organization	
Lunch	30 minutes	At a time negotiated with the organization	
Issue Resolution OR Surveyor Planning / Team Meeting	30 minutes	End of each day except last; can be scheduled at other times as necessary	
Daily Briefing	30-45 minutes	Start of each survey day except the first day; can be scheduled at other times as necessary	
Competence Assessment & Credentialing of Licensed Independent Practitioners	60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Environment of Care and Emergency Management	60-90 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Life Safety Code Building Assessment	30 minutes	At a time negotiated with the organization	
Leadership and Data Use	90 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization. The topics of Infection Control and Medication Management will be covered in this discussion.	
Report Preparation	60-90 minutes	Last day of survey	
CEO Exit Briefing	15 minutes	Last day of survey	
Organization Exit Conference	30 minutes	Last day, final activity of survey	
For Nursing Care Centers that elect the Post-Acute Care Certification option The following activity will be incorporated into the survey agenda as noted under the Suggested Scheduling of Activity column.			
Transitions of Care Session	60 minutes	Only occurs in organizations that elect the optional Post-Acute Care Certification. Occurs towards the middle of survey at a time negotiated with the organization.	

Home Care Accreditation Program Document List

As a Home Health, Home Infusion Therapy, Hospice, Pharmacy and/or Home Medical Equipment/DMEPOS organization, you will need the following information and documents available for the surveyor to begin reviewing during the Preliminary Planning activity with continued review throughout the survey.

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

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

Documents Needed Within One Hour of Surveyor Arrival

General Organization Information

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

Tracer Selection Documentation (Lists needed within one hour of surveyor arrival)

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

Documents Needed During the Course of the Survey

General Organization Information

- Marketing material
- Admission packet – Documents such as patient rights and responsibilities, advanced directives, consents, charges, medication education information

- Policies and Procedures including:
 - Home Safety – safety checklist, O2, signs, fire extinguisher, smoke alarm
 - Do not use abbreviations, approved abbreviations
 - Medication management policy
 - High alert medications
 - Look Alike Sound Alike (LASA) [for inpatient Hospice only]
 - Assessment and reassessment policies
 - Process/criteria for pain assessment and reassessment
 - Process/policy for case conferencing
 - Complaint process/policy
 - Budget & Surety Bond - DMEPOS
 - Equipment cleaning policy - DMEPOS
 - After Hours On-Call log - DMEPOS and Pharmacy
- Selected personnel files for employees and contractors observed during the survey will be requested for review

Performance Monitoring and Improvement Documentation

- Performance improvement data (12 months for re-surveys) including perception of care/satisfaction data
- Medication error reports and adverse drug reactions
- Fall reduction program, fall risk assessment and evaluation of program
- Patient event, incident, or unusual occurrence reports logs or summary data
- Complaint logs
- Staff event, incident, unusual occurrence reports (for example: falls, sharps injury)
- Infection Control Summary Reports, 12 months of surveillance data
- Infection Control Plan including risk analysis
- Hand hygiene program, including policy, goals and surveillance data
- Flu program including goals and analysis of refusal data
- Emergency Management plan (Annual drill and evaluation of drills)
- Clean room monitoring records - Providers of Infusion Pharmacy Services
- Most recent culture of safety and quality evaluation data

Documents Required on Deemed Status Surveys

1. Unduplicated admissions for the past 12 months with diagnosis, start of care date and disciplines
2. Discharged patients for the past 12 months with diagnosis, start of care date and disciplines
3. Last State survey report, if applicable
4. Annual program evaluation
5. Budget, capital expenditures – 3 years
6. Quarterly record review documentation (recent 12 months)
7. HHA 12 month education calendar (HHA training program, if applicable)
8. CASPER provider reports (Please provide this data by lunch of day one)
 - a. Risk Adjusted Potentially Avoidable Event Report (12 months)
 - b. Potentially Avoidable Event Report: Patient Listing (12 months)
 - c. Agency Patient Related-Characteristics Report
 - d. OASIS Submission Statistics by Agency report
 - e. Error Summary Report by HHA

9. HQRP/QAPI reports for the past quarter (initial survey) or past year (re-survey)

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

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

1. Prioritized Potential Emergencies (Hazard Vulnerability Analysis)
2. Emergency Operations Plan
3. Documentation of annual review and update of Emergency Operations Plan, including communication plans
4. Continuity of Operations Plan
5. Documentation of completed/attempted contacts with local, state, tribal, regional, federal EM officials in organization's service area
6. Annual training
7. Patient evacuation procedures (inpatient hospice)
8. Tracking system for patients sheltered on-site and patients relocated to alternate site (inpatient hospice)
9. Tabletop exercise protocol
10. Patient emergency instructions based on assessed needs (home health agencies)
11. Integrated system risk assessments, plan, and annual review

For Hospice Inpatient facility based care sites:

- Environment of care data
- **LOGS DEMONSTRATING TESTING FOR:**
 1. Generator load tests
 2. Automatic transfer switches
 3. Battery powered exit and egress signs
 4. SEPSS
 5. Supervisory signals
 6. Audible, manual and visual fire alarms
 7. Fire pumps
 8. Fire department outside connections
 9. Staff badges that open locked doors
 10. Sliding and rolling smoke and fire doors
 11. Water tank level alarms (cold weather)
 12. Water tank temperature
 13. Main drain for obstruction
 14. Fire extinguishers
 15. Fire extinguisher maintenance
- **DOCUMENTS DEMONSTRATING:**
 1. Fire drills with staff participation
 2. Water temperature in patients' rooms
 3. Policy and testing for water biologicals
 4. Cooler and freezer temperature logs (kitchen)
 5. Fire suppression system in hood over gas range is cleaned (kitchen)
 6. Kitchen hood, duct work and filters are cleaned
 7. Dishwasher temperatures

8. Eye wash water tests
9. SDS for all cleaning products
10. Wood fireplace vents / chimney cleaned

- **POLICIES:**

1. Conduct of environmental tours
2. Biological testing
3. Narcotic disposal process
4. Expired / recalled medication process
5. Patients bringing home medications into IPU

For Pharmacy Surveys:

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

Please note that this is not intended to be a comprehensive list of documentation that may be requested during the survey. Surveyors may need to see additional documents throughout the survey to further explore or validate observations or discussions with staff.

Home Care Accreditation Survey Activity List

Activity Name	Suggested Duration of Activity	Suggested Scheduling of Activity	Organization Participants (Refer to the Survey Activity Guide for more information)
Surveyor Arrival and Preliminary Planning	30-60 minutes	1 st day, upon arrival	
Opening Conference	30-60 minutes	1 st day, as early as possible; may be combined with the Orientation to Organization on surveys of shorter duration	
Orientation to Organization	45 minutes	1 st day, as early as possible; may be combined with the Opening Conference on surveys of shorter duration	
Individual Tracer	90-120 minutes	Individual Tracer activity occurs throughout the survey; the number of individuals that surveyors trace varies by organization. Travel to perform tracer activity (e.g., patient home visits) will be planned into this time.	
Lunch	30 minutes	At a time negotiated with the organization	
Issue Resolution OR Surveyor Planning / Team Meeting	30 minutes	End of each day except last; can be scheduled at other times as necessary	
Daily Briefing	15-30 minutes	Start of each survey day except the first day; can be scheduled at other times as necessary	
Competence Assessment	30-60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization or in conjunction with Leadership session	
Environment of Care and Emergency Management	45-90 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
System Tracer – Data Management	60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization. If this is the only system tracer taking place during survey, the topics of Infection Control and Medication Management will be covered in this discussion.	
Leadership	60 minutes	Towards the middle or end of survey at a time negotiated with the organization	
Report Preparation	90-20 minutes	Last day of survey	
CEO Exit Briefing	15-30 minutes	Last day of survey	
Interim Exit	30 minutes	Last activity on last day of survey on surveys occurring simultaneously with other program surveys, e.g., hospital	
Organization Exit Conference	30-45 minutes	Last day, final activity of survey	
Note: The following activities may be incorporated into the survey agenda as noted under the Suggested Scheduling of Activity column.			
System Tracer – Infection Control	30-60 minutes	After some individual tracer activity has occurred; topic may be covered during the Data Management system tracer depending on the length of survey	

Activity Name	Suggested Duration of Activity	Suggested Scheduling of Activity	Organization Participants (Refer to the Survey Activity Guide for more information)
System Tracer – Medication Management	30-60 minutes	After some individual tracer activity has occurred; topic may be covered during the Data Management system tracer depending on the length of survey	
Life Safety Code Building Assessment (NFPA 101-2012; NFPA 99-2012 Health Care Facilities Code)	60-90 minutes	Only occurs on Facility-Based Hospice surveys; at time negotiated with organization	
Regulatory Review	45-60 minutes	Only occurs on DMEPOS surveys; At time negotiated with organization	

Surveyor Arrival

Joint Commission Participants

Surveyors

Organization Participants

Suggested participants include organization staff and leaders as identified in the Pre-survey Planning process.

Logistical Needs

Identify a location where surveyors can wait for organization staff to greet them and a location where surveyors can consider as their “base” throughout the survey.

Overview

Surveyors arrive at approximately 7:45-7:50 a.m. unless business hours, as provided in the application, indicate that your organization opens later. Surveyors will check in at the front desk, identifying themselves as Joint Commission surveyors.

Surveyor Arrival Activities

- Implement your Readiness Guide as discussed in the Preparing For Surveyor Arrival section
- Notify key organization members as identified in the pre-survey planning session of the surveyor's arrival
- Validate that the survey is legitimate by accessing your Joint Commission extranet site. A staff member in your organization with a login and password to your Joint Commission extranet website will follow through with this by:
 - Accessing the Joint Commission's website at www.jointcommission.org
 - Click on “the Joint Commission Connect” logo
 - Enter a login and password
 - If you cannot access the extranet site to validate the survey or surveyors, call your Account Executive
- Your organization's extranet site contains the following information (posted by 7:30 a.m. on the morning of your survey):
 - Notification of scheduled Joint Commission event authorizing the surveyor's presence for the unannounced survey
 - Surveyor name(s), picture and biographical sketch
 - Scheduled survey dates
- If you have not already downloaded a copy of your survey agenda, do so at this time.
- Begin gathering and presenting documents as identified in the Document List applicable to your program(s). Surveyors will start reviewing this information immediately.

Surveyor Preliminary Planning Session

Joint Commission Participants

Surveyors

Organization Participants

Suggested participants include the staff responsible for coordinating The Joint Commission survey and others as needed and identified by surveyors.

Logistical Needs

The suggested duration of this session is approximately 30 to 60 minutes. Surveyors need a workspace they can use as their “base” for the duration of the survey. This area should have a desk or table, telephone, **internet access**, and access to an electrical outlet, if possible. Provide the surveyors with the name and phone number of a key contact person who will assist them in planning for the survey and their tracer selection.

Refer to the program-specific Document Lists on the preceding pages and have as much of this information available for the surveyor as possible for this activity.

Objectives

Surveyors will:

- Review organization documents to become acquainted with your organization
- Plan for tracer activity

Overview

After surveyors have arrived and their identification has been verified, surveyors immediately begin planning for tracer activity by reviewing the documents you provide them. They begin discussing the focus of the survey with the other surveyors (when applicable). If documents are not available for surveyors to review during this session, they will proceed to areas where care, treatment, or services are provided and begin individual tracer activity.

For **complex organizations** being surveyed under more than one accreditation manual or for more than one service under one accreditation manual), surveyors review information from all accredited programs. It is important to have documents available at this session for each program being surveyed.

Opening Conference

Joint Commission Participants

Surveyors

Organization Participants

Suggested participants include members of the governing body and senior leadership (representing all accredited programs/services). Attendees should be able to address leadership's responsibilities for planning, resource allocation, management, oversight, performance improvement, and support in carrying out your organization's mission and strategic objectives. Other attendees may include at least one member of the governing body or organization trustee and leaders of the medical staff, when applicable.

Logistical Needs

The duration of this session is approximately 15 minutes. Immediately following this session is the Orientation to Your Organization. If possible, designate a room or space that will hold all participants and will allow for an interactive discussion. Inform surveyors at this time of any agenda considerations that may impact the activities for the day.

Objectives

Surveyors will:

- Describe the structure of the survey
- Answer questions your organization has about the survey
- Review your organization's expectations for the survey

Overview

Surveyors introduce themselves and describe each component of the survey agenda. Surveyors describe the System Tracers they will conduct. It is important for you to discuss and review your organization's expectations for the on-site survey with the surveyor(s). Questions about the on-site visit, schedule of activities, availability of documents or people and any other related topics should be raised at this time. Surveyors will also take time to introduce your organization to the revised Clarification procedures and new SAFER™ reporting process.

Nursing Care Centers: Surveyors explain the patient and resident-centered approach to the survey process and the need to interview patients and residents privately.

Orientation to Your Organization

Joint Commission Participants

Surveyors

Organization Participants

Suggested participants include the same participants as the Opening Conference. Suggested participants include members of the governing body and senior leadership (representing all accredited programs/services). Attendees should be able to address leadership's responsibilities for planning, resource allocation, management, oversight, performance improvement, and support in carrying out your organization's mission and strategic objectives. Other attendees may include administrators, at least one member of the governing body or organization trustee and leaders of the medical staff, when applicable.

For Office-Based Surgery organizations: It is very helpful if physicians can be present for at least some portion of this session.

Logistical Needs

The suggested duration of this session is approximately 30-60 minutes. **Do not prepare a formal presentation.** This session is an interactive discussion, and it is usually combined with the Opening Conference.

Objective

Surveyors will learn about your organization through an interactive dialogue to help focus subsequent survey activities.

Overview

During this session surveyors become acquainted with your organization. They begin to learn how your organization is governed and operated, discuss leaders' planning priorities, and explore your organization's performance improvement process.

Governance and operations-related topics for discussion include:

- Organization's mission, vision, goals, and strategic initiatives
- Organization structure
- Operational management structure
- Information management, especially the format and maintenance of medical records
- Contracted services and performance monitoring, including telemedicine services
- Health care errors reduction and/or patient/resident/individual served safety initiatives
 - **Critical Access Hospitals, Hospitals:** Processes in place for reporting "close calls" or "near misses"
 - **Critical Access Hospitals, Hospitals:** Frequency with which process is being used, analysis of data, including root cause analyses
- National Patient Safety Goals (July 1, 2019 revised goal requirements for Anticoagulant therapy (NPSG.03.05.01 for **Ambulatory Care-Medical Centers only, Hospital, Critical Access Hospital and Nursing Care Centers**) and Suicide risk reduction (NPSG.15.01.01 for **Hospital, Behavioral Health Care and Human Services**)
- Community involvement
- Leader's role in emergency management planning
- The organization's patient population
- Organization activities related to risk awareness, detection and response as it relates to cyber emergencies
- **Critical Access Hospitals, Hospitals:** Assessment of the organization's culture and attention to safety
 - Instrument being used
 - Scope of assessment
 - Response rate
 - Assessment results

- Actions to improve results
- **Critical Access Hospitals, Hospitals:** Organization's code of conduct and behavior for physicians and staff
- **Ambulatory Care, Home Care, Hospital:** Cleaning, disinfection and sterilization
- **Behavioral Health Care and Human Services:** Use of a standardized tool or instrument to measure outcomes
- **Nursing Care Centers:** Culture transformation, initiatives for patient and resident centered care
- **Ambulatory Care, Critical Access Hospital, Home Care, Hospital, and Nursing Care Centers:** Pain assessment, pain management including nonpharmacologic treatment modalities, and safe opioid prescribing, when applicable
- **Hospital:** Patient flow, specifically, inpatient admission sources, volume and types of patients seen in the emergency department, how ED throughput is monitored, managing care of patients presenting with conditions outside the scope of services (e.g., mental health, trauma), patient boarding
- **Hospital:** Organ procurement and donation including conversion rates
- **Laboratory:** Test utilization and process for addition/deletion of tests and quality management system in place (e.g. IQCP)
- **Home Care, Pharmacy:** Medication compounding services, scope, types, structure, workflows, and technology in use
- **Ambulatory Care, Critical Access Hospital, Hospital:** Imaging services, scope, types, including fluoroscopy services, locations, safety

Discussion topics include your:

- Leaders' ideas of your organization's potential risk areas
- Leader's approach to completing the Focused Standards Assessment (FSA) Tool and methods used to address areas needing improvement (resurveys only)
- Management and leadership's oversight and other responsibilities

Senior Leadership Role in Improving Performance discussion topics may include:

- How leaders set expectations, plan (set priorities), assess, and measure initiatives to improve the quality of services
- Routine performance monitoring and identifying and prioritizing improvement projects
- Use of data in strategic and project-level decision-making and planning
- Improvement methodology and improvement tools being used
- Organization approach to safety, including selection of Proactive Risk Assessment topics, resulting improvements, and Board/Governance involvement in safety issues
- Provision of personnel and resources including time, information systems, data management, and staff training

Note: Surveyors will request examples of performance improvement initiatives including evidence that performance was achieved and sustained.

Individual Tracer Activity

Joint Commission Participants

One surveyor per individual tracer

Organization Participants

Suggested participants include staff and management involved in the individual's care, treatment, and services.

Logistical Needs

The suggested duration of individual tracer activity varies but typically is 60-120 minutes. Care is taken by surveyors to assure confidentiality and privacy and they will seek the help and guidance of staff in this effort. Surveyors may use multiple individual served/patient/resident records of care, treatment or services during an individual tracer. The purpose of using the record is to guide the review, following the care, treatment, or services provided by the organization to the individual served/patient/resident.

A surveyor may arrive in a setting/unit/program/service and need to wait for staff to become available. If this happens, the surveyor may use this time to evaluate environment of care issues or observe the care, treatment, or services being rendered.

If there are multiple surveyors conducting the survey, they will make every effort to avoid visiting areas at the same time and will try to minimize multiple visits to the same location. However, an individual tracer does follow where the individual served/patient/resident received services.

Objective

The surveyor will evaluate your organization's compliance with standards as they relate to the care and services provided to individuals served/patients/residents.

Overview

The majority of survey activity occurs during individual tracers. The term "individual tracer" denotes the survey method used to evaluate your organization's compliance with standards related to the care, treatment, and services provided to an individual served/patient/resident. Most of this survey activity occurs at the point where care, treatment, or services are provided.

Initially, the selection of individual tracer candidates is based on your organization's clinical services as reported in your e-application and the general risk areas identified for the accreditation program which are listed in the Intra-Cycle Monitoring (ICM) Profile. Surveyors will also consider any organization-specific risk areas listed in the ICM Profile. As the survey progresses, the surveyors may select individuals served/patients/residents with more complex situations, which are identified through the system tracers, and whose care crosses programs. For Laboratory surveys, additional tracers may be selected through review of proficiency testing and quality control data.

The individual tracer begins in the setting/unit/program/service/location where the individual served/patient/resident and his/her record of care are located. The surveyor starts the tracer by reviewing a record of care with the staff person responsible for the individual's care, treatment, or services. The surveyor then begins the tracer by:

- Following the course of care, treatment, or services provided to the individual served/patient/resident from preadmission through post discharge
- Assessing the interrelationships between disciplines, departments, programs, services, or units (where applicable), and the important functions in the care, treatment or services provided
- Identifying issues that will lead to further exploration in the system tracers or other survey activities such as Environment of Care and Leadership Sessions

During the individual tracer, the surveyor observes the following (includes but is not limited to):

- Care, treatment or services being provided to individuals served/patients/residents by clinicians, including physicians
- **Nursing Care Centers:** Patients who will be discharged on antimicrobials
- The medication process (e.g., preparation, dispensing, administration, storage, control of medications)
- Infection control issues (e.g., techniques for hand hygiene, sterilization of equipment, disinfection, food sanitation, and housekeeping)
- The process for planning care, treatment or services
- The environment as it relates to the safety of individuals served/patients/residents and staff
- **Laboratory:** Quality control, IQCP documentation (as applicable), maintenance and testing performance
- **Behavioral Health Care and Human Services:** Administration of the organization's standardized tool or instrument for measuring outcomes to an individual served
- **Home Care, Pharmacy:** The Home Care pharmacy surveyor will be observing the actual compounding process and reviewing applicable policies as needed. He or she will enter the clean room to observe and will follow all organization requirements for staff entering the clean room (e.g., level of garb used for a pharmacist observing, but not engaging in actual sterile compounding).
 - A minimum of three (3) compounding activities per compounding risk level (low, medium, and high) will be selected. These must:
 - Be representative of the target therapies compounded in the organization
 - Include hazardous medications and radiopharmaceuticals, if they are being compounded in the organization
 - NOTE: If the organization receives compounded radiopharmaceuticals from an outside source, the reviewer will visit the area and speak to the staff that receives these medications.
 - Medium and high-risk compounding will be prioritized. For example, compounding of TPN, compounding of chemotherapy, compounding of product from non-sterile powder such as narcotic infusions
 - If your organization does not do any high-risk compounding, 3 medium and 3 low risk medications will be selected for review.

During the individual tracer, the surveyor interviews staff about:

- Processes as they relate to the standards
- Intradepartmental and interdepartmental communication for the coordination of care, treatment or services. (e.g., hand offs)
- The use of data in the care of patients, and for improving organization performance; their awareness and involvement in performance improvement projects
- Individual served/patient/resident flow through the organization
- National Patient Safety Goals (July 1, 2019 revised goal requirements for Anticoagulant therapy (NPSG.03.05.01 for **Ambulatory Care-Medical Centers only, Hospital, Critical Access Hospital and Nursing Care Centers**) and Suicide risk reduction (NPSG.15.01.01 for **Hospital, Behavioral Health Care and Human Services**))
- Individual served/patient/resident education
- Orientation, education, and competency of staff

- 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
 - 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, staff may be asked to describe their access procedures (passwords, authentication, etc.), confidentiality measures, and instructions on down-time procedures
 - How they approach risk awareness, detection and/or response as it relates to potential cyber emergencies
- **Hospitals, Critical Access Hospitals, and Nursing Care Centers:** The education staff have been provided on antimicrobial resistance and the organization's antimicrobial stewardship program
- **Behavioral Health Care and Human Services:** Process for physical pain screening
- **Behavioral Health Care and Human Services Acute 24-hour settings (includes inpatient crisis stabilization or medical detoxification):** Process for physical pain assessment and treatment or referral for treatment
- **Ambulatory Care, Behavioral Health, Critical Access Hospitals, Home Care, Hospitals, Nursing Care Centers:** Pain assessment, pain management and safe opioid prescribing initiatives, when applicable, and resources made available by the organization; Prescription Drug Monitoring Database and criteria for accessing, when applicable
- **Critical Access Hospitals, Hospitals:** Awareness of and participation in a safety culture assessment; awareness of assessment results
- **Critical Access Hospitals, Hospitals:** Reporting near misses/close calls as well as actual errors; awareness of any organization processes to look at these occurrences
- **Critical Access Hospitals, Hospitals:** Organization's code of conduct/behavior; reporting intimidating behavior or perceived violations of such codes
- **Critical Access Hospitals, Hospitals:** The organization's workplace violence prevention program and any education, training, and resources they have received on workplace violence prevention, including how to report incidents
- **Behavioral Health Care and Human Services:** The standardized tool or instrument that is being used to measure outcomes
- **Home Care, Pharmacy:** Medication compounding related topics such as orientation, performance review of technique, gloved fingertip test and performance of media fill, accessing safety data sheets, staff safety and protection when hazardous medication are being prepared, cleaning hoods or isolators, checking compounding work, beyond use date (BUD)
- **Ambulatory Care:** As applicable to the organization's services, the surveyor may select a patient receiving care, treatment, or services related to the organization's annual antimicrobial stewardship goal and discuss: Antimicrobial stewardship guidelines the organization is using and staff training and education about appropriate prescribing practices.
- Other issues

During the individual tracer, the surveyor may speak with available licensed independent practitioners about:

- Organization processes that support or may be a barrier to individual served/patient/resident care, treatment, and services
- Communications and coordination with other licensed independent practitioners (hospitalists, consulting physicians, primary care practitioners)

- Discharge planning, or other transitions-related resources and processes available through the organization
- Awareness of roles and responsibilities related to the Environment of Care, including prevention of, and response to incidents and reporting of events that occurred
- **Hospitals, Critical Access Hospitals, and Nursing Care Centers:** The education or information they have been provided on antimicrobial resistance and the organization's antimicrobial stewardship program
- **Ambulatory Care:** As applicable to the organization's services, the surveyor may select a patient receiving care, treatment, or services related to the organization's annual antimicrobial stewardship goal and discuss: Antimicrobial stewardship guidelines the organization is using and provider training and education about appropriate prescribing practices.
- **Ambulatory Care, Behavioral Health Care and Human Services, Critical Access Hospitals, Home Care, Hospital, and Nursing Care Centers:** Pain assessment, pain management and safe opioid prescribing initiatives, when applicable and resources made available by the organization; Prescription Drug Monitoring Database and criteria for accessing, when applicable
- **Critical Access Hospitals, Hospitals:** Awareness of and participation in a safety culture assessment; awareness of assessment results
- **Critical Access Hospitals, Hospitals:** Reporting near misses/close calls as well as actual errors; awareness of any organization processes to look at these occurrences
- **Critical Access Hospitals, Hospitals:** Organization's code of conduct/behavior; reporting intimidating behavior or perceived violations of such codes
- **Critical Access Hospitals, Hospitals:** The organization's workplace violence prevention program and any education, training, and resources they have received on workplace violence prevention, including how to report incidents
-

During the individual tracer, the surveyor interviews individuals served/patients/residents and their families about:

- Coordination and timeliness of services provided
- Education, including discharge instructions
- Response time when call bell is initiated or alarms ring, as warranted by care, treatment or services
- Perception of care, treatment or services
- Staff observance of hand-washing and verifying their identity
- Understanding of instructions (e.g., diet or movement restrictions, medications, discharge and provider follow-up), as applicable
- **Ambulatory, Critical Access Hospitals, Home Care, Hospitals:** How staff involved them in their pain management plan of care, what their pain management plan of care includes (non-pharmacologic, pharmacologic or a combination of approaches)
- **Hospital:** Discharge planning and instructions
- Rights of individuals served/patients/residents
- **Behavioral Health Care and Human Services:** Their experience with the standardized tool or instrument to measure and track their outcomes including their understanding of how it is used to monitor their progress, and whether anyone from their care team discuss data with them
- **Home Care, Pharmacy:** The infusion the patient is receiving, including about the frequency, delivery, storage, etc.

- Other issues

Home Medical Equipment only: The surveyor requests the manufacturer, model, and serial numbers for all medical equipment provided by your organization.

Home Medical Equipment Mail Order: The surveyor traces mail order clients/patients in the same manner. They will utilize telephone support in lieu of patient home visits.

Home Medical Equipment Walk-in Business: The surveyor traces the client/patient services when they arrive at your organization. Due to the unscheduled nature of this business, survey activity is interrupted to accommodate tracers for walk-in clients/patients.

Using individual tracers for continuous evaluation

Many organizations find tracer activity helpful in the continuous evaluation of their services. If you choose to conduct mock tracers, in addition to clinical services, consider the following criteria in selecting the individual served/patient/resident.

Selection Criteria

- Individuals served/patients/residents related to system tracers such as infection control and medication management
- Individuals served/patients/residents who move between programs/services (e.g. individuals served/patients/residents scheduled for a follow-up in ambulatory care, home care patients received from the hospital, long term care residents transferred from the hospital, individuals served receiving behavioral health care and human services and ambulatory health care services, individuals served moving from behavioral health care residential program to a day program, patients referred to another specialty provider within the same organization, patients who received radiology or laboratory services, assisted living residents receiving home care services)
- Individuals served/patients/residents recently admitted
- Individuals served/patients/residents due for discharge or recently discharged
- Individuals served/patients/residents who cover multiple additional criteria listed below

Ambulatory Health Care and Office Based Surgery: Surgery/Anesthesia Services

- Operative and other procedures
- IV/Infusion therapy
- Blood/blood component administration
- Alternative complementary care
- Care for a terminal condition
- Pediatric or less than 18 year old care
- Geriatric care
- Pain Management, including a patient receiving opioid medications

Medical/Dental Services:

- Maternal/childcare
- Pediatric or less than 18 year old care
- Geriatric care
- Terminal condition
- Equipment maintenance

Bureau of Primary Health Care:

Care provided to:

- School-based health center patients
- Homeless patients
- Migrant and seasonal farm workers
- Individuals in public housing
- Individuals with HIV/AIDS

Other Services:

- Pain Management (uncontrolled pain)
- High risk areas
- Equipment Maintenance
- Cleaning, disinfection, and sterilization
- Point of Care Testing (CLIA Waived Testing)

Behavioral Health Care and Human Services:

Care provided through programs and services to:

- High risk populations (restraint use, seclusion, suicidal)
- Vulnerable populations (very young [child welfare recipients], very old, reclusive, persons with intellectual or developmental disabilities)
- Long length of stay populations (perhaps more complicated)

Home Care (any service, as applicable)

Care provided to:

- A patient who is on a high-risk medication or piece of equipment
- A patient receiving ventilator care
- A pediatric patient or a patient < 18 years old
- A patient receiving Maternal/Childcare
- A patient receiving IV/Infusion therapy
- A patient receiving blood/blood component administration
- A patient undergoing acute care re-hospitalizations
- A patient receiving personal care and support services
- A patient receiving alternative complementary care
- A patient receiving oxygen therapy
- A patient in a terminal condition

Hospice Services:

- A patient receiving facility-based care within the past 12 months
- A patient receiving continuous care/respite care
- A patient to whom infusion therapy is being administered
- A pediatric patient or a patient <18 years old
- A patient receiving alternative complementary care
- A patient being treated for pain

Home Medical Equipment:

Patients who use:

- Custom adult wheelchairs (usually fixed frame requiring assessment and fitting)
- Custom pediatric wheelchairs (usually fixed frame requiring assessment and fitting)
- Custom seating systems associated with the provision of wheelchairs
- Custom power wheelchairs (including power stretchers, etc.)
- Standard adult and pediatric power wheelchairs (custom and non-custom)
- Custom adult and pediatric ambulatory aids (prone standers, circular walkers, etc.)
- A customer receiving multiple types of equipment
- A customer receiving clinical respiratory services
- A customer receiving rehab technology services
- A patient receiving customized orthotics or prosthetics
- A patient using respiratory equipment
- A patient using durable medical equipment
- A patient using specialized equipment with supplies

Pharmacy:

A patient receiving a high-risk medication

Hospitals and Critical Access Hospitals:

- A patient in the intensive care units (MICU, SICU, CVCU, etc.)
- A patient who entered the health care system through the emergency department
- A patient with cardiac arrest
- A patient in labor and delivery services (including patients scheduled for C-section)
- A patient who receives sedation and anesthesia (includes hand-off communication)
- A patient on a skilled nursing unit and/or subacute care
- A patient who is a 23-hour admit
- A patient receiving dialysis
- A psychiatric patient
- A pediatric patient
- A patient receiving radiology or nuclear medicine services
- A patient receiving rehabilitation services
- A patient who is a possible organ donor or transplant recipient
- A patient receiving waived lab services
- A deceased patient or terminal patient
- A patient discharged (or retrospective review and interview of recently discharged patient)
- A patient receiving opioid medications

Laboratory

- Patient sample testing in laboratory sections (i.e., hematology, chemistry, microbiology, blood bank)
- Policy and procedures that guide testing performance of patient samples
- Maintenance of laboratory equipment
- Pre- and Post- analytical procedures

Nursing Care Centers

- Patient or resident receiving health services coordination (i.e., medication management, skin integrity, complex medical services)
- Patient or resident with limited mobility
- Resident who smokes
- Resident from a special population (children/young adults, neurologic ITBI, developmentally disabled)
- Resident with a dementia diagnosis
- Resident on an antipsychotic medication
- Resident residing in the organization's distinct dementia or memory care unit, if applicable
- Resident receiving supervised assistance with one or more Activities of Daily Living
- Patient or resident receiving rehabilitation therapy
- Patient or resident receiving opioid medications
- Organization's quality indicators from MDS, if available

Program Specific Tracer – Continuity of Care

Joint Commission Participants

Surveyor

Organization Participants

Suggested participants include staff involved in an individual's care, treatment, or services.

Logistical Needs

This focused tracer occurs during time designated for Individual Tracer Activity.

Objectives

The surveyor will:

- Evaluate the effectiveness of your organization's processes from prescribing a diagnostic study through the follow-up of the patient
- Identify processes and system level issues contributing to missed follow-up of diagnostic studies

Overview

Organizations providing medical services, by design, have patients who often receive care from multiple clinicians. A frequently cited concern by care providers is missing an abnormal test result and failing to coordinate necessary follow-up. The surveyor conducts an in-depth evaluation of the communication, coordination, and continuity of care for a patient receiving laboratory or diagnostic studies.

The surveyor reviews the clinical record and may interview the patient, family, and other health care staff involved in the patient's care.

Applicable Programs

BHC

[24 hour care settings only;Addictions, Children & Youth,
Residential Treatment, Group
homes, Developmental Disabilities,
Foster /Therapeutic Foster Care,
Mental Health]**Program Specific Tracer – Elopement****Joint Commission Participants**

Surveyor

Organization Participants

Suggested participants include staff and management who have been involved in the care, treatment, or services of the individual served

Logistical Needs

This focused tracer occurs during time designated for Individual Tracer Activity

Objectives

The surveyor will:

- Evaluate the effectiveness of the organization's processes to prevent elopement therefore enhancing safety
- Identify process and system level issues contributing to successful elopements

Overview

The surveyor selects an individual served who eloped multiple times. The surveyor begins by reviewing the case/clinical record for the events leading up to the elopement of the individual served. The surveyor evaluates your organization's physical environment and security systems.

The surveyor interviews staff about the elopement and the processes that are in place to prevent elopement and ensure the safety of individuals served.

The surveyor also interviews the individual served, if available, and family, if applicable about:

- Their perception of the services provided, the episode of elopement, the causation and treatment, and use of restraints
- Elopement prevention activities for which they are aware
- Guidance provided from staff to prevent escalation in the future

Program Specific Tracer – Continuity of Foster/Therapeutic Foster Care

Joint Commission Participants

Surveyor

Organization Participants

Suggested participants include the case manager, individual served, and foster parents/family members

Logistical Needs

This focused tracer occurs during time designated for Individual Tracer Activity

Objectives

The surveyor will:

- Evaluate the effectiveness of the foster care agency's processes surrounding number of foster home placements
- Identify processes and system level issues contributing to multiple placements

Overview

A problem in Foster Care may be the issue of multiple foster home placements of a single individual served. This leads to disconnects in the continuity of care, a sense of alienation and isolation, and potential for the foster care agency/organization missing serious problems with the individual served.

The surveyor selects an individual served with multiple foster homes within the foster care agency being surveyed. The surveyor conducts a home visit at the current foster home and interviews the individual served about their experience with foster care homes; their perception of issues that led to multiple placements; and their involvement in the process including communications from their case worker.

The surveyor also interviews foster parents/caregivers, when possible, about the placement process and how they were assessed for fostering.

The surveyor interviews the case manager about:

- the assessment processes
- content and use of information communicated from a state or county agency
- process and content of basic assessment to ensure the safety of the individual served and foster family when emergency placement is made
- compliance with the triage process for initial placement
- the use of guiding criteria for appropriate placement
- ongoing evaluation of the foster family

Program Specific Tracer – Violence

Joint Commission Participants

Surveyor

Organization Participants

Suggested participants include staff and management involved in the care, treatment, or services of the individual served.

Logistical Needs

This focused tracer occurs during time designated for Individual Tracer Activity

Objectives

The surveyor will:

- Evaluate the effectiveness of your organization's processes to control violence and ensure the safety of others
- Identify process and system level issues contributing to violent behavior

Overview

The surveyor selects an individual served who had a history of violent behavior with or without injury to self, staff, or others. The surveyor begins the tracer by reviewing the clinical record to identify the documentation of events leading up to the violence. The surveyor also evaluates the following:

- The physical environment that could make violent behavior possible
- Measures taken by your organization to ensure security for individuals served
- Security systems such as security cameras and alarm mechanisms, when present

The surveyor interviews the individual served and family about the following:

- Their perception of the episodes of violent behavior and use of restraints
- Violent behavior prevention activities
- Guidance provided from staff to prevent further violent behavior

The surveyor interviews staff about the following issues:

- The episodes of violent behavior
- Communication to other caregivers
- Inclusion of the individual served and family in identifying the risk for and prevention of violent behavior
- The risk assessment process
- Restraint use
- Orientation and training of staff about violent behavior risks and de-escalation techniques

Program Specific Tracer - Suicide Prevention

Joint Commission Participants

Surveyor

Organization Participants

Staff and management who have been involved in the care, treatment, or services of the individual served

Logistical Needs

This focused tracer occurs during time designated for Individual Tracer Activity

Objectives

The surveyor will:

- Evaluate the effectiveness of your organization's suicide prevention strategy
- Identify processes and system level issues contributing to suicide attempts

Overview

Suicide ranks as the 11th most frequent cause of death (third most frequent in young people) in the United States, with one person dying from suicide every 16.6 minutes. Suicide of a care recipient while in a staffed, round-the-clock care setting has been the #1 most frequently reported sentinel event to the Joint Commission. Identification of individuals at risk for suicide while under the care of or following discharge from a behavioral health care and human services organization or a hospital psychiatric inpatient setting, is an important first step in protecting and planning the care of these at-risk individuals.

The surveyor begins by reviewing the record of the patient/individual served to attain an understanding of services provided and individual served/patient specific issues. The surveyor interviews the clinical staff working with the individual served/patient about the following issues:

- Crisis process
- Initial assessment process
- Reassessment process
- Environmental assessment for ligatures and other risks for self-harm and/or suicide (BHC, HAP)
- Planning of care, treatment or services
- Mitigation plans for individual served/patient at high-risk for suicide (BHC, HAP)
- Continuum of care, treatment or services
- Education provided to the individual served/patient and family
- Orientation, training, and competency of clinicians
- Staffing
- Information management

Program Specific Tracer - Laboratory Integration

Joint Commission Participants

Surveyor

Organization Participants

Suggested participants include laboratory and other hospital staff

Logistical Needs

This focused tracer occurs during time designated for Individual Tracer Activity

Objectives

The surveyor will:

- Evaluate the consistent application of processes related to laboratory testing throughout the hospital
- Evaluate the exchange of information (specimen collection and handling, specimen identification) and integration of the laboratory processes in the hospital setting
- Evaluate the involvement of laboratory personnel in important processes within the hospital, such as point of care testing

Overview

The surveyor traces the processes and flow of communication between the laboratory and hospital units, beginning with the order for testing, and moving through physician/licensed independent practitioners actions based on testing results.

This tracer does not address laboratory functioning, quality control, proficiency testing, or technical competence. It does address the communication and integration between the hospital and the laboratory. The surveyor will review collected data and seek to understand actions taken by leaders.

Program Specific Tracer – Patient Flow

Joint Commission Participants

Surveyor

Organization Participants

Staff involved in patient care, treatment, or services throughout the hospital and leaders responsible for the planning, development and oversight of related systems, as available

Logistical Needs

This focused tracer occurs during time designated for Individual Tracer Activity

Objectives

The surveyor will:

- Look for organization awareness and improvements in patient flow
- Evaluate process issues throughout the hospital contributing to patient flow concerns

Overview

Growing concerns from the health care field about increasing patient congestion continue. Poorly managed patient flow most often impacts vulnerable areas in the hospital first, such as the emergency department, critical care units and surgical areas; but these are not always the causative factors and answers lie throughout the hospital. Treatment delays, medical errors and generally, unsafe practices thrive in the presence of patient congestion; these are precursors to and contributing factors in negative sentinel events. Many hospitals have improved their flow of patients through due diligence. Joint Commission accredited hospitals are required to identify and correct patient flow issues throughout their organization. While evidence of patient flow issues surface in the emergency department, post anesthesia care unit or other patient care units, corrective improvements must be organization-wide.

Surveyors may trace patients who were affected by patient flow issues, (e.g., bed availability delays, lengthy boarding experiences, transport or transfer delays, delays in performing tests and receiving test results, availability of providers), during their hospitalization that may or may not have impacted their care, treatment or services. Surveyors seek information at different locations throughout the hospital about unit-specific and hospital-wide processes that support unrestricted patient flow.

Discussions with leaders occur to learn more about the data that is being collected and monitored related to patient flow. Surveyors will want to learn about leaders sharing accountability with the medical staff for patient flow situations, and the actions being taken throughout the organization to mitigate the impact of patient flow issues. Surveyors will have these discussions with leaders per the planned agenda encounters; however, if a department leader or manager is available during the tracer the surveyor will speak with them at that time.

Program Specific Tracer – Staffing

Joint Commission Participants

Surveyors

Organization Participants

The surveyor will suggest participants. This may include CNAs, as applicable; agency staff; non-nursing ancillary staff; administrator; family council members, if available (may be telephonic); and other leaders

Logistical Needs

This focused tracer occurs during time designated for Individual Tracer Activity. Documents that are requested include staffing plans, staff variance reports, and meeting minutes.

Objectives

The surveyor will:

- Evaluate actions taken by your organization during staff turnover to ensure positive outcomes to resident care
- Identify processes and possibly system issues contributing to negative resident outcomes in light of staff or administrative turnover

Overview

The focus of this session is to identify breeches in continuity of care and explore operational processes in the presence of staff or administrative turnover.

The surveyor conducts individual interviews with staff that includes the following discussions:

- Processes pertaining to the care of residents to prevent negative outcomes
- Barriers to those processes
- Staff's knowledge of the residents for which they are assigned
- Perception of issues leading to turnover
- Staff communication
- Recruitment and hiring practices
- Orientation and training
- Changes in policy, procedure, vision, expectations

The surveyor also conducts interviews with residents and/or their family members (family interviews can be conducted telephonically) to ask questions about:

- The care received and the perceived barriers to that care
- Communication regarding administrative and staff turnover
- Changes in the provision of care when there is administrative or staff turnover

The surveyor conducts individual interviews with leadership (for example, governing body member, administrator, director of nursing, etc.) to discuss their knowledge regarding:

- MDS outcomes
- Association of negative outcomes with staff issues
- Follow-up actions taken
- Monitoring of actions taken
- Communication of changes in mission, vision, process, etc.
- Methods used to stabilize or prevent turnover

Program Specific Tracer – Equipment & Supply Management**Joint Commission Participants**

Surveyor

Organization Participants

Suggested participants include staff from various areas such as drivers, technicians, and warehouse employees.

Logistical Needs

This focused tracer occurs during time designated for Individual Tracer Activity

Objectives

The surveyor will:

- Learn how your organization processes equipment and supplies from initial receipt through decommissioning
- Evaluate the implementation effectiveness for specific pieces of equipment
- Identify processes and system issues contributing to failed equipment/supply management

Overview

During this tracer the surveyor focuses on high risk equipment identified from individual tracers. They evaluate all aspects of procurement, inventory, cleaning, maintenance, and decommissioning. The surveyor spends time walking through the sites responsible for the equipment management plan to evaluate the following:

- Safe environment and processes
- Staff education about the equipment/supplies
- Storage
- Obtaining physician orders
- Selection of the most suitable equipment/supplies to meet the patient's needs
- Preparation for delivery
- Delivery and set-up
- Tracking equipment location
- Patient education about the care and use of equipment/supplies
- Preventive maintenance
- Equipment failure management, including back-up
- Recall of equipment – monitoring, back-up equipment process
- Equipment returns - cleaning and inspection processes
- Equipment repair
- Obsolete inventory
- Incident management

The surveyor interviews staff about:

- Any of the above processes
- Orientation, training and competency evaluation processes

Applicable Programs

OME

[Home Health / Personal Care,
Home Infusion Therapy, HME, and
Hospice]**Program Specific Tracer – Fall Reduction****Joint Commission Participants**

Surveyor

Organization Participants

Suggested participants include staff and management who have been involved in the individual's care, treatment, or services

Logistical Needs

This focused tracer occurs during time designated for Individual Tracer Activity

Objectives

The surveyor will:

- Learn how your organization evaluates the patient's risk for falls
- Evaluate the action taken to reduce the risk of falling
- Understand your organization's plan for reducing the risk of injury, should a fall occur
- Identify processes and system issues contributing to a high re-hospitalization rate
- Evaluate the organization's compliance with NPSG.09.02.01 (Reduce the risk of falls).

Overview

During this tracer, the surveyor begins where the patient's home care record is located.

The surveyor interviews the direct care provider about the following issues:

- Entry into care
- Risk assessment process for falls
- Identification of in-home environment
- Care planning process
- Coordination of care and communication process to internal and external customers
- Fall reduction education to the patient and caregiver

The surveyor conducts a home visit and interviews the patient and/or the caregiver about:

- Possible unsafe environmental issues that could lead to a fall
- Relevancy of the patient's medication to potential for falls
- Knowledge level about their fall risk status and preventive techniques to remain safe in the home

Applicable Programs

OME

[Medicare Certified Home
Health only]**Program Specific Tracer – Hospital Readmission****Joint Commission Participants**

Surveyor

Organization Participants

Suggested participants include staff and management involved in the individual's care, treatment, or services.

Logistical Needs

This focused tracer occurs during time designated for Individual Tracer Activity

Objectives

The surveyor will:

- Evaluate the action taken to reduce the hospital readmission rate
- Evaluate the accuracy of medication lists and education
- Identify processes and system issues contributing to a high re-hospitalization rate

Overview

This tracer is conducted when the home health organization has a significantly higher percentage of patients who had to be admitted to the hospital or need urgent, unplanned medical care.

The surveyor begins this tracer where the home care record is maintained.

The surveyor interviews the case manager or direct care provider about the following issues:

- Entry into care
- Assessment of the patient
- Care planning process
- Coordination of care between patient care providers
- Education provided to the patient

The surveyor conducts a home visit and interviews the patient/caregiver about the following issues:

- Conditions leading to re-hospitalization
- Review medication
- The patients understanding about their medical condition and treatment.
- Educational materials received from your organization

Special Issue Resolution

Joint Commission Participants

Surveyors

Organization Participants

None, unless otherwise requested by the survey team

Scheduling Guidelines

For surveys lasting more than one day, 30 minutes is scheduled toward the end of each day except the last for surveyors to conduct either Special Issue Resolution or engage in Surveyor Planning or Team Meeting activity. The surveyor will inform your organization's contact person what activity they will be conducting.

Logistical Needs

Surveyors will inform your organization's contact person of what documentation, if any, is needed for the Issue Resolution activity if being conducted and any staff who they would like to speak with or locations they want to visit.

Overview

This time is available for surveyors to explore any issues that may have surfaced during the survey and could not be resolved at the time they were identified (staff unavailable for interview, visit to another location required, additional file review required, etc.). Depending on the circumstances, this may include:

- The review of policies and procedures
- The review of additional patient/resident/individual served records to validate findings
- Discussions with staff, if necessary
- Review of personnel and credentials files
- Review of data, such as performance improvement results
- Other issues requiring more discussion

Surveyor Planning/Team Meeting

Joint Commission Participants

Surveyors

Organization Participants

None

Scheduling Guidelines

For surveys lasting more than one day, 30 minutes is scheduled toward the end of each day except the last for surveyors to conduct either Special Issue Resolution or engage in Surveyor Planning or Team Meeting activity. The surveyor will inform your organization's contact person of the activity they will be conducting.

Logistical Needs

Surveyors will inform the organization's contact person if they will need to have any information available.

Overview

Surveyors use this session to debrief on the day's findings and observations and plan for upcoming survey activities.

Before leaving the organization, surveyors will return organization documents to the survey coordinator / liaison. If surveyors have not returned documentation, your organization is encouraged to ask surveyors for the documents prior to their leaving.

Daily Briefing

Joint Commission Participants

Surveyors

Organization Participants

Suggested participants include representative(s) from governance, CEO/Administrator or Executive Director, individual coordinating the Joint Commission survey, and other staff at the discretion of organization leaders

Logistical Needs

The suggested duration for this session is approximately 15 to 30 minutes and it occurs every morning of a multi-day survey, except for the first day. Surveyors may ask to hold a daily briefing before concluding activity on the first day, depending on survey length and circumstances. If a surveyor is visiting a remote location, you may be asked for assistance with setting up a conference call to include all surveyors and appropriate staff from locations that were visited.

Objective

The surveyor will summarize the events of the previous day and communicate observations according to standards areas that may or may not lead to findings.

Overview

The surveyors briefly summarize the survey activities completed the previous day. During this session the surveyors make general comments regarding significant issues from the previous day, note potential non-compliance, and emphasize performance patterns or trends of concern that could lead to findings of non-compliance. The surveyors will allow you the opportunity to provide information that they may have missed or that they requested during the previous survey day. You may also present surveyors with information related to corrective actions being implemented for any issues of non-compliance. Surveyors will still record the observations and findings but will include a statement that corrective actions were implemented by the organization during the on-site survey.

Your organization should seek clarification from the surveyors about anything that you do not understand. Note that the surveyors may decide to address your concerns during a Special Issue Resolution Session, later in the day. It is important for you to seek clarification if you do not understand anything that the surveyors discuss.

Competence Assessment and Credentialing/Privileging

Joint Commission Participants Surveyor

Organization Participants

Suggested participants include staff responsible for the human resources processes; orientation and education of staff; assessing staff competency; assessing licensed independent practitioner and other credentialed practitioner competency. There should be someone with authority to access information contained in personal and credential files. For **complex organizations** (being surveyed under more than one accreditation manual or for more than one service under one accreditation manual), representatives from each applicable accreditation program or service should be available.

Logistical Needs

The suggested duration for this session is 30-60 minutes. In order to plan for a file review, inform the surveyors of your process for maintaining competency records. The review of files is not the primary focus of this session; however, the surveyor verifies process-related information through documentation in personnel or credential files. The surveyor identifies specific staff, licensed independent practitioners, or other credentialed practitioners whose files they would like to review.

Objectives

The surveyor will:

- Learn about your organization's competence assessment process for staff, licensed independent practitioners, and other credentialed practitioners
- Learn about your organization's orientation, education, and training processes as they relate to staff, licensed independent practitioners, and other credentialed practitioners

Overview

The surveyor discusses 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, and what has been 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 your organization, job responsibilities, and/or clinical responsibilities
- Experience, education, and abilities assessment
- Ongoing education and training
 - **Behavioral Health Care and Human Services:** Related to screening for physical pain. In **acute 24-hour settings (including inpatient crisis stabilization or medical detoxification):** Related to education on pain assessment and management
- **Nursing Care Centers:** Education on antimicrobial resistance and antimicrobial stewardship (Note: surveyors will not review human resource records or medical staff records related to antimicrobial stewardship) (NCC only)
- **Ambulatory Care:** As applicable to the organization's services: Any educational materials that address the organization's annual antimicrobial stewardship goal and strategies promoting appropriate prescribing practices.
- Competency assessment, maintenance, and improvement
- Competency assessment process for contracted staff, as applicable
- Process for granting of privileges to licensed independent practitioners (AHC, NCC, OBS, OME)
- **Behavioral Health Care and Human Services:** Process for assigning clinical responsibilities (BHC only)
- **Home Care, Pharmacy:** Compounding staff competence assessment
- Other topics and issues discovered during tracer activity

Competence Assessment

Joint Commission Participants

Surveyor

Organization Participants

Suggested participants include staff responsible for the human resources processes; orientation and education of staff; assessing staff competency. There should be someone with authority to access information contained in personal files. For **complex organizations** (being surveyed under more than one accreditation manual or for more than one service under one accreditation manual), representatives from each applicable accreditation program or service should be available.

Logistical Needs

The suggested duration for this session is 30-60 minutes. In order to plan for a file review, inform the surveyors of your process for maintaining competency records. The review of files is not the primary focus of this session; however, the surveyor verifies process-related information through documentation in personnel files. The surveyor identifies specific staff whose files they would like to review.

Objectives

The surveyor will:

- Learn about your organization's competence assessment process for staff
- Learn about your organization's orientation, education, and training processes as they relate to staff, encountered during individual tracers

Overview

The surveyor discusses 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, and what has been done with the results
- Performance improvement initiatives related to competency assessment for staff
- Orientation of staff to your organization, job responsibilities, and/or clinical responsibilities
- Experience, education, and abilities assessment
- Ongoing education and training
 - Education on antimicrobial resistance and antimicrobial stewardship (Note: surveyors will not review human resource records or medical staff records related to antimicrobial stewardship)
 - Resuscitation (for example, mock code, skills day, etc.)
 - Workplace violence prevention
- Competency assessment, maintenance, and improvement
- Competency assessment process for contracted staff, as applicable
- Other topics and issues discovered during the tracer activity

Environment of Care and Emergency Management Session

Joint Commission Participants

Surveyor

Organization Participants

Suggested participants include individuals familiar with the management of the environment of care and emergency management in all major areas within your organization. This may include the safety management coordinator, security management coordinator, facility manager, building utility systems manager, information technology (IT) representative, and the person responsible for emergency management.

Objective

The surveyor will assess your organization's degree of compliance with relevant standards and identify vulnerabilities and strengths in your organization's management of the environment of care and emergency management processes.

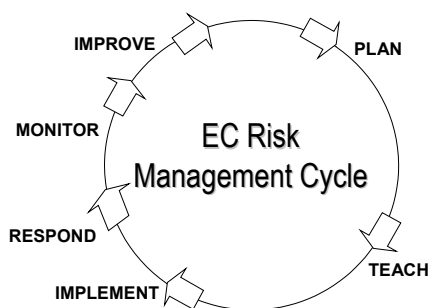
Overview

The duration of this session is approximately 45-90 minutes depending on the type of organization, services provided and facilities, and will consist of two parts: Environment of Care/Emergency Management discussion and Environment of Care tracer.

During the first part, there is a group discussion that takes approximately 70% of this session. Surveyors are not the primary speakers during this time; they are listeners to the discussion; it is not intended to be an interview. The surveyors review the Environment of Care risk categories as indicated in the matrix below, and safety data analysis and actions taken by your organization.

The remaining time is spent as the surveyor observes and evaluates your organization's performance in managing a particular risk or management process in the environment of care. The management process or risk selected for observation is based on the environment of care documents previously reviewed, observation by other surveyors, and knowledge gained during the group discussion of this session.

Environment of Care Discussion and Emergency Management (Approximately 70% of session time) – Be prepared to discuss how the various Environment of Care risk categories¹ and construction activities, when applicable, are addressed in each of the following six management processes.



Plan

- What specific risks related to its environment of care have been identified by your organization?

Teach

- How have roles/responsibilities for staff/volunteers been communicated by your organization.

¹ The environment of care risk categories include general safety and security, hazardous materials and waste, fire safety, medical/laboratory equipment, and utilities (see matrix on the next page for applicability of risk categories to each accreditation program).

Implement

- What procedures and controls (both human and physical components) does your organization implement to minimize the impact of risk to patients, visitors, and staff?

Respond

- What procedures does your organization implement to respond to an environment of care incident/failure?
- How, when, and to whom are environment of care problems, incidents, and/or failures reported within your organization.

Monitor

- How is environment of care performance (both human activities and physical components) monitored by your organization
- What monitoring activities have taken place within the last 12 months (on re-surveys)?

Improve

- What environment of care issues are currently being analyzed?
- What actions have been taken as a result of monitoring activities?

The following matrix is provided to assist in determining patterns of management process or risk category areas of concern and strengths.

	SAFETY and SECURITY ²	HAZMAT ²	EMG. MGT ²	FIRE ²	MED/LAB. EQ. ¹	UTILITIES	CONSTRUCTION ²
PLAN							
TEACH							
IMPLEMENT							
RESPOND							
MONITOR							
IMPROVE							

Note: 1 = Not applicable to Behavioral Health Care and Human Services

2 = Not applicable to Long Term Care Medicare/Medicaid Certification-Based Option Surveys

If your organization wants to conduct a mock Environment of Care Session:

1. Identify a high risk process or category
2. Determine the location for that risk or category in your plans, e.g. safety, security etc.
3. Trace the risk or category through the phases in the first column: planning, teaching, implementing, responding, monitoring and improving
4. Note any gaps between what exists and what should be in place
5. Modify the process, as needed

Be prepared to discuss your organization's performance addressing the **emergency management requirements** including performance in:

- Identifying potential emergencies that could affect demand for organization services or the organization's ability to provide services (sometimes referred to as a, Hazard Vulnerability Analysis)
- Risk, detection, and response to cyber emergencies, including leadership support for IT system resilience, and IT representation in or informing emergency management planning and activities
- Determining response strategies and how the Emergency Management Plan supports these strategies
- Identifying your role in relation to the community, county, or region emergency management program
- Identifying processes for the timely sharing of information with other health care organizations that provide services within the contiguous geographic area (*for hospitals and long term care organizations only*)
- Identifying an "all hazards" command structure that links with the community's command structure and
- Making any necessary improvements to its emergency management based on critiques of emergency management drills

Emergency Management CMS Final Rule – Applies to Home Health, Hospice, Ambulatory Surgery Centers using Joint Commission accreditation for deemed status purposes, and Rural Health Clinics and Federally Qualified Health Centers

Joint Commission surveyors will evaluate compliance with the CMS Emergency Management regulations. These regulations will be evaluated using current Joint Commission standards plus additional elements of performance (EPs) developed specifically to align with the CMS requirements. During the Emergency Management session and tracer activities, surveyors will assess the following issues in the regulation using current and revised standards:

Emergency management program that includes, but is not limited to the following:

Emergency plan, including the following:

- Review and update at least every two years, including communication plans
- Identification of patient populations served, and services offered
- Continuity of operations and succession and delegation of authority plans
- Cooperation and collaboration with local, tribal, regional, state, and federal emergency management officials
- Facility-based and community-based risk analysis (**deemed Ambulatory Surgery Centers, Home Health and Hospice only**)

Policies and procedures, including the following:

- Review and update at least every two years of policies and procedures related to emergency management plan
- Scope of responsibilities for evacuated patients
- Role of volunteers and integration of federal health care workers
- Federal disaster waivers
- Subsistence needs of sheltered/evacuated patients and staff (**deemed Home Health and Hospice only**)
- Informing state/local officials of on-duty staff and patients that cannot be located (**deemed Home Health only**)
- Tracking staff and patients (**deemed Ambulatory Surgery Centers, and Hospice only**)

Communication, including the following:

- Contact information on staff, physicians, volunteers, tribal groups, and others
- Communication with external sources of assistance for emergency response
- Primary/secondary means of communicating with external authorities (**deemed Ambulatory Surgery Centers, Home Health and Hospice only**)
- Means of providing information on condition/location of patients to community and local incident command system (ICS) (**deemed Ambulatory Surgery Centers, Home Health and Hospice only**)

Training and testing, including the following:

- Train all new and existing staff in emergency procedures initially, at least every two years, and when policies and procedures are significantly updated, and document the training
- Conducts at least one exercise annually (deemed Ambulatory Surgery Centers and Home Health only)
- Conducts two exercises annually (deemed Hospice providing inpatient care in their own facilities only)
- Outreach to community to participate in community exercises (Ambulatory Surgery Centers, Rural Health Clinics and Federally Qualified Health Centers)

Integrated Healthcare Systems option, including the following:

- Confirmation of participation in the system's integrated emergency management plan
- Designation of a staff member(s) who will collaborate with the system in developing the program
- Documentation of the organization's emergency management activities and plan in relation to the system's integrated emergency management program
- Communication procedures for planning and response activities in coordination with the system's integrated emergency preparedness program

Environment of Care Tracer (Approximately 30% of session time)

The surveyor observes and evaluates your organization's performance in managing the selected Environment of Care risk. They observe implementation of those management processes determined to be potentially vulnerable or trace a particular risk(s) in one or more of the environment of care risk categories your organization manages by:

- Beginning where the risk is encountered or first occurs. (i.e., a starting point might be where a particular safety or security incident occurs, a particular piece of medical equipment is used, or a particular hazardous material enters your organization)
- Having staff describe or demonstrate their roles and responsibilities for minimizing the risk, what they are to do if a problem or incident occurs, and how to report the problem or incident
- Assessing any physical controls for minimizing the risk (i.e., equipment, alarms, building features)
- Assessing the emergency management plan for mitigation, preparedness, response, and recovery strategies, actions and responsibilities for each priority emergency
- Assess the emergency plan for responding to utility system disruptions or failures (e.g., alternative source of utilities, notifying staff, how and when to perform emergency clinical interventions when utility systems fail, and obtaining repair services)
- If equipment, alarms, or building features are present for controlling the particular risk, reviewing implementation of relevant inspection, testing, or maintenance procedures
- If others in your organization have a role in responding to the specific problem or incident, having them describe or demonstrate that role, and reviewing the condition of any equipment they use in responding

If the risk moves around in your organization's facility (i.e., a hazardous material or waste), the surveyor follows the risk from "cradle to grave."

Facility Orientation – Life Safety Surveyor

Applicability

This activity only applies to Critical Access Hospitals and Hospitals.

Joint Commission Participants

Life Safety Surveyor

Organization Participants

Suggested participants include the individual who manages your organization's facility(ies) and other staff at the discretion of your organization. **Due to the limited amount of time the Life Safety surveyor is onsite, please be prepared to facilitate this activity upon his/her arrival.**

Logistical Needs

Upon arrival of the surveyor, an escort will be needed to take him/her to the **main** fire alarm panel to verify that it is functional. The surveyor will then meet with an organization staff member(s) to become oriented to the layout of the building. This activity is greatly facilitated if the organization has plans and drawings available that display the building fire safety features. Other documents needed for Part I of this session include your organization's:

- Policies and procedures for Interim Life Safety Measures (ILSMs)
- Written fire response plans
- Evaluations of fire drills conducted for the past 12 months
- Maintenance records for fire protections and suppressions equipment,
- Maintenance records for emergency power systems
- Maintenance records for piped medical gas and vacuum systems

A detailed listing of these documents along with their related standards and elements of performance appears in the ***Life Safety and Environment of Care Document List and Review Tool*** found later in this guide.

Objectives

The surveyor will:

- Assess the **main** fire alarm panel
- Become familiar with the building layout (including arrangement of smoke compartments, location of any suites, age of building additions, areas with sprinklers, areas under construction, and any equivalencies granted by the Joint Commission).
- Evaluate the effectiveness of processes for identifying and resolving *Life Safety Code*® (NFPA 101-2012) or environment of care risks
- Evaluate the effectiveness of processes for activities developed and implemented to protect occupants during periods when a building does not meet the applicable provisions of the *Life Safety Code*® (NFPA 101-2012) or during periods of construction
- Evaluate the effectiveness of processes for maintaining fire safety equipment and fire safety building features
- Evaluate the effectiveness of processes for maintaining and testing any emergency power systems
- Evaluate the effectiveness of processes for maintaining and testing any medical gas and vacuum systems
- Educate attendees on potential actions to take to address any identified *Life Safety Code*® (NFPA 101-2012) or environment of care risks

Life Safety Code® Building Assessment

Applicability

This activity only applies to Critical Access Hospitals and Hospitals including all CMS certified hospital outpatient surgical departments, regardless of the number of patients served, and other outpatient services locations.

Joint Commission Participants

Life Safety Code Surveyor, Clinical Surveyor in outpatient locations

Organization Participants

Suggested participants include the individual who manages your organization's facility(ies) and other staff at the discretion of your organization.

Logistical Needs

The surveyor will need a ladder and flashlight for this activity and the escort needs to have keys or tools necessary to open locked rooms, closets, or compartments to allow the surveyor access to and observation of space above the ceilings.

Objectives

The surveyor will:

- Evaluate the effectiveness of processes for maintaining fire safety equipment and fire safety building features (*NFPA 99-2012*)
- Evaluate the effectiveness of processes for maintaining and testing any emergency power systems (*NFPA 99-2012*)
- Evaluate the effectiveness of processes for maintaining and testing any medical gas and vacuum systems (*NFPA 99-2012*)
- Determine the degree of compliance with relevant *Life Safety Code®* (*NFPA 101-2012*) requirements
- Educate attendees on potential actions to take to address any identified *Life Safety Code®* (*NFPA 101-2012*) problems

Overview of Building Tour

Surveyors will:

- Assess Operating Room(s) for proper pressure relationships
- Assess required fire separations
- Assess required smoke separations (at least two)
- Assess hazardous areas, such as soiled linen rooms, trash collection rooms, and oxygen storage rooms
- Conduct an "above the ceiling" survey at each location identified above by observing the space above the ceiling to identify:
 - penetrations of smoke, fire or corridor walls
 - smoke or fire walls that are not continuous from slab-to-slab and outside wall to outside wall
 - penetrations or discontinuities of rated enclosures including hazardous areas, stairwells, chutes, shafts, and floor or roof slabs
 - corridor walls that are not slab-to-slab or do not terminate at a monolithic ceiling (if the building is fully sprinkled and the ceiling is smoke tight, the walls may terminate at the ceiling line)
 - the presence or absence of required smoke detectors or fire dampers
 - the presence or absence of required fire proofing on structural members such as columns, beams, and trusses
- Verify that fire exits per building and verify that they are continuous from the highest level they serve to the outside of the building

- Assess any kitchen grease producing cooking devices
- Assess any laundry and trash chutes (including the bottoms of any laundry and trash chutes)
- Assess the condition of all emergency power systems and equipment
- Verify that there is a reliable emergency power system that supplies electricity when normal electricity is interrupted to the following areas: exit route illumination, emergency/urgent care areas, areas where electrically powered life-support equipment is used, operating rooms, and postoperative recover rooms
- Assess any medical gas and vacuum system components including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets

Documentation of Findings

If a LSC deficiency will be recorded as a finding in the Summary of Survey Findings Report. Any “below-the-ceiling” LSC deficiencies identified by other survey team members will also be documented as a finding in the Summary of Survey Findings Report.

Emergency Management

Joint Commission Participants

Surveyor (or Life Safety Code Surveyor)

Organization Participants

Suggested participants include individuals familiar with emergency management within your organization. This may include the emergency management coordinator, safety management coordinator, security management coordinator, facility manager, building utility systems manager, information technology (IT) representative, nursing administration, infection control staff, and organizational leadership including representation from the Medical Staff.

Logistics

The suggested duration of the Emergency Management session is approximately 60-90 minutes. In preparation for this session, the surveyor evaluates the Hazard Vulnerability Analysis, the Emergency Operation Plan, annual evaluation of the Emergency Operation Plan from the previous year, and Emergency Management (EM) drills and after action reports

Objective

The surveyor will assess your organization's degree of compliance with relevant standards and identify vulnerabilities and strengths in your organization's emergency management processes structure, operations, and planning activities.

Overview

The surveyor initiates discussion around the four emergency management categories: mitigation, planning, response, and recovery. Discussion topics include:

- Your organization's involvement with your community and its relationship with other health care organizations
- Inventory of the assets it has on-site, that would be needed during an emergency.
- Capabilities and response efforts when the organization cannot be supported by the local community for at least 96 hours.
- Planning performance for the six critical functions:
 - Communication (including backup communications capabilities)
 - Resources and assets
 - Safety and Security
 - Staff responsibilities (including orientation/ competency/training of staff)
 - Utilities management
 - Patient and clinical support activities
- Your organization's processes for the disaster privileging of licensed independent practitioners and verification of other practitioners who are required to have licensure, certification or registration
- Recent improvements to the Emergency Operations Plan or any lessons learned from your emergency management exercises.
- Risk, detection and response to cyber emergencies, including leadership support for IT system resilience, and IT representation in or informing emergency management planning and activities

Emergency Management CMS Final Rule – Applies to Hospitals and Critical Access Hospitals using Joint Commission accreditation for deemed status purposes

Joint Commission surveyors will evaluate compliance with the CMS Emergency Management regulations. These regulations will be evaluated using current Joint Commission standards plus additional elements of

performance (EPs) developed specifically to align with the CMS requirements. During the Emergency Management session and tracer activities, surveyors will assess the following issues in the regulation using current and revised standards.

Emergency management program that includes, but is not limited to the following:

Emergency plan, including the following:

- Review and update at least every two years, including communication plans
- Identification of patient populations served, and services offered
- Continuity of operations and succession and delegation of authority plans
- Cooperation and collaboration with local, tribal, regional, state, and federal EM officials

Policies and Procedures, including the following:

- Review and update at least every two years of policies and procedures related to emergency management plan
- Scope of responsibilities for evacuated patients
- Role of volunteers and integration of federal health care workers
- Federal disaster waivers
- Subsistence needs of sheltered/evacuated patients and staff
- Informing state/local officials of on-duty staff and patients that cannot be located
- Tracking staff and patients

Communication, including the following:

- Contact information on staff, physicians, volunteers, tribal groups, and others
- Communication with external sources of assistance for emergency response
- Primary/secondary means of communicating with external authorities
- Means of providing information on condition/location of patients to community and local incident command system (ICS)

Training & Testing, including the following:

- Train all new and existing staff in emergency procedures initially, at least every two years, and when policies and procedures are significantly updated, and document the training
- Conducts at least two exercises annually
- Training in fire prevention and cooperation with firefighting and disaster authorities (**applies to Critical Access Hospitals only**)
- Outreach to community to participate in community exercises

Emergency and Standby Power

- Generator location

Integrated Healthcare Systems option, including the following:

- Confirmation of participation in the system's integrated emergency management plan
- Designation of a staff member(s) who will collaborate with the system in developing the program
- Documentation of the organization's emergency management activities and plan in relation to the system's integrated emergency management program.
- Communication procedures for planning and response activities in coordination with the system's integrated emergency preparedness program.

Transplant Hospitals:

- Transplant center representation in emergency planning
- Protocols addressing transplant center(s), organ procurement organizations, waivers, etc.

The survey team will follow-up on emergency management related issues during Individual Tracers, System Tracers, Leadership session, and other activities as needed.

Life Safety Code® Building Assessment

Applicability

- This activity applies to all Ambulatory Surgical Centers, both deemed status and non-deemed status surveys.
- This activity also applies to non-deemed Ambulatory Care or Office-Based Surgery organizations designated as ambulatory health care occupancies (four or more individuals who are simultaneously rendered incapable of self-preservation).
- This activity does not apply to Behavioral Health Care and Human Services organizations designated as business occupancies.
- For the Home Care accreditation program, this activity only applies to certain facility-based hospice settings.

See the Life Safety standards chapter overview in each program's Accreditation Manual for more information.

Joint Commission Participants

Surveyor

Organization Participants

Suggested participants include the individual who manages your organization's facility(ies) and other staff at the discretion of your organization.

Logistical Needs

The surveyor will need a ladder and flashlight for this activity and the escort needs to have keys or tools necessary to open locked rooms, closets, or compartments to allow the surveyor access to and observation of space above the ceilings. **NOTE:** Nursing Care Center surveyors will limit their *Life Safety Code*® tour to issues below the ceiling and will not require ladder and flashlight.

In preparation for this session, the surveyor meets with an organization staff member to become oriented to the layout of the building (including arrangement of smoke compartments, location of any suites, age of building additions, areas with sprinklers, areas under construction, and any equivalencies granted by the Joint Commission). This activity is greatly facilitated if the organization has plans and drawings available that display the building fire safety features. The surveyor will also review your organization's processes for Interim Life Safety Measures (ILSMs).

Objectives

During this session, the surveyor will:

- Evaluate the effectiveness of processes for maintaining fire safety equipment and fire safety building features (*NFPA 99-2012*)
- Evaluate the effectiveness of processes for identifying and resolving *Life Safety Code*® (*NFPA 101-2012*) problems
- Evaluate the effectiveness of processes for activities developed and implemented to protect occupants during periods when a building does not meet the applicable provisions of the *Life Safety Code*® (*NFPA 101-2012*) or during periods of construction
- Evaluate the effectiveness of processes for maintaining and testing any emergency power systems (*NFPA 99-2012*)
- Evaluate the effectiveness of processes for maintaining and testing any medical gas and vacuum systems (*NFPA 99-2012*)
- Determine the degree of compliance with relevant *Life Safety Code*® (*NFPA 101-2012*) requirements

- Educate attendees on potential actions to take to address any identified *Life Safety Code®* (NFPA 101-2012) problems

Facility Orientation

The surveyor will meet with appropriate organization staff to become oriented to the:

- Layout of the building (including arrangement of smoke compartments, location of any suites, age of building additions, areas with automatic sprinklers, areas under construction, and any equivalencies granted by the Joint Commission)
- Organization processes for Interim Life Safety Measures (ILSMs)

Building Tour

During the building tour, the surveyor will:

- Assess operating/procedure rooms for proper pressure relationships (if any)
- Assess hazardous areas, such as soiled linen rooms, trash collection rooms, and oxygen storage rooms
- Assess required fire separations
- Assess required smoke separations (at least two)
- Conduct an "above the ceiling" survey at each location identified above by observing the space above the ceiling to identify:
 - penetrations of smoke, fire or corridor walls
 - smoke or fire walls that are not continuous from slab-to-slab and outside wall to outside wall
 - penetrations or discontinuities of rated enclosures including hazardous areas, stairwells, chutes, shafts, and floor or roof slabs
 - corridor walls that are not slab-to-slab or do not terminate at a monolithic ceiling (if the building is fully sprinklered and the ceiling is smoke tight, the walls may terminate at the ceiling line)
 - the presence or absence of required smoke detectors or fire dampers
 - the presence or absence of required fire proofing on structural members such as columns, beams, and trusses
- Verify that fire exits per building and verify that they are continuous from the highest level they serve to the outside of the building
- Assess any kitchen grease producing cooking devices
- Assess the bottoms of any laundry and trash chutes
- Assess the **main** fire alarm panel (if any)
- Assess the condition of emergency power systems and equipment
- Assess any medical gas and vacuum system components including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets

Documentation of Findings

A LSC deficiency will be recorded as a Requirement for Improvement in the Summary of Survey Findings Report.

System Tracer – Data Management

Joint Commission Participants

Surveyors

Organization Participants

Suggested participants vary depending on the focus of the tracer. Surveyors inform your organization who should participate in this session.

Logistical Needs

The suggested duration for this activity is 30-90 minutes depending on the number of days surveyors spend onsite and the size and complexity of your organization. A room that can accommodate both organization and Joint Commission participants is needed.

Objective

Surveyors will learn about how your organization is using data to evaluate the safety and quality of care being provided to individuals served/patients/residents. They will also seek to understand, as well as, assess your organization's performance improvement processes including the management and use of data.

Overview

During the Surveyor Planning Session, surveyors review your organization's data. Surveyors will review your organization's data and performance improvement projects during planning activity in preparation to discuss the following topics:

- Planning for data use including how your organization identifies and prioritizes measurement and performance improvement projects
- Data collection methodology to ensure that all data is collected as planned, and that it is accurate and reliable
- Data aggregation and analysis and the processes for turning it into useful information
- Data use in your organization – be prepared with examples of how it is used on an ongoing basis, how it is used in periodic performance monitoring and project based activities
- Any improvement methodology or tools being used in performance improvement initiatives

Data-related topics that will be discussed during this session include:

- Infection Control
- Antimicrobial Stewardship including data and reports demonstrating improvement. If the data demonstrates that antimicrobial stewardship improvement is not needed make sure the surveyor is informed.
- Medication Management
- **Ambulatory Care, Critical Access Hospitals, Hospitals:** Data being collected on pain assessment, pain management and safe opioid use
- **Ambulatory Care:** As applicable to the organization's services: Any data the organization is collecting, analyzing, or reporting related to the organization's annual antimicrobial stewardship goal.
- **Hospital and Critical Access Hospital:** Antimicrobial Stewardship including:
 - A document that describes how the organization uses the *CDC's Core Elements of a Hospital Antibiotic Stewardship Program*. This information can be a separate document or can be included in other antimicrobial stewardship documents. This documentation does not have to be provided in a lengthy format but needs to describe how the core elements are addressed in their antimicrobial stewardship program.

- Organization-approved antimicrobial stewardship protocols (e.g. policies, procedures or order sets are acceptable)
- Antimicrobial stewardship multidisciplinary team
- National Patient Safety Goal data
- Contracted services performance monitoring
- Organization directed data collection
- **Behavioral Health Care:** Use of standardized tool or instrument for outcome measurement and use of the data generated at both the individual and organization level
- Proactive risk assessment, when applicable
- Regulated data collection by program, e.g., OASIS, MDS, other federal or state reporting, etc.
- Incident/error reporting
- Staffing issues
- **Hospitals:**
 - Core Measures
 - Patient flow
 - Readmission rates
- **Critical Access Hospitals and Hospitals:**
 - Assessing the organization's culture of safety
 - Instrument being used and scope of use (organization-wide or limited implementation)
 - Response rate and tracking over time
 - Results reporting
 - Benchmarking (internal and external)
 - Quality improvement projects undertaken to improve safety culture

System Tracer – Infection Control

Joint Commission Participants

Surveyors

Organization Participants

Suggested participants include the infection control coordinator for each program being surveyed; physician member of the infection control team; clinicians from the laboratory; clinicians knowledgeable about the selection of medications available for use and pharmacokinetic monitoring, as applicable; facility or facilities staff; organization leadership; and staff involved in the direct provision of care, treatment, or services.

Logistical Needs

The duration of this session is approximately 30-60 minutes. The surveyor may need a quiet area for brief interactive discussion with staff who oversee the infection control process. The remaining session is spent where the care, treatment, or services are provided.

Objectives

The surveyor will:

- Learn about the planning, implementation, and evaluation of your organization's infection control program
- Identify who is responsible for day-to-day implementation of the infection control program
- Evaluate your organization's process for the infection control plan development, outcome of the annual infection control evaluation process, and oversight of opportunities for improvement
- Understand the processes used by your organization to reduce infection

Overview

The infection control session begins during one of the individual tracers where the surveyor identifies a individual served/patient/resident with an infectious disease. This session is conducted in two parts. During the first part, surveyors meet with staff from all programs being surveyed to discuss your organization's infection control program. During the remaining time, surveyors spend their time where care, treatment, or services are provided.

Topics of discussion include:

- How individuals with infections are identified
- Laboratory testing and confirmation process, if applicable
- Staff orientation and training activities
- Current and past surveillance activity
- Analysis of infection control data
- Reporting of infection control data
- Prevention and control activities (for example, staff training, staff and licensed independent practitioner vaccinations and other health-related requirements, housekeeping procedures, organization-wide hand hygiene, food sanitation, and the storage, cleaning, disinfection, sterilization and/or disposal of supplies and equipment)
- Staff exposure
- Physical facility changes that can impact infection control
- Actions taken as a result of surveillance and outcomes of those actions

Note: These topics are covered by surveyors during other activities on surveys that do not have a specific system tracer related to infection control.

System Tracer – Medication Management

Joint Commission Participants

Surveyors

Organization Participants

Suggested participants include clinical and support staff responsible for medication processes.

Logistical Needs

The suggested duration of this session is approximately 30-60 minutes. A room is needed to accommodate organization and Joint Commission surveyor participation.

Objectives

The surveyor will:

- Learn about your organization's medication management processes
- Evaluate the continuity of medication management from procurement of medications through monitoring, if applicable
- Evaluate the medication reconciliation process during "hand-offs" from one level of care to another, if medication is prescribed

Overview

The surveyor targets a individual served/patient/resident receiving a specific medication. The review begins with the individual's record of care then follows the medication throughout the system.

For **complex organizations** being surveyed under more than one accreditation manual or for more than one service under one accreditation manual, the surveyor selects an individual served/patient/resident who is receiving a high-risk medication, who moves between or who has the potential of moving between programs/services. If a program is not involved in the selected medication, then a surveyor from each program will trace a high risk medication through their program.

For **Home Care Pharmacy** organizations being surveyed: The surveyor will observe the sterile compounding process as part of the Medication Management session, or as part of a patient tracer.

Other discussion issues include:

- **Hospital:** Antimicrobial Stewardship including:
 - A document that describes how the organization uses the *CDC's Core Elements of a Hospital Antibiotic Stewardship Program*. This information can be a separate document or can be included in other antimicrobial stewardship documents. This documentation does not have to be provided in a lengthy format but needs to describe how the core elements are addressed in their antimicrobial stewardship program.
 - Organization-approved antimicrobial stewardship protocols (e.g. policies, procedures or order sets are acceptable)
 - Antimicrobial stewardship multidisciplinary team
- **Ambulatory Care:** As applicable to the organization's services: Antimicrobial stewardship guidelines related to the organization's annual antimicrobial stewardship goal.
- Process for reporting errors, system breakdowns, near misses, or overrides
- Data collection, analysis, systems evaluation, and performance improvement initiatives
- Medications brought into an organization by the patient/resident/individual served
- Education of staff and individual served/ patient/resident
- Information management systems related to medication management
- Individual served/ patient/resident involvement in medication management

Note: These topics are covered by surveyors during other activities on surveys that do not have a specific system tracer related to medication management.

Applicable Programs

BHC

[Foster / Therapeutic Foster Care only]

Foster Family Home Visits**Joint Commission Participants**

Surveyor

Organization Participants

Suggested participants include the case manager, foster parent or family, and individual served

Logistical Needs

This focused tracer occurs during time designated for Individual Tracer Activity. The suggested duration for this activity is approximately 90 minutes. Time will be spent in the agency, traveling, and in the foster family home. To help with planning for this session, identify the foster parents/family scheduled for a visit that a Joint Commission surveyor can observe. This provides the surveyor with an opportunity to interview the individual served and the family about the foster care program. You will need to obtain written permission for the home visit from the foster parent/family. This signed permission form should be kept by your organization.

Objectives

The surveyor will:

- Assess the interaction among the foster parents/family, the individual served, and the case worker
- Assess the environmental safety issues in the home

Overview

Prior to the home visit, the surveyor asks the Case Manager for an overview of the services and care required by and provided to the individual served. This overview includes the following:

- History of the individual served
- The medical and emotional assessments of the individual served
- The case plan
- Special needs of the individual served
- The plan for coordination with other service providers
- Permanency goal for the individual served (children/youth only)
- The Case Manager's understanding of organization policies, procedures, job responsibilities and performance improvement

During the home visit, the surveyor observes the home environment for:

Staff/individual served/foster family interaction including:

- Safety, security, and confidentiality
- Communication in a language the individual served/foster family can understand
- Encouragement by the case manager for the individual served/foster family to verbalize and ask questions
- Respect for the privacy of the individual served and foster family
- Respect for their culture/religious beliefs

Care, including:

- Provision of a nurturing care environment
- Recognition of (and provision for) the assessed special needs of the individual served
- Opportunities for the individual served to interact with siblings and other members of the family of origin, if indicated in the case plan(children/youth only)
- Participation of the individual served/foster family in case planning, permanency planning (children/youth only) and planning for independent living (when appropriate)

Environmental safety issues including:

- Life safety issues such as smoke detectors in or near the sleeping room of the individual served and a large window or other means of secondary egress from the sleeping room
- Safe storage, handling, and dispensing of medications in the home

- Sanitary living conditions

Depending on the level of maturity of the individual served, and their condition, and personal wishes, the surveyor interviews him or her (without the foster parents present) to discover the opinions about his or her placement, agency support, protection of his or her individual rights, involvement in case plan decisions, and permanency planning (for children/youth only). The surveyor interviews the individual served in the presence of the case manager or other agency staff or may talk privately with him or her as long as they stay in visual contact with the foster parents and the case manager. This casual talk may include the following topics:

- His or her involvement in case planning, permanency planning (for children/youth only), and preparation for independent living (if appropriate)
- Steps taken to meet any “special needs” that may have been identified during assessment
- How his or her unique cultural/ethnic/religious needs (if any) are addressed
- How the foster parents handle the situation if he or she doesn’t obey the house rules”
- His or her understanding of their rights to safety and privacy (to learn how these issues are addressed by your organization and the foster family)
- His or her contacts with organization staff and the support services received

The surveyor will ask about information the foster parents/family received from your organization related to the following topics:

- The special physical, emotional, and social needs of the individual served
- The rights of the individual served, foster family, and family of origin
- Procedures for reporting incidents and accidents
- Support services available from your organization and the community
- Foster care financial reimbursement issues
- Respite care policies and procedures
- How to ensure a safe living environment
- Provision for the educational and health needs of the individual served
- Confidentiality of information
- How the special cultural/ethnic needs of the individual served are addressed
- Education and training provided by your organization
- Requirements for foster care family licensure
- Competency assessment and evaluation

The surveyor is also interested to know if the foster parent/family have ever identified any problems with the support or services offered by your organization and, if so, how these problems were handled.

Applicable Programs

BHC

[Foster / Therapeutic Foster Care Only]

Foster Parents Group Meeting**Joint Commission Participants**

Surveyor

Organization Participants

Suggested participants include staff who are familiar with your organization's foster care services and foster parents who are representative of all the foster care services provided by your organization.

Logistical Needs

This focused tracer occurs during time designated for Individual Tracer Activity. The suggested duration of this session is approximately 60 minutes. During this session, surveyors visit foster homes. You are responsible for making all arrangements for this visit, including securing a location, notifying foster parents of the date, time, and place. If you host a regularly scheduled meeting with foster parents for training, education, communication, or other purposes, explore the possibility of scheduling this meeting during the survey. It may be held any afternoon or evening of the survey except for the last day.

Objectives

The surveyor will:

- Learn about your organization's recruitment, licensing, and training process
- Learn about the preparation of foster parents to meet the needs of individuals served
- Learn about your organization's foster care program from the foster parent's perspective

Overview

Foster parents provide important information about a foster care program's services and support which makes them key participants in an accreditation survey. A Foster Parents Group meeting provides a surveyor the opportunity to speak with more foster parents than individual home visits will allow.

The surveyor asks about information foster parents receive from your organization regarding the following areas:

- The special physical, emotional, and social needs of the individual served
- The rights of the individual served, foster family, and family of origin
- Procedures for reporting incidents and accidents
- Support services available from your organization and the community
- Foster care financial reimbursement issues
- Respite care policies and procedures
- How to ensure a safe living environment
- Provision for the educational and health needs of the individual served
- Confidentiality of information
- How the special cultural/ethnic needs of the individual served are addressed
- Education and training provided by your organization
- Requirements for foster care family licensure, including competency

Proficiency Testing Validation/Performance Improvement Data Review

Joint Commission Participants

Surveyor

Organization Participants

Laboratory director(s) on all CLIA certificates held by the organization, the laboratory administrative director and/or manager and other staff or laboratory staff as designated by the organization

Logistical Needs

The suggested duration of this session is approximately 30 minutes. A room is needed to accommodate organization and Joint Commission surveyor participation.

Objective

The surveyor will verify that the laboratory is enrolled and participates in a CMS-approved proficiency testing program for each regulated analyte and will review proficiency testing performance for regulated and non-regulated analytes (if applicable), including documentation of remedial action for each result exceeding acceptable limits.

Overview

During this session the surveyor will review and discuss the following documents with laboratory representatives:

- All proficiency testing results for the last two years (previous six testing events)
- All records of test handling, preparation, processing, examination, and results reporting and signed attestation statements provided by the proficiency feedback reports
- Documentation of review of each proficiency report and documentation of review of problems or potential problems with remedial actions, as indicated
- Performance improvement data
- Record retention policies and procedures

Applicable Programs

OME

[HME only]

Regulatory Review - HME**Joint Commission Participants**

Clinician surveyor

Organization Participants

Suggested participants include those responsible for billing, posting revenue and reconciliation of accounts. Additionally, staff responsible for budgeting and oversight of client complaints will be interviewed.

Logistical Needs

The suggested duration of this session is approximately 60 minutes. A location with access to accounting documents is needed. Surveyors can go to the billing staff desks and review information on the computer if that is the most convenient way of viewing the information.

Objective

The surveyor will learn about your organization's financial management processes relative to Medicare/Medicaid billing and receivables

Overview

During this session the surveyor will want to learn about your organization's processes for internal oversight and reconciliation processes (monitoring) to ensure that:

- Medicare/Medicaid is being billed only for supplies and equipment provided the a patient/client; and
- Medicare/Medicaid payments are being appropriately assigned to a patient/client account; and
- Money is being deposited into the organization's account.

Surveyors will want to interview staff about your organization's process for complaint receipt, tracking and resolution and will ask to see your complaint log.

Annual Budget Review: Your organization's annual budget will be reviewed if it is available.

Regulatory Review - LAB

Joint Commission Participants

Surveyor

Organization Participants

Laboratory leadership

Logistical Needs

The suggested duration of this session is approximately 30 minutes. A room is needed to accommodate organization and Joint Commission surveyor participation.

Objective

The surveyor will verify that licensing and services provided by the laboratory comply with law and regulation.

Overview

During this session the surveyor will:

- Verify CLIA certificates:
 - Director
 - Specialties/subspecialties
 - Type corresponds to level of testing
- Verify license requirements of lab, director and staff
- Verify proficiency testing provider and enrollment period
- Determine test volumes per CMS guidelines for specialties
- Review of IQCP documentation, if applicable
- Review the documentation of SARS-CoV-2 test result reporting:
 - Review logs to assure that all test results have been reported.
 - If faxing: Verify fax transmittal confirmation that the faxes are successful.
 - If electronic or manual: Verify that the process has been validated.

Clinical Leadership and Staff Discussion

Joint Commission Participants

Surveyor

Organization Participants

Required participants include at a minimum:

- Clinical leadership
- One licensed independent practitioner or clinical staff member from each satellite/remote site that is not scheduled for a site visit
- One clinical staff member responsible for providing direct care to any special population for which the Health Center receives specific funding support (for example, homeless, migrant and seasonal farm workers, public housing residents, HIV/AIDS)
- A cross section of providers including physicians, dentists, other licensed independent practitioners, nurses, social workers, and other categories of staff who provide direct care to patients
- If all sites are scheduled for a visit, at least one person who may not otherwise be available to participate in the site visit, for example, part-time individual with clinical responsibilities who is not scheduled to work on the day of the site visit, part-time or week-end staff member, individual with a schedule conflict which would preclude participation during a scheduled on-site visit

Logistical Needs

The suggested duration of this session is approximately 60 minutes.

The surveyor will review the health care plan, credentialing and privileging policies and procedures, risk management policies and procedures, and clinical practice guidelines

Objectives

The surveyor will:

- Understand the clinical staff's role in your organization
- Learn about the clinician's understanding of performance improvement approaches and methods, and their involvement in your organization's approach to performance improvement
- Assess the interrelationships and communication between and among disciplines, departments, programs, services or settings, when applicable to your organization

Overview

Based on prior survey findings and other available information the surveyor assesses issues according to the following framework:

- Pre-entry and entry phases of the continuum of care
 - Linkage with and use of available information sources about the patient's needs
 - Linkages with other care settings within and/or outside your organization
 - Availability of and access to services consistent with your organization's mission, populations, and treatment settings or services to meet the patient's needs, including BPHC required services
 - Arrangements with other organizations and the community to facilitate entry and access to comprehensive health and social services
 - Referrals and transfers to meet the patient's needs and BPHC requirements
 - The use of clinical consultants and contractual arrangements
- Care within your organization
 - Scope of service being provided directly or indirectly; including those required by BPHC
 - Continuous flow of services from assessment through treatment and reassessment

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

Governance Discussion Session

Joint Commission Participants

Administrative surveyor (or clinician surveyor on surveys with one surveyor)

Organization Participants

Required participants include at least the following:

- Chairperson/President or Vice-Chair/Vice President
- Treasurer or Chair of the Finance Committee
- A board member who represents the users/patients/consumers, if one of the above officers is not a patient/user/consumer
- If the center receives funding for any special population groups (e.g. Migrant and Seasonal Farm Workers, Homeless Individuals, Residents of Public Housing), the representative for this population group

Note: *Board members may participate by conference call.*

Logistical Needs

The suggested duration of this session is approximately 45 to 60 minutes.

Objective

The surveyor will learn about your organization's governance, particularly as it pertains to compliance with BPHCs statutory and regulatory requirements.

Overview

The surveyor begins this session with a brief overview of the Joint Commission's mission and goals as well as a description of the benefits of the combined Joint Commission - BPHC survey. Discussion is based on relevant standards-based issues, BPHC Program Expectations required by law or regulation, and information presented by your organization during the opening conference and orientation to the organization. Information gained during the session is used to assess levels of compliance with BPHC statutory and regulatory requirements. Assessments of compliance with The Joint Commission standards may also occur.

The surveyor addresses the following issues:

- The structure and composition of the governing body
- The functioning, participation, and involvement of the governing body in the oversight and operation of your organization
- The level of communication among the board members
- The governing body's perception and implementation of its role in your organization, especially regarding the governance, and mission and strategy expectations
- The knowledge of the governing body members with respect to federal law and regulation
- The governing body's understanding of performance improvement approaches and methods and involvement in your organization's approach to performance improvement
- Pertinent Joint Commission Leadership standards relevant to the governing body's role in your organization

The surveyor engages the governing body participants in discussions regarding new processes or services in your organization, and about the collaboration and involvement of appropriate leaders and other individuals.

The surveyor reviews and summarizes the issues or opportunities for improvement that relate to the BPHC's statutory and regulatory requirements and those that are Joint Commission standards-related areas that will be addressed in subsequent system or patient tracers.

Leadership Session

Joint Commission Participants Surveyors

Organization Participants

Suggested participants include senior leaders who have responsibility and accountability for design, planning, and implementation of organization processes. Leaders typically include but are not limited to members of the governing body/trustee, CEO, and leaders of the medical staff and clinical staff.

For complex surveys, there is a single Leadership Session that will include discussion of all programs and services being accredited at the time of this survey. Surveyors from all programs should participate in this session if they are onsite. Your organization should have leadership representation from all programs undergoing survey.

Logistical Needs

The suggested duration of this session is approximately 60 minutes.

Objective

Surveyors will explore leadership's responsibility for creating and maintaining your organization's systems, infrastructure, and key processes which contribute to the quality and safety of care, treatment, or services.

Overview

During this session, surveyors will explore, through organization-specific examples,

- Leadership commitment to improvement of quality and safety
- Creating a culture of safety
- Robust process improvement
- Observations that may be indicative of system-level concerns

The surveyor facilitates discussion with leaders to understand their roles related to performance of your organization-wide processes and functions. This discussion will be a mutual exploration of both successful and perhaps less successful organization performance improvement initiatives, or introduction of a new service or an optimal performing department, unit or area vs. one in need of improvement. Surveyors will want to hear how leaders view and perceive these successes and opportunities and learn what they are doing to sustain the achievements, as well as encourage and support more of the same success. Throughout the discussion surveyors will listen for examples of:

- The planning process used
- How data is used once it is collected
- Leaders' chosen improvement methodology and tools and their satisfaction with the approach and how well it is serving their needs and those of staff

- The approach used to change processes and work flow
- How information about newly implemented processes is communicated throughout your organization
- How leaders assess the culture of safety throughout the organization
- How leaders envision the performance of processes that are selected for improvement
- Leadership support and direction, including planning and resource allocation
- The degree to which the implementation is comprehensive and organization-wide
- The relationship of the function or process to patient/resident/individual served safety and quality
- How the effective performance of the function or process is evaluated and maintained

Surveyors will also want to talk in more detail about topics such as:

- **Ambulatory Care:** As applicable to the organization's services: Antimicrobial stewardship efforts, including identification of an individual responsible for antimicrobial stewardship activities and the organization's annual antimicrobial stewardship goal.
- **Hospitals and Critical Access Hospitals:** Antimicrobial stewardship
- **Ambulatory Care, Critical Access Hospitals, Hospitals:** Pain assessment, management, and safe opioid prescribing
- **Hospitals and Critical Access Hospitals:** Safety culture in the organization, including
 - Assessment process/tool
 - Scope of assessment activity
 - Response rates
 - Willingness of people at all levels to discuss safety issues
 - Internal or external benchmarks
 - Board involvement in setting expectations
 - Leaders' response to safety concerns
 - Improvement projects undertaken to improve safety culture scores
- **Hospitals and Critical Access Hospitals:** Code of conduct/behavior for physicians and staff
 - Is it the same for everyone?
 - How do staff report intimidating behavior?
 - Is your organization monitoring frequency of intimidating or disrespectful behavior occurrences?
 - Have you been able to reduce or eradicate intimidating and disrespectful behavior?
 - Discuss organization policies and procedures for dealing with intimidating behavior
- **Hospitals and Critical Access Hospitals:** Managing near misses, close calls, actual errors
 - What is the process for staff and licensed independent practitioners to report such occurrences?
 - How often is it used? Any recent examples?
 - How does the organization determine whether actual errors, when a patient is harmed, were a system error or a person is responsible and should be held accountable?
 - Does the organization conduct root cause analyses of all near misses/close calls?

Leadership and Data Use Session

Joint Commission Participants

Surveyors

Organization Participants

Suggested participants include 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).

Logistical Needs

The suggested duration of this session is approximately 90 minutes.

Objective

Surveyors will explore and evaluate how leaders of the organization oversee the collection and use of data to evaluate the safety and quality of care being provided to patients and residents, where the organization is on its journey to high reliability, and to understand and assess the organization's performance improvement process.

Overview

During this session, the surveyor will facilitate discussion with staff to understand the organization's adoption of performance improvement fundamental principles such as:

- Efforts to achieve the characteristics of a high reliability organization—flexibility, agility, ability to sustain effective performance
- Leaders' chosen improvement methodology and tools and their satisfaction with the approach and how well it is serving their needs and those of staff

The surveyor will want to discuss how performance improvement principles are integrated into organization systems, processes, and outcomes such as

- MDS outcomes
- Medication monitoring through data including medication errors, adverse events, utilization, pain management and prescribing practices including use of opioids
 - Medical director involvement in pain assessment, pain management
- Infection prevention and control, collection and use of surveillance data
- The influenza vaccination program, including education, vaccination goals, and vaccination rates
- Antimicrobial stewardship
 - The organization's use of the CDC's *The Core Elements of Antibiotic Stewardship for Nursing Homes*
 - Demonstration that antimicrobial stewardship is an organizational priority
 - Antimicrobial stewardship multidisciplinary team functions
 - Organization development and approval of antimicrobial stewardship protocols (e.g. policies, procedures or order sets)
 - Antimicrobial stewardship data collection, analyses and reports

- Data and reports demonstrating antimicrobial stewardship improvement (if available)
- 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 culture transformation planning process, evaluation of culture transformation efforts, and the quality of person-centered care being provided to patients and residents

For NCC Organizations that elect the Post-Acute Care Certification option

The following additional topics will be explored by the surveyor during the Leadership and Data Use Session:

- Post-acute patients that are readmitted to the hospital or emergency department
- Opportunities for improvement identified following the discharge of post-acute patients

For NCC Organizations that elect the Memory Care Certification option

The following additional topics will be explored by the surveyors during the Leadership and Data Use Session:

- The role of the Coordinator in the provision of dementia care, programs, and services
- How the organization remains current with trends in the provision of dementia care
- Efforts to minimize the use of psychotropic medications, particularly antipsychotic medications

Medical Staff Credentialing and Privileging
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Joint Commission Participants

One clinician surveyor

Organization Participants

Suggested participants include the President of the medical staff; Medical Director and Medical Staff Coordinator, if applicable; and Medical staff credentials committee representatives.

Logistical Needs

The suggested duration of this session is approximately 60 minutes. The surveyor requests specific credential files of practitioners who are identified from tracers, from OR log, from the ICU and special procedures unit logs, etc. The type of files a surveyor requests are from high-risk specialties, non-physician specialties, non-physician licensed independent practitioners, moonlighters, hospitalists, practice outside the usual scope of specialty, and low volume specialties. When a **Nursing Care Center** is integrated with the hospital, the surveyor reviews credential files of the Medical Director of the NCC and other licensed independent practitioners.

The surveyor also requests the Medical Staff Bylaws, Rules, and Regulations, Medical Executive Committee minutes, peer review and focused monitoring records for the session.

Objectives

The surveyor will:

- Learn about the process used to collect data relevant to appointment decisions, the process for granting and delineating privileges, and the structures that guide consistency of implementation (e.g., bylaw requirements)
- Evaluate the credentialing and privileging process for the medical staff and other licensed independent practitioners who are privileged through the medical staff process

Overview

During this session, the surveyor discusses with organization participants:

- How your organization collects data used in making decisions on appointment, granting and delineating privileges
- Consistent implementation of the credentialing and privileging process for the medical staff and other licensed independent practitioners who are privileged through the medical staff process
- Processes for granting privileges and the delineation of privileges
- Whether practitioners practice within the limited scope of delineated privileges
- The link between peer review and focused monitoring to the credentialing and privileging process
- Potential concerns in the credentialing, privileging, and appointment process
- Education on antimicrobial resistance and antimicrobial stewardship (Note: surveyors will not review medical staff records related to antimicrobial stewardship)

Surveyor Report Preparation

Joint Commission Participants

Surveyors

Organization Participants

None

Logistical Needs

The suggested duration of this session is approximately 60-120 minutes. Surveyors need a room that includes a conference table, power outlets, telephone, and internet access.

Overview

Surveyors use this session to compile, analyze, and organize the data collected during the survey into a report reflecting your organization's compliance with the standards. Surveyors will provide you with the opportunity to present additional information at the beginning of this session if there are any outstanding surveyor requests or further evidence to present from the last day of survey activity. Surveyors may also ask organization representatives for additional information during this session.

CEO Exit Briefing

Joint Commission Participants

Surveyors

Organization Participants

Suggested participants include the Chief Executive Officer (CEO) or Administrator, if available

Logistical Needs

The suggested duration of this session is approximately 10 to 15 minutes.

Objectives

Surveyors will:

- Review the survey findings as represented in the Summary of Survey Findings Report
- Discuss any concerns about the report with the CEO/Administrator
- Determine if the CEO/Administrator wishes to have an Organization Exit Conference or if the CEO/Administrator prefers to deliver the report privately to your organization

Overview

Surveyors will review the Summary of Survey Findings Report (organized by chapter) with the most senior leader. Surveyors will discuss any patterns or trends in performance. Surveyors will also discuss with the most senior leader if they would like the Summary of Survey Findings Report copied and distributed to staff attending the Organization Exit Conference.

Organization Exit Conference

Joint Commission Participants

Surveyors

Organization Participants

Suggested participants include the CEO/Administrator (or designee), senior leaders and staff as identified by the CEO/Administrator or designee.

Logistical Needs

The suggested duration of this session is approximately 30 minutes and takes place immediately following the Exit Briefing.

Objectives

Surveyors will:

- Verbally review the Summary of Survey Findings Report, if desired by the CEO
- Review identified standards compliance issues

Overview

Surveyors will verify with participants that all documents have been returned to the organization. You are encouraged to question the surveyor about the location of documents if you are unsure.

Surveyors will review the Summary of Survey Findings Report with participants. Discussion will include the SAFER™ matrix, Requirements for Improvement, and any patterns or trends in performance. Surveyors will provide information about the revised Clarification process. If follow-up is required in the form of an Evidence of Standard Compliance (ESC) the surveyors explain the ESC submission process.

Note: Surveyors will direct you to information on your extranet site that explains “What Happens after Your Survey.”

For complex organizations (being surveyed under more than one accreditation manual or for more than one service under one accreditation manual), there may be instances when surveyors from other programs will not be present for the entire duration of the survey. In this situation, the surveyor departing early will request an Interim Exit Conference where he/she may provide your organization with a brief oral report of their findings and at that time will respond to questions.

For Hospital, Ambulatory Surgery Centers and Home Care & Hospice Deemed Status, surveyors communicate their findings relating to the Medicare Conditions of Participation. This includes describing the regulatory requirements that the organization does not meet and the findings that substantiate these deficiencies.

Organization Guide for OPTIONAL Memory Care Certification (MCC)

Joint Commission Participants:
Surveyor

Organization Participants:
Staff involved in patient or resident care, support staff, and clinical management staff, interdisciplinary team

Objective:
To survey nursing care centers identified to take part in optional certification.

Logistical Needs:
During the surveyor planning session, your organization will need to provide the surveyor with information related to the memory care services provided at your nursing care center. This information will help the surveyor determine the areas of focus for the certification survey.

- 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

Overview:
Memory Care (MCC) certification is optional and can be obtained initially through an extension survey or as part of your triennial accreditation survey. Once certification is obtained, recertification will always occur at the time of the triennial survey. If an extension survey is chosen as the route for initially obtaining MCC certification, then only the unique MCC accreditation requirements are evaluated during the certification survey. When MCC certification is obtained as part of the accreditation survey, all nursing care center standards as well as the unique MCC accreditation requirements are evaluated.

Documents to have available:
There are no additional documents required for the MCC survey beyond the list of documents to have available for the accreditation survey.

Scope of MCC survey:
The MCC survey will focus on evaluating the organization's provision of care needed for patients or residents who have been diagnosed with memory-impacting conditions such as Alzheimer's disease or dementia. The survey will include an evaluation of how the organization:

- Coordinates care through collaborative assessment and planning
- Provides care that is consistent with current advances in dementia care practices
- Ensures staff possess the knowledge and competency to assess and provide care for a patient or resident population with memory impairment
- Provides activity programming matched with the patient's or resident's cognitive ability, memory, attention span, language, reasoning ability, and physical function.
- Manages patient or resident behaviors with emphasis on the use of non-pharmacological interventions as an alternative to antipsychotic medication use
- Provides a safe and supportive physical environment to promote safety and minimize confusion and overstimulation
- Conducts PI activities related to MCC

Organization Guide for OPTIONAL Post-Acute Care Certification

Joint Commission Participants:
Surveyor

Organization Participants:
Staff involved in patient care, support staff, and clinical management staff, interdisciplinary team

Objective:
To survey nursing care centers identified to take part in optional certification.

Logistical Needs:
During the surveyor planning session, your organization will need to provide the surveyor with information related to the types of post-acute care services provided at your nursing care center, such as stroke, post-op wound care, or orthopedic rehab. Additionally, you will want to be prepared to share the average length of stay and census, as well as whether or not post-acute care services are provided in a distinct unit(s) or throughout the organization. This information will help the surveyor determine the areas of focus for the certification survey.

Overview:
Post-Acute Care (PAC) certification is optional and can be obtained initially through an extension survey or as part of your triennial accreditation survey. Once certification is obtained, recertification will always occur at the time of the triennial survey. If an extension survey is chosen as the route for initially obtaining PAC certification, then only the unique PAC accreditation requirements are evaluated during the certification survey. When PAC certification is obtained as part of the accreditation survey, all nursing care center standards as well as the unique PAC accreditation requirements are evaluated.

Documents to have available:
In addition to the list of documents to have available for the accreditation survey, organizations taking part in the optional PAC certification survey should have the following additional documents available:

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

Scope of PAC survey:
The survey will focus on evaluating the organization's provision of goal-directed, time-limited medically complex care or rehabilitative services to patients who have typically been recently hospitalized. Additionally, the survey will include an evaluation of how the organization:

- Uses clinical practice guidelines to guide the provision of care, treatment, and services of the post-acute patient
- Identifies early warning signs of a change in patient's condition and responds to a decline in condition
- Helps the patient transition from the nursing care center to a lower level of care setting or home
- Manages the discharge/post-discharge process to minimize the risk of unnecessary rehospitalizations
- Conducts initial and ongoing assessments
- Ensures physician availability and provides medical director oversight
- Provides collaborative effective communication processes
- Conducts provider hand-offs
- Conducts staff competencies
- Conducts PI activities related to PAC

Transitions of Care Session

Joint Commission Participants

Surveyor

Organization Participants

Suggested participants include 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).

Logistical Needs

The suggested duration of this session is approximately 60 minutes.

Objective

Surveyors will explore and evaluate the effectiveness of the organization's processes related to transitions of care of the post-acute patient, and to help the organization identify opportunities for process improvement.

Overview

During this session, the surveyor will facilitate discussion with staff to understand their roles related to the following processes:

- The admission process, including sources of patient referrals, procedures followed to determine if a prospective patient is eligible for admission, how communication occurs between care settings, and physician coordination of care
- Provider hand-off, including the availability of advance information to ensure timely availability of needed medications, equipment, and accommodations
- The medication reconciliation process during transitions between care settings
- How to recognize and respond to a patient's change in condition
- The development, implementation, and evaluation of the effectiveness of clinical practice guidelines
- Physician availability to meet the needs of the post-acute patient population
- The discharge process, including the provision of patient/family education, and how the organization facilitates the transfer of important information to other service providers
- The surveyor may also speak with patients and family members who have recently been admitted to the post-acute care setting or who are close to being discharged
- The post-discharge process, including the topics discussed during the follow-up communication with the patient and/or family, and how this information is used for process improvement
- The medical director's review of admissions, transfers and discharges for appropriateness

Organization Guide for OPTIONAL Primary Care Medical Home (PCMH) Certification

Joint Commission Participants:
Surveyor

Organization Participants:
Staff involved in patient care, support staff, and clinic management staff

Objective: To survey ambulatory care clinics identified by a hospital to take part in optional primary care medical home certification.

Logistical Needs:
Hospitals can choose which sites they want PCMH certified. Therefore, during the surveyor planning session, your hospital will need to provide the surveyor with information related to the services provided at those ambulatory care clinics that have been selected for primary care medical home certification, the locations or distance of the clinic from the hospital site, and the individuals who are serving in the role of the primary care clinician at each site. This information will help the surveyor determine which sites will be visited.

Overview: Primary care medical home certification is optional and can be obtained initially through an extension survey (focused only on PCMH-specific requirements) or as part of your triennial accreditation survey. Once certification is obtained, re-certification will always occur at the time of the triennial survey.

If an extension survey is chosen as the route for initially obtaining PCMH certification, then only the unique PCMH accreditation requirements are evaluated during the certification survey.

When PCMH certification is obtained as part of the accreditation survey, all hospital standards as well as the unique PCMH accreditation requirements are evaluated.

Documents to have available:

- Performance improvement data related to:
 - Disease management outcomes
 - Patient access to care
 - Patient experience and satisfaction related to access to care, treatment, or services, and communication
 - Patient perception of the comprehensiveness, coordination, and continuity of care, treatment, or services
 - Patient perception of the continuity of care
- PCMH Self-assessment tool (completion of this tool is optional). A copy of the tool can be downloaded from The Joint Commission's website at <https://www.jointcommission.org/accreditation-and-certification/certification/certifications-by-setting/hospital-certifications/primary-care-medical-home-certification/>

Scope of PCMH Site Visit:

The survey will focus on evaluating the organization's provision of patient-centered care, comprehensive care, coordinated care, and superb access to care. Additionally, the survey will include an evaluation of the organization's system-based approach to quality, that is, the commitment to quality and quality improvement through ongoing engagement in activities such as:

- Using evidence-based medicine and clinical decision support tools,
- Guiding shared decision making with patients and families,
- Engaging in performance measurement and improvement,
- Measuring and responding to patient experiences and patient satisfaction, and
- Practicing population health management.

The site visit will include evaluation of hospital accreditation standards as well as unique PCMH standards when the certification occurs at the time of the accreditation survey. An extension survey for performed for certification purposes would only include evaluation of the unique PCMH requirements.

Individual tracer activity for unique PCMH requirements will focus on areas such as:

- Information provided to patients related to access to care, treatment and services, as well as primary care clinician information (for example, information related to selection of primary care clinician, how to access clinic staff, make appointments, and obtain specialty care)
- Tracking and follow-up on referrals and test results
- Interdisciplinary team collaboration and communication
- Involvement of patients in establishing treatment goals
- How patients are assessed for health literacy, where this is information documented in the medical record and how do they ensure it is available to all care team members
- The development of self-management goals, when are they developed, and where are they documented in the medical record?
- 24/7 access to prescription renewal requests, test results, clinical advice for urgent health care needs, and appointment availability
- Competence of primary care clinicians and staff
- PI activities related to PCMH



Life Safety & Environment of Care Document List and Review Tool

Effective: 1/1/2022

The following pages present documentation required by the Hospital Accreditation Program Life Safety (LS), and selected Environment of Care (EC) standards. The Life Safety surveyor will begin review of these documents soon after arrival for the onsite survey.

Surveyors may request other EC and LS documents, as needed, throughout the survey.

This list also includes some elements of performance that do not require documentation but appear as reminders to both organizations and surveyors of these expectations.

Organizations may want to consider using this tool in their continuous compliance and survey readiness efforts.

Revisions to this document are identified by underlined text.

Additional resources, including a Fire Drill Matrix, are available on The Joint Commission website, Physical Environment Portal which is accessible using the following link: <https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/>.

Legend: C=Compliant; NC=Not compliant; NA=Not applicable; IOU=Surveyor awaiting documentation

STANDARD - EPs	See Legend				Document / Requirement	Yes	No	
	C	NC	NA	IOU				
LS.01.01.01					Buildings serving patients comply w/ NFPA 101 (2012)			
EP 1					Individual assigned to assess Life Safety Code® compliance			
EP 2					Building Assessment to determine compliance with Life Safety (LS) chapter <i>(frequency of assessment is defined by the hospital)</i>			
EP 3					Current and accurate drawings w/ fire safety features & related square footage <ul style="list-style-type: none"> a. Areas of building fully sprinklered (if building only partially sprinklered) b. Locations of all hazardous storage areas c. Locations of all fire-rated barriers d. Locations of all smoke-rated barriers e. Sleeping and non-sleeping suite boundaries, including size of identified suites f. Locations of designated smoke compartments g. Locations of chutes and shafts h. Any approved equivalencies or waivers 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
EP 5					Deemed Hospitals: Documentation of inspections and approvals made by state or local AHJs			
EP 7					The hospital maintains current Basic Building Information (BBI) within the Statement of Conditions (SOC).			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.01.01					The hospital manages safety and security risks.			
EP 17					The hospital conducts an annual worksite analysis related to its workplace <u>violence prevention program</u> . The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the <u>analysis</u> . Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Yes	No	
	C	NC	NA	IOU				
EC.02.03.01					Hospital Manages Fire Risk – Fire Response Plan			
EP 9					<p>The written fire response plan describes the specific roles of staff and LIPs at and away from fire including:</p> <ul style="list-style-type: none"> • When and how to sound and report fire alarms • How to contain smoke and fire • How to use a fire extinguisher • How to assist and relocate patients • How to evacuate to areas of refuge <p>Staff and LIPs periodically instructed on/kept informed of duties under plan</p> <p>Copy of plan readily available with telephone operator or security <u>NFPA 101-2012: 18/19.7.1; 7.2</u></p>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
EC.02.03.05					Fire Protection and Suppression Testing and Inspection					
EP 1					Supervisory Signals-including: Control valves; pressure supervisory; pressure tank, pressure supervisory for a dry pipe (both high and low conditions), steam pressure; water level supervisory signal initiating device; water temperature supervisory; and room temperature supervisory. <u>NFPA 72-2010: Table 14.4.5</u>	Quarterly				
EP 2					Water flow devices <u>NFPA 72-2010: Table 14.4.5</u> <u>NFPA 25-2011: Table 5.1.1.2</u>	Semiannual				
					Tamper switches <u>NFPA 72-2010: Table 14.4.5</u>	Semiannual				
EP 3					Duct, heat, smoke detectors, and manual fire alarm boxes	Annually				

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
EC.02.03.05					Fire Protection and Suppression Testing and Inspection					
					NFPA 72-2010: Table 14.4.5; 17.14					
EP 4					Notification devices (audible & visual), and door-releasing devices NFPA 72-2010: Table 14.4.5	Annually				
EP 5					Emergency services notification transmission equipment NFPA 72-2010: Table 14.4.5	Annually				
EP 6					Electric motor-driven fire pumps tested under no-flow conditions NFPA 25-2011: 8.3.1; 8.3.2	Monthly				
					Diesel-engine-driven fire pumps tested under no-flow conditions NFPA 25-2011: 8.3.1; 8.3.2	Weekly				
EP 7					Water storage tank high and low level alarms NFPA 25-2011: 9.3; Table 9.1.1.2	Semiannual				
EP 8					Water storage tank low water temp alarms (cold weather only) NFPA 25-2011: 9.2.4; Table 9.1.1.2	Monthly				
EP 9					Sprinkler systems main drain tests on all risers NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1	Annually				
EP 10					Fire department connections inspected (Fire hose connections N/A) NFPA 25-2011: 13.7; Table 13.1.1.2	Quarterly				
EP 11					Fire pump(s) tested – under flow NFPA 25-2011: 8.3.3	Annually				
EP 12					Standpipe flow test every 5 years NFPA 25-2011: 6.3.1; 6.3.2; Table 6.1.1.2	5 years				
EP 13					Kitchen suppression semi- annual testing	Semiannual				

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
EC.02.03.05					Fire Protection and Suppression Testing and Inspection					
					NFPA 96-2011: 11.2					
EP 14					Gaseous extinguishing systems inspected (no discharge req.) <u>NFPA 12-2011: 4.8.3 and NFPA 12A-2009: Chapter 6</u>	Annually				
EP 15					Portable fire extinguishers inspected monthly <u>NFPA 10-2010: 7.2.2; 7.2.4</u>	Monthly				
EP 16					Portable fire extinguishers maintained annually <u>NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1</u>	Annually				
EP 17					Fire hoses hydro tested 5 years after install; every 3 years thereafter <u>NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6</u>	5 years / 3 years				
EP 18					Smoke and fire dampers tested to verify full closure <u>NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5</u>	1 year after install				
						At least every 6 years thereafter				
EP 19					Smoke detection shutdown devices for HVAC tested <u>NFPA 90A-2012: 6.4.1</u>	Annually				
EP 20					All horizontal and vertical roller and slider doors tested <u>NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2</u>	Annually				
EP 25					Inspection and testing of door assemblies by qualified person. Does not include nonrated doors, including corridor doors to patient care rooms and smoke barrier doors. <u>NFPA 101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80- 2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105- 2010: 5.2.1</u>	Annually				
EP 27					Elevators with firefighters' emergency operations	Monthly				

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
EC.02.03.05					Fire Protection and Suppression Testing and Inspection					
					NFPA 101-2012: 9.4.3; 9.4.6					
EP 28					Documentation of maintenance testing and inspection activities for EPs 1-20 and 25 includes: activity name; date; inventory of devices, equipment or other items; frequency; contact info for person performing activity; NFPA standard; activity results <u>NFPA 25-2011: 4.3; 4.4; NFPA 72-2010: 14.2.1; 14.2.2; 14.2.3; 14.2.4</u>					
COMMENTS:										

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.05.07					Emergency Power Systems are Maintained and Tested			
EP 1					At least monthly performs functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs <u>NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5</u>	Monthly		
EP 2					Every 12 months performs functional test of battery powered lights on the inventory required for egress and exit signs for a duration of 1 ½ hours For new construction, renovation, or modernization battery-powered lighting in locations where deep sedation and general anesthesia are administered is tested annually for 30 minutes with test results and completion dates documented <u>NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5</u>	Annually		

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.05.07					Emergency Power Systems are Maintained and Tested			
EP 3					Functional test of Level 1 SEPSS, monthly; Level 2 SEPSS, quarterly, for 5 minutes or as specified for its class Annual test at full load for 60% of full duration of its class NFPA 111-2010: 8.4	Monthly Quarterly Annually		
					<i>Note 1: Non-SEPSS tested per manufacturer's specifications</i>	Per Mfr.		
					<i>Note 2: Level 1 SEPSS defined for critical areas and equipment</i>			
					<i>Note 3: Class defines minimum time which SEPSS is designed to operate at rated load without recharging</i>			
EP 4					Emergency power supply system (EPSS) inspected weekly, including all associated components and batteries NFPA 110-2010: 8.3.1; 8.3.3; 8.3.4; 8.4.1	Weekly		
EP 5					Emergency generators tested monthly for 30 continuous minutes under load (plus cool-down) NFPA 99-2012: 6.4.4.1	Monthly		
EP 6					Monthly load test for diesel-powered emergency generators conducted with dynamic load at least 30% of nameplate rating or meets mfr. recommended prime movers' exhaust gas temperature; OR	Monthly		
					Emergency generators tested once every 12 months using supplemental loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes for total of 1 ½ continuous hours NFPA 99-2012: 6.4.4.1	Annually		
EP 7					All automatic and manual transfer switches monthly/12 times per year with results and completion dates documented NFPA 99-2012: 6.4.4.1	Monthly		
EP 8					Fuel quality test to ASTM standards NFPA 110-2010: 8.3.8	Annually		
EP 9					Generator load test once every 36 months for 4 hours NFPA 110-2010, Chapter 8	36 Months		

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.05.07					Emergency Power Systems are Maintained and Tested			
EP 10					Generator 4-hour test performed at, at least 30% nameplate NFPA 110-2010, Chapter 8	36 Months		
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD			Testing Dates
	C	NC	NA	IOU		Yes		No	
EC.02.05.09					Medical Gas and Vacuum Systems are Inspected and Tested				
EP 7					<p>Test, inspect and maintain critical components of piped medical gas and vacuum systems, waste anesthetic gas disposal (WAGD), and support gas systems on the inventory.</p> <p>Inventory of critical components includes at least all source subsystems, control valves, alarms, manufactured assemblies containing patient gases, and inlets and outlets with activities, dates and results documented</p> <p>No prescribed frequency; recommend risk assessment if < annual <u>NFPA 99-2012: 5.1.14.2; 5.1.15; 5.2.14; 5.3.13</u></p>	Per policy			
EP 8					Location of and signage for bulk oxygen systems <u>NFPA 99-2012: 5.1.3.5.12</u>	On Bldg. Tour			
EP 9					Emergency oxygen supply connection <u>NFPA 99-2012: 5.1.3.5.13</u>	On Bldg. Tour			
EP 10					Review medical gas installation/modification/breech certification results for cross connection, purity, correct gas, and pressure <u>NFPA 99-2012: 5.1.2; 5.1.4; 5.1.14.4.1; 5.1.14.4.6; 5.2.13</u>	As applicable			

STANDARD - EPs	See Legend				Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD			Testing Dates
	C	NC	NA	IOU			Yes	No	
EC.02.05.09					Medical Gas and Vacuum Systems are Inspected and Tested				
EP 11					Medical gas supply and zone valves are accessible and clearly labeled NFPA 99-2012: Table 5.1.11 NFPA 99-2012: 5.1.4; 5.1.11.1; 5.1.11.2; 5.1.14.3; 5.2.11; 5.3.13.3; 5.3.11	On Bldg. Tour			
EP 12					Handling, transfer, storage, labeling, transfilling of cylinders NFPA 99-2012: 11.5.3.1; 11.6.1; 11.6.2; 11.6.5; 11.7.3	Per policy			
COMMENTS:									

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1	Q2	Q3	Q4 Annual
	C	NC	NA	IOU						
EC.02.03.03					Fire Drills					
EP 1					Fire drills once per shift per quarter in health care occupancies; Quarterly in each building defined as ambulatory health care occupancy (If available, please provide five quarters of fire drill data)	Quarterly				
EP 2					Fire drills every 12 months from date of last drill: Business Occupancies	Annually				
EP 3					When quarterly fire drills are required, ALL are unannounced <ul style="list-style-type: none"> Drills held at unexpected times and under varying conditions – greater than one hour apart Drills include transmission of fire alarm signal and simulation of emergency fire conditions NFPA 101-2012: 18/19: 7.1.7; 7.1; 7.2; 7.3	Quarterly (See fire drill matrix)				
EP 4					Staff participate in the drills according to the hospital's fire response plan	YES	NO			
EP 5						YES	NO			

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1	Q2	Q3	Q4 Annual
	C	NC	NA	IOU						
EC.02.03.03					Fire Drills					
					Critiques include fire safety equipment and building features, and staff response					
COMMENTS:										

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.05.01					Manages risks associated with utility systems			
EP 15					<p>In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature and humidity. <i>(form of and frequency of assessment per hospital policy)</i></p> <p>Note: For more information about areas designed for control of airborne contaminants, the basis for design compliance is the Guidelines for Design and Construction of Health Care Facilities, based on the edition used at the time of design (if available).</p>			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Yes	No
	C	NC	NA	IOU			
EC.02.05.02					Manages risks associated with utility systems – Water Management Program		
EP 1					<u>Verify individual or team responsible for oversight and implementation of the water management program</u>		
EP 2					<u>Review water management program to verify the following components are included:</u> <ul style="list-style-type: none"> • <u>Diagram of water supply sources, treatment systems, processing steps, control measures, and end-use points</u> • <u>Water risk management plan identifies areas where potentially hazardous conditions may occur</u> • <u>Plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time</u> • <u>Evaluation of immunocompromised patients</u> 		

STANDARD - EPs	See Legend				Document / Requirement	Yes	No
	C	NC	NA	IOU			
EC.02.05.02					Manages risks associated with utility systems – Water Management Program		
					<ul style="list-style-type: none"> Monitoring protocols and acceptable ranges for control measures 		
EP 3					Verify that the water management program includes documentation of the following: <ul style="list-style-type: none"> Results of all monitoring activities Corrective actions and procedures to follow if test results are outside of acceptable limits Corrective actions taken when control limits are not maintained 		
EP 4					Verify water management program reviewed annually and when changes have been made to the water system that add risk, new equipment or at-risk systems have been added that could generate aerosols or be source for Legionella		
COMMENTS:							

STANDARD - EPs	See Legend				Document / Requirement	Yes	No
	C	NC	NA	IOU			
EC.02.04.01					Management of Medical Equipment Risks		
EP 2					Non-deemed status requirement: Maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized by physical risk associated with use (including all life-support equipment) and equipment incident history. Evaluates new types of equipment before initial use to determine whether they should be included in the inventory. OR Deemed status requirement: Maintains a written inventory of all medical equipment.		
EP 3					High-risk medical equipment identified on the inventory		
EP 4					Inventory includes activities and associated frequencies for maintaining, inspecting, and testing all medical equipment on the inventory. Activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of an alternative equipment maintenance (AEM) program.		
COMMENTS:							

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.04.03					Medical equipment inspection, testing and maintenance			
EP 2					<p>All high-risk equipment.</p> <p>Note 1: High-risk equipment includes medical equipment for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment.</p> <p>Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of medical equipment completed in accordance with manufacturers' recommendations must have a 100% completion rate.</p> <p>Note 3: Scheduled maintenance activities for high-risk medical equipment in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the hospital's AEM program.</p>			
EP 3					<p>Non-high-risk equipment identified on the medical equipment inventory</p> <p>Note: Scheduled maintenance activities for non-high-risk medical equipment in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the hospital's AEM program.</p>			
EP 4					Conducts performance testing of and maintains all sterilizers			
EP 10					All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99-2012: Chapter 14.			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.05.05					Utility system inspection, testing and maintenance			
EP 4					<p>High-risk utility system components on the inventory with completion date and results of activities documented</p> <p>Note 1: A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment.</p> <p>Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components completed in accordance</p>			

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.05.05					Utility system Inspection, testing and maintenance			
					with manufacturers' recommendations must have a 100% completion rate. Note 3: Scheduled maintenance activities for high-risk utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate.			
EP 5					Infection control utility system components on the inventory with completion date and results of activities documented Note 1: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components completed in accordance with manufacturers' recommendations must have a 100% completion rate. Note 2: Scheduled maintenance activities for infection control utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate.			
EP 6					Non-high-risk utility system components on the inventory with completion date and results of activities documented Note: Scheduled maintenance activities for non-high-risk utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the hospital AEM program.			
EP 7					Line isolation monitors (LIM), if installed, are tested at least monthly by actuating the LIM test switch. For LIM circuits with automated self-testing, a manual test is performance at least annually. <u>NFPA 99-2012: 6.3.2; 6.3.3; 6.3.3.3.2; 6.3.4</u>			
COMMENTS:								

Legend: C=Compliant; NC=Not compliant; NA=Not applicable; IOU=Surveyor awaiting documentation

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.01.01					The hospital manages safety and security risks.			
EP 1					The hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities.			

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.01.01					The hospital manages safety and security risks.			
					Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.			
EP 3					The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.01.01.01					The hospital plans activities to minimize risks in the environment of care.			
EPs 1-9					<p>The hospital has a written plan for managing the following;</p> <p>EP-4 Environmental Safety EP-5 Security EP-6 Haz Materials EP-7 Fire Safety EP-8 Medical Equipment EP-9 Utility Systems</p> <p>Note 1: One or more persons can be assigned to manage risks associated with the management plans described in this standard.</p> <p>Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.</p> <p>Note 3: For further information on waiver and equivalency requests, see https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/life-safety-code-information-and-resources/ and NFPA 99-2012: 1.4.</p>			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.04.01.01					The hospital collects information to monitor conditions in the environment.			
EP 15					Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness.			

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.04.01.03					The hospital plans activities to minimize risks in the environment of care.			
EP 2					The hospital uses the results of data analysis to identify opportunities to resolve environmental safety issues.			

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.04.01.05					The hospital improves its environment of care.			
EP 1					The hospital takes action on the identified opportunities to resolve environmental safety issues.			

STANDARD - EPs	See Legend				Document / Requirement	Addressed in policy?		Implemented as required?	
	C	NC	NA	IOU		Yes	No	Yes	No
LS.01.02.01					Interim Life Safety Measures (ILSM)				
EP 1					ILSM policy identifying when and to what extent ILSM implemented				
EP 2					Alarms out of service 4 or more hours in 24 hours or sprinklers out of service more than 10 hours in 24 hours in an occupied building - Fire watch / Fire Dept. notification NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2				

STANDARD - EPs	See Legend				Document / Requirement	Addressed in policy?		Implemented as required?	
	C	NC	NA	IOU		Yes	No	Yes	No
LS.01.02.01					Interim Life Safety Measures (ILSM)				
EP 3					Signs for alternate exits posted				
EP 4					Daily inspection of routes of egress (See also 19.7.9.2 RE: daily inspections)				
EP 5					Temporary but equivalent systems while system is impaired				
EP 6					Additional firefighting equipment provided				
EP 7					Smoke tight non-combustible temporary barriers				
EP 8					Increased surveillance implemented				
EP 9					Storage and debris removal				
EP 10					Additional training on firefighting equipment				
EP 11					Additional fire drill per shift per quarter				
EP 12					Temporary systems tested and inspected monthly				
EP 13					Additional training on building deficiencies, construction hazards, temp measures				
EP 14					Training for impaired structural or impaired compartment fire safety features				
EP 15					Other ILSM's				
COMMENTS:									

NOTE: The following evaluation will be completed during the building tour.

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.02.01					The hospital manages risks related to hazardous materials and waste.			
EP 1					The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation. (See also IC.02.01.01, EP 6; MM.01.01.03, EPs 1 and 2)			

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.02.01					The hospital manages risks related to hazardous materials and waste.			
EP 3					The hospital has written procedures, including the use of precautions and personal protective equipment, to follow in response to hazardous material and waste spills or exposures.			
EP 11					For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation.			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.01.01					The hospital manages safety and security risks.			
EP 1					<p>The hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities.</p> <p>Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.</p>			
EP 3					The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.			
EP 9					The hospital has written procedures to follow in the event of a security incident, including an infant or pediatric abduction.			
EP 10					When a security incident occurs, the hospital follows its identified procedures.			
COMMENTS:								

A Tag – Summary Review Sheet – Deemed Hospital Medical Record Review

Medical Record Review Components	TJC Standard	A Tag/CoP
Admitting diagnosis	RC 02.01.01 EP 2	A0463 – 482.24(c)(4) (ii)
H&P 30 days prior or within 24 hours	PC 01.02.03 EP 4 RC 01.03.01 EP 3 RC 02.01.03 EP 3	A0458 – 482.24(c)(4)(1)(A) A0358 – 482.22(c)(5)(i) A0952 – 482.51(b)(1)(i)
H&P Update	PC 01.02.03 EP 5 RC 01.03.01 EP 4	A0461 – 482.24(c)(4)(i)(B) A0359 – 482.22(c)(5)(ii) A0952 – 482.51(b)(1)(ii)
All orders , including verbal orders, are dated, timed, and authenticated	PC 02.01.03 EP 1 RC 01.01.01 EP 7, 13 RC 01.02.01 EP 3, 4 RC 02.03.07 EP 3, 4, 6	A0454 – 482.24(c)(2)
Orders, nursing notes, reports of treatment, medication records, radiology reports, lab reports, vital signs, and other information necessary to monitor the patient's condition	RC 02.01.01 EP 2	A0467 – 482.24(c)(4)(vi) A0539 – 482.26(b)(4) orders radiologic services A0553 – 482.26(d) A0630 – 482.28(b)(2) orders for patient diets A1051 – 482.53(d) A1133 – 482.57(b)(4) respiratory care orders
RN supervises and evaluates nursing care Nursing care plan	PC 01.02.03 EP 3,6 PC 01.02.05 EP 1 PC 01.03.01 EP 1, 5, 23 PC 02.01.01 EP 5	A0395 – 482.23(b)(3) A0396 – 482.23(b)(4)
Inform patient of rights	RI 01.01.01 EP 2	A0117 – 482.13(a)(1)
Informed consent	RC 02.01.01 EP 4 RI 01.03.01 EP 1, 2	A0466 – 482.24(c)(4)(v) A0955 – 482.51(b)(2)
Advanced directives – does patient have one, patient notified of hospital policy, advance directive in record	RC 02.01.01 EP 4 RI 01.05.01 EP 1, 9	A0132 – 482.13(b)(3) A0466 – 482.24(c)(4)(v)
Patient asked about notifying family and physician about inpatient admission	RI 01.02.01 EP 1	A0133 – 482.13(b)(4)
Patient informed of visitation rights	RI 01.01.01 EP 2	A0216 – 482.13(h)(1) &(2)
Medication administration is in accordance with order and is for the right patient, at the right time, correct dose and route	MM 06.01.01 EP 1, 3, 9 MM 05.01.07 EP 5 PC 02.01.03 EP 1 PC 02.01.01 EP 15	A0405, A0406, A0409 482.23(c), (c)(1), (c)(1)(i), (c)(1)(ii), (c)(3), (c)(4)
Medical record information justifies admission and continued hospitalization, supports the diagnosis, and describes patient's progress and response to Medication and services; entries are legible, complete, dated, timed and authenticated	RC 01.01.01 EP 5, 7,13 RC 01.02.01 EP 4 RC 01.04.01 EP 1 RC 02.01.01 EP 2 PC 02.01.03 EP 1	A0449, A0450, A0454 482.24(c), (c)(1), (c)(2)
Nutritional needs	PC 01.02.01 EP 3 PC 01.03.01 EP 1 PC 02.02.03 EP7	A0629 – 482.28(b)(1), (b)(2)
Discharge planning in early stage of hospitalization	PC 04.01.03 EP 1	A0800 – 482.43(a)
Discharge planning evaluation – eval of pt needing post-hospital services, pt capacity for self-care	PC 04.01.03 EP 2, 4 RC 02.01.01 EP2	A0806, A0811 482.43(b)(3), (b)(4), (b)(6)

Medical Record Review Components	TJC Standard	A Tag/CoP
Discharge plan – document arrangements made for initial implementation of the discharge plan, including training and materials provided to the patient or patient's informal caregiver	PC 04.01.03 EP 1-4	A0820 – 482.43(c)(3)
Discharge planning – pt and family counseled to prepare them for discharge	PC 04.01.05 EP 1, 2, 7	A0820 – 482.43(c)(5)
Reassess discharge plan	PC 01.02.03 EP 3	A0821 – 482.43(c)(4)
Discharge summary with outcome of hospitalization, disposition, and f/u care	RC 02.04.01 EP 3	A0468 – 482.24(c)(4)(vii)
List of HHAs or SNFs was presented to the patient	PC 04.01.01 EP 22-25	A0823 – 482.43(c)(6), (c)(7),(c)(8)
Necessary medical information is forwarded to next provider(s) of care	PC 04.02.01 EP 1	A0837 – 482.43(d)
Final diagnosis with completion of the medical record within 30 days	RC 02.01.01 EP 2 RC 01.03.01 EP 1	A0469 – 482.24(c)(4)(viii)
Documentation of self-administration of hospital issued medication as reported by patient Documentation of self-administration of medication brought in by patient as reported by patient	RC 02.01.01 EP 2	A0412 – 482.23(c)(6)(i)(E) A0413 – 482.23(c)(6)(ii)(E)
Results of consultative evaluations	RC 02.01.01 EP 2	A0464 – 482.24(c)(4)(iii)
Results of consultative evaluations	RC 02.01.01 EP 2 RC 02.01.03 EP 8	A0465 – 482.24(c)(4)(iv)
Complications , HAIs, and unfavorable reactions to drugs and anesthesia	RC 02.01.01 EP 2 RC 02.01.03 EP 8	A0465 – 482.24(c)(4)(iv)
Pre-anesthesia eval within 48 hours prior to surgery or anesthesia	PC 03.01.03 EP 18	A1003 – 482.52(b)(1)
Intraoperative anesthesia record or report	PC 03.01.05 EP1 RC 02.01.03 EP 1	A1004 – 482.52(b)(2)
Post anesthesia eval no later than 48 hours after surgery or anesthesia	PC 03.01.07 EP 7, 8	A1005 – 482.52(b)(3)
Conduct suicide risk assessment for patients being treated for emotional or behavioral disorders	NPSG 15.01.01 EP 1	A0144 – 482.13(c)(2)
Written notice to patient of resolution of complaint	RI 01.07.01 EP 18	A0123 – 482.13(a)(2)(iii)
Documentation of justification of simultaneous use or restraints and seclusion	PC 03.05.13 EP 1	A0183 – 482.13(e)(15)(ii)
Documentation of the use of restraint or seclusion includes: -Any in person evaluation (see also 482.13(e)(8)(ii)(e)(12)(1)(A&B) and 482.13(e)(12)(ii)(A-D) -Patients' behavior and interventions -Alternatives or other less restrictive interventions attempted -Patient's condition or symptoms that warranted use of restraint or seclusion -Patient's response to interventions used, including rationale for continued use (see also 482.13(e)(9) -Assessments and reassessments -Intervals for monitoring (see also 482.13(e)(10) and (e)(15)(i and ii) -Revisions to plan of care -Plan of care reflects assessments, intervention, and evaluation (see 482.13(e)(4)(i) -Patient behavior and staff concerns regarding safety risks to patients, staff, and others that necessitated restraint or seclusion	PC 03.05.15 EP 1	A0184-A0188 – 482.13(E)(16)(i-v) A0172, A0178, A0179 – 482.13 (e)(8)(ii), (e)(12)(i)(A&B) and (e)(12)(ii)(A-D) A0164, A0165 – 482.13 (e)(2&3) A0715, A0183 – 482.13(e)(10) & (e)(15)(i&ii) A0166 – 482.13(e)(4)(i) A0168,A0169, A0171, A0173 – 482.13(e)(5),(e)(8)(i)(A-C), (e)(8)(iii) A0170 – 482.13(e)(7) A0182 – 482-13(e)(14)

Medical Record Review Components	TJC Standard	A Tag/CoP
-any injuries -any deaths -Identity of practitioner who ordered restraint or seclusion -Orders (see also 482.13 (e)(5), (e)(6), (e)(8)(i)(A-C) and (e)(8)(iii)) -Notification of use of restraint and seclusion to the attending (see also 482.13(e)(7)) -Consultation (see also 482.13(e)(14))		
Restraints properly and safely applied	PC 03.05.03 EP 1	A0167 – 482.13(e)(4)(ii)
Medical record includes date and time death associated with use of restraint/seclusion was reported to CMS or recorded in the internal log or other system	PC 03.05.19 EP 2,3	A0214 – 482.13(g)(3)(i) and (ii)
Entries in internal log or other system -made no later than 7 days after date of death -include patient's name, date of birth, date of death, name of practitioner responsible for patient's care, medical record number and primary diagnosis(es)	PC 03.05.19 EP 3	A0214 – 482.13(g)(4)(i) and (ii)
Documentation of notification of or attempts to notify patient of potentially infectious blood	PC 05.01.09 EP 2	A0592 – 482.27 (b)(6)(iii)
If hospital unable to locate patient, it documents in the medical record the extenuating circumstances that caused notification to exceed 12 weeks.	PC 05.01.09 EP 2	A0592 – 482.27(b)(7)(i)(B)

Medical Staff-Related Standards Compliance Evaluation Guides

The material presented in this section is representative of what surveyors use when they are evaluating compliance with the Medical Staff-related standards in the **Hospital** and **Critical Access Hospital** accreditation programs. Organizations may find these tools useful to continuous compliance and survey readiness efforts.

- 1. Medical Staff Bylaws Review Guide**
- 2. Medical Staff and Related Standards Compliance Evaluation Guide**
- 3. Professional Graduate Medical Education Program Standard Compliance Evaluation Guide**
- 4. Credentials File Review Tool**

Medical Staff Bylaws Review Guide

	MS.01.01.01 - Medical Staff Bylaws address self-governance and accountability to the governing body.
EP	DESCRIPTION
1	Medical Staff Develops Medical Bylaws, rules and regulations and policies.
2	Medical Staff adopts and amends Medical Staff Bylaws. Bylaws become effective only upon governing body approval.
12	The structure of the medical staff
13	Qualifications for appointment to the medical staff
14	Process for privileging and re-privileging LIP, which may include other practitioners*
15	Duties and privileges (prerogatives) related to each category of the med staff
16	Requirement for completing/documenting H&P by physician or qualified individual—Including time frames 30 days prior to admission/registration or within 24 hours after, and the requirement for update.
17	Description of those members of the medical staff eligible to vote
18	Process by which org MS selects or elects and removes MS officers*
19	List of all the officer positions for the medical staff
20	The MEC's function, size, and composition; authority delegated to MEC to act on MS behalf; how such is delegated or removed
21	Process for selecting or electing and removing MEC members*
23	That the MEC acts on behalf of MS between meetings as defined by MS
24	Process for adopting and amending the medical staff bylaws*
25	Process for adopting/amending the MS rules and regulations, and policies*
26	Process for credentialing/re-credentialing LIP, may include other practitioners*
27	Process for appointment/re-appt to membership on the med staff*
28	Indications for automatic suspension of MS membership or clinical privileges
29	Indications for summary suspension of MS membership or clinical privileges
30	Indications for termination or suspension of MS membership and/or termination, suspension, or reduction of privileges
31	Process for automatic suspension of MS membership or clinical privileges*
32	Process for summary suspension of MS membership or clinical privileges*
33	Process for recommending termination or suspension of MS membership and/or termination, suspension or reduction of clinical privileges*
34	The fair hearing and appeal process*
35	Composition of the fair hearing committee
36	If departments of MS exist , the qualifications, roles, and responsibilities of department chair

	Qualifications - Board certification or comparable competence
	<p>a) Roles and responsibilities</p> <ul style="list-style-type: none"> • Clinically related activities of the department • Administrative activities of dept, unless provided by hospital • Continuing surveillance of prof perf of all in dept with privileges • Recommending to the med staff the criteria for departmental clinical privileges • Recommending clinical privileges for each member of dept • Assessing and recommending to hospital authority off-site sources of care • Integration of dept or service into primary functions of org • Coordination and integration of inter- and intra-departmental services • Development and implementation of policies and procedures • Recommendations for sufficient number of qualified and competent persons to provide care, treatment, and services • Determination of qualifications and competence of dept or service non-LIP • Continuous assessment and quality improvement • Maintenance of quality control programs, as appropriate • Orientation and continuing education of persons in dept or svc • Recommending space and resources needed by the dept or service
37	<ul style="list-style-type: none"> • Process by which med staff at each hospital are advised of their right to opt out of unified& integrated medical staff structure after a majority vote to maintain a separate medical staff for their hospital. <i>N.B.: Applies to multihospital systems with unified/integrated medical staff and deemed status*</i>
38	When MS allows an assessment in lieu of a comprehensive H&P for patients receiving specific outpatient surgical or procedural services, MS bylaws specify that the assessment is completed and documented after registration, but prior to a procedure requiring anesthesia services.

Other Medical Staff and Related Standards that address bylaws requirements		
Standard	EP	DESCRIPTION
EM.02.02.13	2	Bylaws must identify individuals responsible for granting disaster privileges to volunteer licensed independent practitioners.
MS.02.01.01		The medical staff executive committee makes recommendations, as defined in the bylaws directly to the governing body on, at least, all the following EPs 8-12 of this Standard.
	8	Medical staff membership
	9	The organized medical staff's structure
	10	The process used to review credentials and delineate privileges
	11	The delineation of privileges for each practitioner privileged through the medical staff process
	12	The executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups
MS.06.01.03	4	The credentialing process is outlined in the medical staff bylaws*
MS.06.01.05	11	Completed applications for privileges are acted on within the time period specified.
MS.06.01.13	1	Temporary privileges are granted to meet an important patient care need for the time period defined in the medical staff bylaws.

Other Medical Staff and Related Standards that address bylaws requirements		
Standard	EP	DESCRIPTION
MS.10.01.01	5	The fair hearing process developed by the medical staff must, with the governing body, provide a mechanism to appeal adverse decisions as provided in the medical staff bylaws

*Only basic steps must be included in the Bylaws. Details may be in the Bylaws or Rules and Regulations or policies, as applicable. For instance, information on disaster privileging is required in the Bylaws such as that disaster privileges may be granted when the Emergency Operations Plan has been activated in response to a disaster and the individuals responsible for granting disaster privileges (see EM.02.02.13 EP 2), but the details of primary source verification, etc. are not required in the Bylaws and may be in policy or the Emergency Operations plan.

EP 1-11 of MS.01.01.01 may be in the bylaws, but they are not required to be. While discussion of Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation and their use may be contained in the Bylaws, they are not a required part of the Bylaws of the Medical Staff.

Updated: 12/3/2020

Medical Staff and Related Standards Compliance Evaluation Guide

1- Credentialing Process Discussion			
YES	NO	Credentialing Discussion – If no issues found in document review, begin meeting with the discussion of the credentialing process.	
<input type="checkbox"/>	<input type="checkbox"/>	Ask them to discuss the credentialing process – application, processing, role of department chair, Cred Comm, Medical Executive Committee, Governing Body. Basic steps must be in bylaws (See also: MS Bylaws Checklist for relevant EPs of MS.01.01.01) Privileges are granted for a period not to exceed 2 years. Practitioner is notified in writing of the decision Re: appointment, reappointment, privileges.	MS.02.01.01 EP8, 11 MS.06.01.03 EP4 MS.06.01.07 EP9 MS.06.01.09 EP1
<input type="checkbox"/>	<input type="checkbox"/>	Discuss how primary source verification (PSV) is performed for licensure, training, competence. Training and competence PSV in writing for privileges requested. Licensure at initial, renewal, and request for new privileges. (PSV for competency and training only on initial appt unless new/additional privileges requested.	MS.06.01.03 EP6
<input type="checkbox"/>	<input type="checkbox"/>	Evidence of Provider ID verification (Hospital or government-issued picture ID) DEA Registration, when required by MS, hospital, or state.	MS.06.01.03 EP5 LD.04.01.01 EP2 <i>Scored only if DEA has expired</i>
<input type="checkbox"/>	<input type="checkbox"/>	Are peer recommendations considered; how are "peers" defined and, if yes, did written peer recommendations include information regarding the medical/clinical knowledge, clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism of the practitioner?"	MS.07.01.03 EP1-4
<input type="checkbox"/>	<input type="checkbox"/>	When are the National Practitioner Data Bank (NPDB) queries performed: Must be at least at initial/re-appointment and whenever new privileges are requested: Is there a statement regarding provider's health and ability to perform the requested procedures?	MS.06.01.05 EP7 MS.06.01.05 EP6
<input type="checkbox"/>	<input type="checkbox"/>	Is there a process for evaluation of identified red flags Re: voluntary or involuntary: licensure reductions/termination, reduced/revoked privileges, MS membership terminations, etc. at the same or previous organizations? This should be a credible process that involves MS leaders.	MS.06.01.05 EP9
<input type="checkbox"/>	<input type="checkbox"/>	Is there an expedited credentialing process? If so, are at least 2 voting Board members on the approving committee? Are there established criteria for ineligibility, and do they include an incomplete application and adverse MEC recommendation?	MS.06.01.11 EP1 MS.06.01.11 EP2
<input type="checkbox"/>	<input type="checkbox"/>	How are criteria for granting privileges determined and approved (<i>does the Governing Body approve?</i>) Do the criteria include licensure, training, evidence of current competency, peer recommendations, and information from other organizations, when applicable?	MS.06.01.05 EP2
<input type="checkbox"/>	<input type="checkbox"/>	Temporary privileges: Time periods must be defined in bylaw Must be no more than 120 Days. (See also box 3 below - file review)	MS.06.01.13 EP1
<input type="checkbox"/>	<input type="checkbox"/>	Telemedicine: How are these credentialed? They should all be granted privileges by the originating site but may do so in the usual way -OR- By contractual arrangement to accept the credentialing information from a Joint Commission Accredited or CMS certified Organization -OR- Joint Commission accredited or CMS Certified accept the privilege decision of distant site if all of these are met by the distant site <ul style="list-style-type: none"> and the privileges to be exercised are granted: List of privileges at distant site is provided 	MS.13.01.01 EP1

		<ul style="list-style-type: none"> FPPE, OPPE information is shared Provider is licensed in the originating site's state 	
<input type="checkbox"/>	<input type="checkbox"/>	<p>CME: Requires that the MS sets priorities for CME topics</p> <p>EP2 Requires CME resources are related to the scope of services of the organization</p> <p>EP3 State CME should be related to outcomes of PI activities</p> <p>EP4 Requires documentation of CME; and</p> <p>EP5 Requires CME to be considered in the credentialing process</p>	MS.12.01.01.EP2-5
2- FPPE/OPPE			
YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	<p>FPPE for all initial or New Privileges</p> <p>EP1 Implemented for all practitioners in all clinical sites and privilege specific (includes LIPs, PAs, APRNs, CRNAs, Dietitians granted privileges to write orders, pharmacists with prescriptive authority, telemedicine provider, etc., exercised in all settings- inpatient or outpatient-on-site or off-site within the scope of the organization's survey; is a focused direct evaluation of the requested/exercised privileges)</p> <p>EP2 The process including criteria is approved by the MS (evaluation should be qualitative and not just quantitative)</p> <p>EP3 The process is clearly defined (<i>i.e., written policy-required: criteria for conducting performance monitoring, method for establishing a monitoring plan specific to the requested privilege, method for determining the duration of performance monitoring, circumstances under which monitoring by an external source is required</i>)</p> <p>EP4 Applied consistently (<i>follow the same process step and documentation requirements for all evaluations</i>)</p>	FPPE: MS.08.01.01 (Review CITE for interim scoring guidelines)
<input type="checkbox"/>	<input type="checkbox"/>	<p>FPPE for Cause</p> <p>EP5 Triggers should be defined clearly (<i>i.e. in policy</i>)</p> <p>EP6 Decisions to initiate FPPE for cause should be based upon objective measures of current performance reflective of quality and/or safety concerns.</p> <p>EP7 Criteria are developed for type of monitoring to be conducted</p> <p>EP8 Measures/actions to address performance issues are defined</p> <p>EP9 These measures/actions are consistently implemented</p>	MS.08.01.01 (Review CITE for interim scoring guidelines)
<input type="checkbox"/>	<input type="checkbox"/>	<p>OPPE:</p> <p>EP1 There is a clearly defined process: e.g. a written policy, bylaw, or Rules and Regulations. The data collection and review must be "ongoing," i.e., more than annually. The annual process would be considered periodic and not ongoing. Could be every 8-9 months or more frequently pursuant to the policy. Process includes all practitioners in all clinical sites and includes methodology of data collection and who/how the data is reviewed and acted upon.</p> <p>EP2 The process requires that the data to be collected is approved by the individual departments and the MS(MEC) or just the MEC there are no departments:</p> <ul style="list-style-type: none"> Aggregate (quantitative) or trended quality metrics are encouraged - e.g., SSI rates, complications, BUT: Qualitative or chart review data may be used The data must be RELEVANT to the specialty or privileges granted Review of data that occurs only when triggered by an incident is NOT acceptable When there are situations in which there is no other way to collect data or assets, then peer recommendations may be used (<i>low or no volume providers</i>) 	MS.08.01.03 (Review CITE for interim scoring guidelines)

		<ul style="list-style-type: none"> Data must be from the organization except for low volume providers who have available data from other accredited or CMS certified organizations. However, any data obtained must be supplemental and cannot be used in lieu of a process to attempt to capture 'local' performance data Use of quantitative (raw) data may be used, however, it cannot be the only type of data used to evaluate performance <p>EP3 The data collection, review, and analysis must be used to inform the credentialing process, i.e., it must be used in the process of determining whether to continue, reduce, or otherwise modify a provider's privileges. This review process should be consistent and documented. This review process should be ongoing, i.e., - reports reviewed when they are produced - not just at the time of the 2-year reappointment</p>	
Other items to review/confirm prior to or during the system tracer meeting			
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Does the Medical Staff (MEC) approve the Dietary Manual for the hospital? Frequency: MS approval should be a part of the usual periodic review of the policy and whenever the manual is substantively amended.	PC.02.02.03, EP22
<input type="checkbox"/>	<input type="checkbox"/>	The Medical Staff Approval by the radiology, nuclear medicine medical director or MEC are acceptable options to approve the qualification of the radiology and nuclear medicine technical staff Frequency: MS approval should occur initially and be a part of the usual periodic review of job descriptions and qualifications or whenever there is a substantive amendment or change in these qualifications	MS.03.01.01 EP 16,17
<input type="checkbox"/>	<input type="checkbox"/>	Is there a process for education of providers in antimicrobial stewardship? Is there a process for education of providers in pain management and safe use of opioid medication? <i>(These standards require evidence of process, but does not have to be documented in individual credentialing files)</i>	MM.09.01.01 EP2 LD.04.03.13 NPSG.06.01.01 EP4 EM.02.02.07 EP8
<input type="checkbox"/>	<input type="checkbox"/>	Disaster Privileges This may be addressed in document review of the Disaster Privileges policy which must comply with all EPs Note: Bylaws document review should confirm that the individuals who may grant disaster privileges is specified in the Bylaws	EM.02.02.13 (see also: MS.01.01.01 EP14)

Updated 12.2.20

Professional Graduate Medical Education Program Standard Compliance Evaluation Guide

Response (if “no” score standard and EP)		Standard, EP, and Compliance Criteria
YES	NO	MS.04.01.01 All EPs (1-9)
<input type="checkbox"/>	<input type="checkbox"/>	<p>MS.04.01.01 EP1 <u><i>This EP has a documentation requirement</i></u></p> <p>Does the organized medical staff have a document that defines a process for supervision by a licensed independent practitioner, with appropriate clinical privileges, of each program participant while carrying out patient care responsibilities?</p> <p>Note: this information should reside in the Rules and Regulations or a Medical Staff approved document.</p>
<input type="checkbox"/> If “yes” continue to next item for EP2	<input type="checkbox"/> If “no” consider also scoring EP3	<p>MS.04.01.01 EP2 <u><i>This EP has a documentation requirement</i></u></p> <p>Does the organization have documentation of written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs?</p> <p>Note: GME trainees have at various levels of their training specific functions and skills they may exercise either independently or with supervision. GME programs must develop criteria to determine the competence and level of independence for each trainee as they advance in the program. See EP3.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>Does the organization provide this information to the organized medical staff and hospital staff?</p> <p>Note: for the resident specific roles and responsibilities to be of use, they must be available to hospital staff in the work centers. The method for making this information available is up to the organization.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>MS.04.01.01 EP3</p> <p>The descriptions from EP2 must include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>MS.04.01.01 EP4 <u><i>This EP has a documentation requirement</i></u></p> <p>The organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so (without prohibiting licensed independent practitioners from writing orders), and what entries, if any, must be countersigned by a supervising licensed independent practitioner.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>MS.04.01.01 EP5</p> <p>Can the organization demonstrate a mechanism for effective communication between the committee(s) responsible for professional graduate education (which may or may not reside within the organization being surveyed) and the organized medical staff and the governing body of the organization being surveyed?</p> <p>Note: a GME program may reside within the hospital being surveyed and usually has a professional graduate medical education committee (GMEC), or the hospital being surveyed may be an affiliated hospital with a training program residing in another</p>

		<p>hospital. Affiliated hospitals often have only a coordinator and not a full GMEC, in which case the hospital should demonstrate a method for effective communication with the hospital owning the training program. See EP6</p> <p>Note: GMEC minutes or Medical Staff Minutes often have evidence of compliance with this EP. The entire Medical Staff is rarely briefed, but specific members on the MEC often are.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>MS.04.01.01 EP6</p> <p>Can the hospital demonstrate a mechanism for effective communication (whether training occurs at the organization that is responsible for the GME program or in a participating local or community organization or hospital)?</p> <p><u>If the hospital surveyed has a professional GMEC, how does it communicate to the medical staff and governing body information about:</u></p> <ul style="list-style-type: none"> • safety and quality of patient care, treatment and services by the training program • related educational and supervisory needs of the training program <p><u>If the hospital surveyed is a community or local participating hospital or organization hospital, do person(s) responsible for overseeing the participants from the program communicate to the organized medical staff and its governing body about:</u></p> <ul style="list-style-type: none"> • patient care, treatment, and services provided by the training program • related educational and supervisory needs of its participants in the GME programs. <p>Note: EP6 is broad and reflects the overall management of the GME program. The GMEC minutes often have evidence of compliance with this EP. See also EP8 for information specific to the governing body.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>MS.04.01.01 EP7</p> <p>Can the hospital demonstrate a mechanism for an appropriate person from the community or local hospital or organization to communicate information to the GMEC about the quality of care, treatment, and services and educational needs of the participants?</p> <p>Note: sometimes GME trainees participate with providers who don't report directly to a GMEC (such as private or community clinics, community based private physicians etc.) and there must be a way for these providers to communicate with the GMEC.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>MS.04.01.01 EP8</p> <p>If the hospital sponsors a GME program and has a GMEC, can the hospital demonstrate it specifically included information about the quality of care, treatment, and services and educational needs to the governing board?</p> <p>Note: while this EP is like EP6, it is specific to elements the sponsoring hospital governing board must be informed of. Compliance is often demonstrated in the Board or GMEC minutes.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>MS.04.01.01 EP9</p> <p>Can the hospital demonstrate how the medical staff demonstrates compliance with residency review committee citations?</p> <p>Note: Graduate medical education programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the American Dental Association's Commission on Dental Accreditation are expected to be in compliance with the above requirements; the hospital should be able to demonstrate compliance with any postgraduate education review committee citations related to this standard.</p> <p>Note: AOA programs may now be accredited under the ACGME.</p>

Updated: 12.2.20

Credentials File Review Tool

[illegible]

Kitchen Tracer Survey Guide

YES	NO		YES	NO	
		Does the org have the following written policies CMS 482.28 A-6018			Does staff have appropriate competencies/skill sets for food/nutrition services? <i>Consider patient assessments, care plans, etc.</i> HR.01.06.01 EP 5 and HR.01.05.01 EP 6
<input type="checkbox"/>	<input type="checkbox"/>	Meal frequency? PC.02.01.01 EP 1 and PC.02.02.03	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Diet ordering/patient tray delivery system? PC.02.02.03 EP7 and PC.02.01.03 EP1 for diet ordering	<input type="checkbox"/>	<input type="checkbox"/>	Diet Manual; approved by medical staff/dietitian & current? <i>Needs to have been published/revised within last 5 years</i> PC.02.02.03 EP22
<input type="checkbox"/>	<input type="checkbox"/>	Non-routine occurrences? <i>e.g. parenteral nutrition, change in diet orders, early/late trays</i> PC.01.02.01 EP3	<input type="checkbox"/>	<input type="checkbox"/>	Do menu options meet patient needs & consider personal preference? PC.02.02.03 EP9
<input type="checkbox"/>	<input type="checkbox"/>	QAPI/IC program; integration of food/dietetic service? IC.02.01.01 EP 1, PC.02.02.03 EP 6 and PC.02.02.03 EP 11	<input type="checkbox"/>	<input type="checkbox"/>	Does the organization have a full-time qualified dietitian or other qualified professional? <i>If a dietitian or other qualified professional is not full-time, interview staff to determine adequacy of the dietary director's qualifications.</i> HR.01.02.05 EP2
<input type="checkbox"/>	<input type="checkbox"/>	Hygiene Practices for food service personnel? IC.02.01.01, EP1			
<input type="checkbox"/>	<input type="checkbox"/>	Kitchen sanitation? IC.02.01.01 EP1, PC.02.02.03 EP 6			
		Did service director ensure the following policies/procedures CMS 482.28(a)(1) A-0620: LD.04.01.05 EP3 & HR.01.02.05 EP 2	<input type="checkbox"/>	<input type="checkbox"/>	Determine the relationship between the Dietary Director, & Lead Dietitian if the director is not a dietitian. Review the job descriptions—are their responsibilities clearly defined? CMS requirement for both roles to have necessary experience to serve population HR.01.01.01 EP 1 and HR.01.01.01 EP 3
<input type="checkbox"/>	<input type="checkbox"/>	Safe food handling? PC.02.02.03 EP6	<input type="checkbox"/>	<input type="checkbox"/>	ServSafe certification/license; if required, do the appropriate staff members have this? HR.01.01.01 EP3
<input type="checkbox"/>	<input type="checkbox"/>	Emergency food supplies? EM.02.02.03 EP3			
<input type="checkbox"/>	<input type="checkbox"/>	Orientation, assignments, supervision & personnel performance? HR.01.04.01, HR.01.06.01, HR.01.07.01	Advanced: You can ask for recent health department inspection to provide baseline for whether issues are ongoing or isolated.		
<input type="checkbox"/>	<input type="checkbox"/>	Menu planning, purchasing, & essential record retention?			

PHYSICAL ENVIRONMENT

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Are areas kept clean/sanitary? IC.02.01.01 EP1	<input type="checkbox"/>	<input type="checkbox"/>	Is the area free of any signs of pests ? If there are pests, has the organization taken steps to address the issue? EC.02.06.01 EP20
<input type="checkbox"/>	<input type="checkbox"/>	Kitchen equipment; is it in safe operating condition? If there is an issue, does the staff have a plan to address it? <i>Manufacturer's recommended periodic maintenance schedule or an acceptable Alternate Equipment Management (AEM) program should be followed.</i> EC.02.06.01 EP26	<input type="checkbox"/>	<input type="checkbox"/>	Is cookware/dishware stored in a clean, dry location? <i>Food contact surfaces should be protected from splash, dust, other contamination, etc. typically being stored at least 18" from the floor. There is no requirement for a solid bottom shelf for storage of food or cooking equipment. The HCO determines how such containers will be protected from splash, etc. Use of solid bottom shelving is an example of a strategy that would be used.</i> IC.02.01.01 EP1 & PC.02.02.03 EP 11
<input type="checkbox"/>	<input type="checkbox"/>	Is all kitchen equipment regularly used? <i>Unused equipment should not be stored in food service areas due to increased risk for pests.</i> IC.02.02.01 EP 4	<input type="checkbox"/>	<input type="checkbox"/>	Are dishes/utensils air dried to prevent cross-contamination? IC.02.01.01 EP1

<input type="checkbox"/>	<input type="checkbox"/>	Is <u>garbage/refuse</u> properly disposed of? EC.02.02.01 EP19	<input type="checkbox"/>	<input type="checkbox"/>	Are <u>wet wiping cloths</u> stored in an approved sanitizing solution & washed daily? IC.02.01.01 EP1
<input type="checkbox"/>	<input type="checkbox"/>	Are sinks clear from items that can be contaminated from splashes? e.g. <i>paper-wrapped straws</i> IC.02.01.01 EP 1	<input type="checkbox"/>	<input type="checkbox"/>	Are <u>food carts</u> clean & in good repair? <i>They should be sanitized after every meal.</i> IC.02.01.01 EP1
Advanced: You can ask a question regarding pest control services that have been accomplished.					

REFRIGERATOR

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<u>Refrigerator temps</u> : have they been monitored? PC.02.02.03 EP11	<input type="checkbox"/>	<input type="checkbox"/>	Is <u>uncooked food</u> (chicken or other meat) stored away from cooked food to prevent contamination? e.g. <i>not stored over cooked food</i> PC.02.02.03 EP11
<input type="checkbox"/>	<input type="checkbox"/>	Are frequency of <u>temp checks & limits</u> (41° or lower) maintained as per policy? PC.02.02.03 EP11	<input type="checkbox"/>	<input type="checkbox"/>	Is <u>prepared food</u> covered & labeled with expiration date? PC.02.02.03 EP11
<input type="checkbox"/>	<input type="checkbox"/>	Is there a process if the temp is inadequate? <i>If possible, PC.02.02.03 EP11 validate the process was followed.</i>	<input type="checkbox"/>	<input type="checkbox"/>	Are <u>open containers</u> labeled with expiration date? PC.02.02.03 EP11
<input type="checkbox"/>	<input type="checkbox"/>	Is there <u>pre-cooked food</u> in the cooling process? Is the organization meeting requirements? <i>Food should be cooled to 70° within 2 hours & to 41° within 4 & total cooling time should not exceed 6 hours.</i> PC.02.02.03 EP11	<input type="checkbox"/>	<input type="checkbox"/>	Are there any <u>expired items</u> ? PC.02.02.03 EP11
<input type="checkbox"/>	<input type="checkbox"/>	Is <u>food stored</u> away from soiled areas & rust? PC.02.02.03 EP11	<input type="checkbox"/>	<input type="checkbox"/>	Is the <u>locking mechanism</u> on the door in proper working condition? EC.02.06.01 EP26
<input type="checkbox"/>	<input type="checkbox"/>	Is <u>food stored</u> to allow for ventilation? PC.02.02.03 EP11	<input type="checkbox"/>	<input type="checkbox"/>	Is staff aware of how to use <u>safety process/mechanism</u> in emergency? HR.01.04.01 EP 1

DRY STORAGE

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Are there any <u>expired items</u> ? PC.02.02.03 EP11	<input type="checkbox"/>	<input type="checkbox"/>	Is the <u>area</u> clean, dry, & well ventilated? <i>This will help with humidity & prevent growth of mold/bacteria.</i> PC.02.02.03 EP11
<input type="checkbox"/>	<input type="checkbox"/>	Are <u>canned goods</u> properly sealed? PC.02.02.03 EP11	<input type="checkbox"/>	<input type="checkbox"/>	Is <u>food stored</u> away from sources of heat/light? <i>This helps preserve shelf life.</i> PC.02.02.03 EP11
<input type="checkbox"/>	<input type="checkbox"/>	Does the kitchen have food storage items/plans for <u>disaster preparedness</u> ? <i>A 96-hour stockpile isn't required for emergency operations. The kitchen should have a role in response to an event, & it should correspond with the organization's Emergency Operations Plan.</i> EM.02.02.03 EP3	<input type="checkbox"/>	<input type="checkbox"/>	Are <u>food containers</u> stored off the floor & away from walls to allow for adequate circulation? e.g. 6" above floor, protected from splashes. . <i>There is no requirement for a solid bottom shelf for storage of food or cooking equipment. The HCO determines how such containers will be protected from splash, etc. Use of solid bottom shelving is an example of a strategy that would be used.</i> PC.02.02.03 EP11

FOOD PREP ASSESSMENT - Interview

YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	<u>Foodborne illness</u> : does the organization take prevention measures? Question if cases have occurred/been resolved. IC.01.03.01 EP1	Advanced: Ask about ladle size & how to determine appropriate proportions.
<input type="checkbox"/>	<input type="checkbox"/>	<u>Sick employees or those with open wounds</u> : is there a procedure for them? PC.02.02.03 EP6 or IC.02.01.01 EP 2	Advanced: Conduct HAZMAT tracer for corrosive lime-a-way used for decalcifying automated dishwashers. Assess adequacy of eyewash station, PPE usage, SDS, staff knowledge, etc.
<input type="checkbox"/>	<input type="checkbox"/>	<u>Thawing food</u> : is there a process? <i>Validate the staff is following the process during</i>	

		observation. Food should not be thawing at room temperature & can be thawed under cold running water or the refrigerator. PC.02.02.03 EP6	
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FOOD PREP ASSESSMENT - Observation

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Hand hygiene ; is staff using proper practices; e.g. <i>washing after touching face or hair</i> PC.02.02.03 EP 6	<input type="checkbox"/>	<input type="checkbox"/>	Monitor food temp checks for hot & cold items PC.02.02.03 EP 6
<input type="checkbox"/>	<input type="checkbox"/>	Are hand washing facilities separate from ones used for food prep? EC.02.06.01 EP1	<input type="checkbox"/>	<input type="checkbox"/>	Review temp logs – did staff maintain logs for each service? Is the process for monitoring temps sufficient? <i>Temps are usually logged at start, midpoint & end if meal service is extended. Ensure adequate process for Potentially Hazardous Foods (PHF) and Time/Temp Controlled for Safety (TCS) Foods</i>
<input type="checkbox"/>	<input type="checkbox"/>	Gloves ; do staff use when appropriate to prevent contamination? e.g. <i>handling raw meat or ready-to-eat foods</i> PC.02.02.03 EP6	<input type="checkbox"/>	<input type="checkbox"/>	Mid meal checks ; does the staff know when these are required? HR.01.04.01 EP 3
<input type="checkbox"/>	<input type="checkbox"/>	Hair nets ; are all staff members wearing? PC.02.02.03 EP6	Final cooking temps should be as follows: PC.02.02.03 EP 6		
<input type="checkbox"/>	<input type="checkbox"/>	Cutting boards/prep surfaces ; are they cleaned properly to avoid contamination? e.g. one for meat, one for veggies & sanitized between uses IC.02.01.01 EP1 Does the staff use clean utensils with bulk foods/ice? PC.02.02.03 EP6	<input type="checkbox"/>	<input type="checkbox"/>	Poultry - 165°
			<input type="checkbox"/>	<input type="checkbox"/>	Ground meat, ground fish, eggs - 155°
			<input type="checkbox"/>	<input type="checkbox"/>	Fish & other meat - 145°
			<input type="checkbox"/>	<input type="checkbox"/>	Precooked, cooled, then reheated - 165°
			<input type="checkbox"/>	<input type="checkbox"/>	Hot food hold temp - 135° or higher
<input type="checkbox"/>	<input type="checkbox"/>	Evaluate dishwasher temps/chemical monitoring processes IC.02.01.01 EP 1	<input type="checkbox"/>	<input type="checkbox"/>	Cold food hold temp - 41° or below

FREEZER **PC.02.02.03 EP11 for food storage**

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Freezer temps ; have they been monitored?	<input type="checkbox"/>	<input type="checkbox"/>	Is the freezer free of any ice buildup? EC 02.06.01 EP 26
<input type="checkbox"/>	<input type="checkbox"/>	Are frequency of checks & temp limits maintained as per policy? <i>Temps should ensure that food remains solid.</i>	<input type="checkbox"/>	<input type="checkbox"/>	Are items labeled appropriately with expiration dates ? <i>There should be no expired items</i> PC 02.02.03 EP11
<input type="checkbox"/>	<input type="checkbox"/>	Is there a process if the temp is inadequate? <i>If possible, validate the process was followed.</i>	<input type="checkbox"/>	<input type="checkbox"/>	If there is pre-cooked food , is the cooling process sufficient? <i>See refrigerator note above</i> PC 02.02.03 EP11
<input type="checkbox"/>	<input type="checkbox"/>	Is food stored away from soiled areas & rust?	<input type="checkbox"/>	<input type="checkbox"/>	Is the locking mechanism on the door in proper working condition? EC.02.06.01 EP26
<input type="checkbox"/>	<input type="checkbox"/>	Is food stored to allow for ventilation?	<input type="checkbox"/>	<input type="checkbox"/>	Is there a process/mechanism in place to prevent staff from being locked in? Can the mechanism be accessed, & is it in working order? <i>It shouldn't be blocked or have any ice buildup.</i>
<input type="checkbox"/>	<input type="checkbox"/>	Is the freezer free from any signs of freezer burn/food discoloration ?	<input type="checkbox"/>	<input type="checkbox"/>	Is staff aware of how to use safety process/mechanism in emergency? HR.01.04.01 EP 1
<input type="checkbox"/>	<input type="checkbox"/>	Are raw foods stored properly? <i>There should be no signs of them dripping on other foods.</i>	<input type="checkbox"/>	<input type="checkbox"/>	

LIFE SAFETY

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Is the kitchen in good repair? e.g. <i>lack of broken floor tiles, delamination, flaking walls, etc.</i>	<input type="checkbox"/>	<input type="checkbox"/>	Are the gaskets intact for kitchen entry/delivery doors to prevent entry from pests? EC.02.06.01 EP1

<input type="checkbox"/>	<input type="checkbox"/>	Do sprinkler heads have adequate 18" clearance? <i>Ensure racks perpendicular to walls do not encroach 18" open space for sprinklers. NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 13-2010: 8.5.5.2; 8.5.5.2.1; 8.5.5.3</i> LS.02.01.35 EP6	<input type="checkbox"/>	<input type="checkbox"/>	Eyewash/shower station ; if required, is it in good working order & located away from hazards? EC.02.02.01 EP5
			<input type="checkbox"/>	<input type="checkbox"/>	Can staff access eyewash station within 10 seconds of hazardous material storage/usage area? EC 02.02.01 EP5
		Evaluate sprinkler head obstructions in BOTH refrigerators & freezers. Be wary of surface mounted fluorescent light fixtures close to sprinkler heads as this does not follow the 18" rule. <i>Refer to attachment for specific criteria.</i>	<input type="checkbox"/>	<input type="checkbox"/>	Has the eyewash inspection log been kept up to date? EC 02.02.01 EP5
<input type="checkbox"/>	<input type="checkbox"/>	Soda fountain machine ; is the CO2 secured? EC 02.06.01 EP 1	<input type="checkbox"/>	<input type="checkbox"/>	Natural gas ; does the organization use this?
<input type="checkbox"/>	<input type="checkbox"/>	Are sewage/pipelines free from signs of water damage? EC 02.06.01 EP 1	<input type="checkbox"/>	<input type="checkbox"/>	Is a gas valve accessible for emergency shutoff & do staff know its location/operation? EC.02.05.05 EP6/ EC 03.01.01 EP2
<input type="checkbox"/>	<input type="checkbox"/>	Deep fat fryer ; is there a K fire extinguisher within 30'? <i>NFPA 96–2011 10.10.1; NFPA 10–2010, 6.6.1; 6.6.2</i> LS.02.01.35 EP11			Is emergency shutoff valve properly labeled? EC.02.05.01 EP9
<input type="checkbox"/>	<input type="checkbox"/>	Deep fat fryer ; is it installed with at least a 16" space between the fryer & surface flames from adjacent cooking equipment? <i>NFPA 96–2011 12.1.2.4</i> LS.02.01.30 EP26			Evaluate the hood system
<input type="checkbox"/>	<input type="checkbox"/>	K fire extinguisher placard identifying need to activate the fixed suppression (ansul) system before using the extinguisher? <i>NFPA 96-2011 10.2.2</i> LS.02.01.35 EP11	<input type="checkbox"/>	<input type="checkbox"/>	Is the hood clean with no grease buildup? <i>NFPA 96-2011 11.6.2</i> LS.2.01.30 EP26
<input type="checkbox"/>	<input type="checkbox"/>	Suppression system ; does staff know how to use it? <i>Instructions for manual operations should be conspicuously posted & reviewed by staff. NFPA 96-2011 11.1.4</i> EC.03.01.01 EP1	<input type="checkbox"/>	<input type="checkbox"/>	Are the steel filter baffles all installed with no gaps & are they in the proper direction? <i>NFPA 96-2011 6.2.3.1; 6.2.3.5</i> LS.2.01.35 EP14
<input type="checkbox"/>	<input type="checkbox"/>	Compressed gas cylinders ; are they properly secured? <i>NFPA 99-2012 11.3; 11.6.2.3</i> EC.02.05.09 EP12	<input type="checkbox"/>	<input type="checkbox"/>	Is grease producing equipment located properly under the hood? <i>NFPA 96-2011 5.2</i> LS.2.01.35 EP14
			<input type="checkbox"/>	<input type="checkbox"/>	Are extinguishing heads pointed properly toward the cooking surface? LS 02.01.35 EP 14
			<input type="checkbox"/>	<input type="checkbox"/>	Electrical panels ; are they clear from obstruction? <i>There should be 36"</i> EC.02.05.05 EP6
			<input type="checkbox"/>	<input type="checkbox"/>	Fire Evacuation & Relocation Plan ; is the staff knowledgeable? <i>NFPA 101-2012: 18/19.7.1; 7.2</i> EC.03.01.01 EP2

Imaging Document Review Guide for Healthcare Organizations

The following documents and data need to be made available to the surveyor for review, based on the imaging modalities provided by your organization. Note: It is not necessary for you to copy these documents for the surveyor, just ensure that they are available for review. This document will assist you with compiling those documents.

1. Facilities and Equipment:

- ☐ Equipment quality control (QC) and performance maintenance (PM) activities for CT, MRI, PET, and NM equipment, with the dates completed (last 12 months) (EC.02.04.01, EP 5 and 10) (EC.02.04.03, EP 16 and 18)
- ☐ CT annual equipment performance evaluation: EC.02.04.03, EP 21
Must be documented, done by medical physicist, and include:
 - Image uniformity
 - Slice thickness accuracy
 - Alignment light accuracy
 - Table travel accuracy
 - Radiation beam width
 - High contrast resolution
 - Low contrast resolution
 - Geometric or distance accuracy
 - CT number accuracy and uniformity
 - Artifact evaluation
- ☐ MRI annual equipment performance evaluation: EC.02.04.03, EP 22
Must be documented, done by medical physicist or MRI scientist, and include
 - Image uniformity for all coils used clinically
 - Signal to noise ratio (SNR) for all coils used clinically
 - Slice thickness accuracy
 - Slice position accuracy
 - Alignment light accuracy
 - High contrast resolution
 - Low contrast resolution
 - Geometric or distance accuracy
 - Magnetic field homogeneity
 - Artifact evaluation
- ☐ NM annual equipment performance evaluation: EC.02.04.03, EP 23
Must be documented, done by medical physicist or nuclear medicine physicist, and include
 - Image uniformity / system uniformity
 - High contrast resolution / system spatial resolution
 - Artifact evaluation
 - Sensitivity
 - Energy resolution
 - Count rate performance
- ☐ PET annual equipment performance evaluation EC 02.04.03, EP 24
Must be documented, done by medical physicist or nuclear medicine physicist, and include
 - Image uniformity / system uniformity
 - High contrast resolution / system spatial resolution
 - Low contrast resolution or detectability
 - Artifact evaluation

- Fluoroscopy annual equipment performance evaluation EC.02.04.03, EP 34
Must be documented, done by a medical physicist, and include:
 - Beam alignment and collimation
 - Tube potential/ kilovolt peak (kV /kVp accuracy)
 - Beam filtration (half value layer)
 - High contrast resolution
 - Low contrast detectability
 - Maximum exposure rate in all imaging modes
 - Displayed air-kerma rate and cumulative air-kerma accuracy (when applicable)
- Image Acquisition Display Monitor Performance Evaluations for CT, MRI, NM, PET EC.02.04.03, EP 25
Must be performed as part of annual equipment performance evaluations and include:
 - Maximum and minimum luminance
 - Luminance uniformity
 - Resolution
 - Spatial accuracy
 Often documented in the CT, MRI, NM, PET, and Fluoro annual equipment performance evaluation
- CT Dose Verification EC.02.04.03 EP 20
 - Annual report from medical physicist on the CTDI vol for adult and pediatric brain and abdomen protocols for each diagnostic CT imaging system
- Lead Apron Assessment EC.02.04.01, EP 2, 4, 5 and EC.02.04.03, EP 3
 - Inventory and inspection for cracks, tears, integrity

2. Radiation Protection and Radiopharmaceutical Management

Radiation Protection and Radiopharmaceutical Management

- Records of radiopharmaceutical receipt and disposition MM.03.01.01, EP 24
- Dosimetry monitoring record for the last 2 years EC.02.02.01, EP 18
- Documentation of dosimetry monitoring at least quarterly by the radiation safety officer or physicist EC.02.02.01, EP 17

Structural Shielding:

If your organization has installed or replaced imaging equipment or modified any rooms where ionizing radiation is emitted or radioactive materials used **since July 1, 2015**, provide the structural shielding design assessment, and the radiation protection survey (EC.02.06.05 EP 4 & 6). Note: The assessment must have been done *before* the renovation, and the survey must have been done *after* the work, but before the area(s) was used for patients.

3. Clinical Policies and Protocols

- Critical Tests: Written procedures or protocols, and data collected on the timeliness of reporting critical results of tests and diagnostic procedures NPSG. 02.03.01, EP1
- CT Protocols: Protocols must be based on current standards of practice and address clinical indication, contrast administration, pediatric or adult, patient size and body habitus, expected radiation dose range. Must include input from interpreting physician, lead imaging technologist, and medical physicist and be reviewed at timeframes established by hospital PC.01.03.01, EP 25 and 26
- Supervision of Contrast Administration: Policy or protocol defining role of LIP in direct supervision of contrast administration, including timely intervention in the event of patient emergency. Either a pharmacist reviews orders for contrast OR a LIP controls the ordering, preparation, and administration of contrast. MM.05.01.01, EP 1
- MRI Safety: Policies address: claustrophobia, noise protection, metal detection, patient emergencies while in scanner, restricting access to scanner for all people not trained in MRI safety EC.02.01.01, EP 14 and 16

4. Reporting and Performance Improvement

- Data collected on thermal injuries during MRI PI.01.01.01, EP 34
- Data collected on incidents and injuries where ferromagnetic objects unintentionally entered MRI scan room PI.01.01.01, EP35

- Data collected on incidents where radiation dose (CTDIvol, DLP, SSDE) exceeded the expected range Identified in the imaging protocol PI.02.01.01, EP 6
5. Staff Competencies
- Credential files for all diagnostic medical physicists who work with CT. HR.01.01.01, EP 33
 - Credential files including certification and annual training on dose optimization for CT techs HR.01.01.01, EP 32, and HR.01.05.03, EP 14
 - Credential files including annual training for all MRI techs on safe MRI practices HR.01.05.03, EP 25
6. Leadership
- Documentation / Radiology Director: must be a qualified MD or DO. MS.06.01.03, EP 9
 - Documentation / Nuclear Medicine: must be a qualified MD or DO. LD 04.01.05, EP 7
 - Documentation / Radiation Safety Officer: must be designated. LD.04.01.05, EP 25
 - Documentation of Medical Staff Approval (usually at Med Exec Comm Meeting) for:
 - Qualifications of radiology staff who use equipment and administer procedures MS.03.01.01, EP16
 - Nuclear Medicine Director's specifications for the qualifications, training, functions, of nuclear medicine staff MS.03.01.01, EP 17
7. Medical Records:
- Reports, including medical record number, documenting radiopharmaceutical dose received for 5 recent inpatients. RC.02.01.01, EP 2
 - Reports, including medical record number, documenting contrast dose and radiation dose for 5 recent inpatients. RC.02.01.01, EP 2, and PC.01.02.15, EP 5
 - Reports, including medical record number, documenting fluoroscopy radiation dose for 5 recent inpatients. PC.01.02.15, EP 13

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