

# Hospital Accreditation Survey Activity Guide

## August 2024





# **Hospital Accreditation**

## **Survey Activity Guide**

**August 2024**

Issue Date: August 1, 2024

# What's New for Hospital Survey Process 2024

New or revised content for 2024 is identified by underlined text within the noted activities.

## Changes effective August 1, 2024

**Individual Tracer Activity** -- The survey process related to informed consent has been revised to align with updated guidance for hospitals from the US Centers for Medicare & Medicaid Services' (CMS), as published in [memo QSO-24-10-Hospitals](#) on April 1, 2024. The guide updates present the expanded surveyor inquiry that will occur during individual tracer activity related to the organization's informed consent process and evaluating if it addresses obtaining consent when practitioners other than the operating practitioner will be participating in and/or performing important tasks related to the surgery or an intimate/sensitive examination (such as breast, pelvic, prostate, and rectal exams) or invasive procedure for educational and training purposes.

## Changes effective July 1, 2024

**Infection Control**—Standard number references updated throughout the guide to reflect the updated accreditation manual chapter.

**NEW! Emergency Management Documentation Review Tool** – This is the same tool surveyors use to evaluate compliance with the Emergency Management requirements which can help your organization monitor performance.

**NEW! Infection Prevention and Control Program Assessment Tool** – In support of the updated standards, this new tool will assist with identifying and evaluating the details of compliance associated with the requirements.

**Medical Staff and Related Standards Compliance Evaluation Guide** – Guide updated to reflect the current OPPE (Ongoing Professional Practice Evaluation) frequency.

Removed all references to “systems tracers” throughout the guide and replaced in some locations with Organization Quality and Performance Improvement Session.

## Changes effective May 1, 2024

**NEW! Organization Quality and Performance Improvement Session** – Retitling the Systems Tracer – Data, Infection Control and Medication Management, and resetting the activity to focus on organization quality and performance improvement processes and work. Three new tools being introduced to facilitate the evaluation of organization quality and performance improvement efforts.

## Changes effective March 1, 2024

**Correction! Life Safety & Environment of Care document List and Review Tool** – EC.02.03.01, EP 9 language on tool edited to remove the reference to licensed practitioners as the EC standards reference to “staff” is inclusive of licensed practitioners; and, added an item to the bulleted list regarding plan contents including “how staff will cooperate with firefighting authorities.” Returned the EC.04.01.01, EC.04.01.03, EC.04.01.05 standards and associated EPs to the tool.

## Changes effective January 1, 2024

**Correction!** **Life Safety & Environment of Care Document List and Review Tool** – Updated to remove all content related to an Alternative Equipment Maintenance program and included references to the section of the Guide titled Guidance on Use of Alternative Maintenance Activities and/or Schedules. These changes appeared in blue highlighted text in the July, 2023 Guide.

**Kitchen Tracer Survey Guide** – Corrected standard number reference for soda machine CO2 and added a new item to life safety section (tethering kitchen appliances) for evaluation.

## Hospital Organization Survey Activity Guide (SAG)

How to Use this Guide .....	6
Preparing for Surveyor Arrival.....	7
Requested Documentation List.....	10
Hospital Accreditation Survey Activity List .....	13
Surveyor Arrival .....	15
Surveyor Preliminary Planning Session .....	16
Opening Conference.....	17
Orientation to the Organization .....	18
Individual Tracer Activity.....	20
Program Specific Tracer – Suicide Prevention, including Ligation and Other Self-Harm Risk Assessment.....	24
Program Specific Tracer – Special Psychiatric Hospital CoPs .....	26
Program Specific Tracer – Laboratory Integration.....	28
Program Specific Tracer – Patient Flow.....	29
Organization Quality and Performance Improvement Session .....	30
Special Issue Resolution .....	38
Surveyor Planning/Team Meeting.....	39
Daily Briefing .....	40
Competence Assessment Session .....	41
Medical Staff Credentialing and Privileging.....	42
Facility Orientation and Document Review – Life Safety Surveyor.....	43
Life Safety Code® Building Assessment.....	45
Emergency Management Session .....	47
Emergency Management Documentation Review Tool.....	51
Leadership Session .....	54
Surveyor Report Preparation .....	56
CEO Exit Briefing.....	57
Organization Exit Conference .....	58
OPTIONAL Primary Care Medical Home (PCMH) Certification.....	59
Life Safety & Environment of Care Document List and Review Tool .....	61
Guidance on Use of Alternate Maintenance Activities and/or Schedules .....	77
A Tag Summary Review Sheet – Deemed Hospital Medical Record Review .....	83
Medical Staff-Related Standards Compliance Evaluation Guides .....	86
Kitchen Tracer Survey Guide – Hospital and Critical Access Hospital .....	96
Imaging Document Review Guide for Healthcare Organizations.....	100
Infection Prevention and Control Program Assessment Tool .....	103

## How to Use this Guide

The Joint Commission's Survey Activity Guide for hospitals 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 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, nursing care center). 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 the programs on these activity lists.

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, hospital, outpatient services, behavioral health.

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.

# Preparing for Surveyor Arrival

## Overview

The surveyors arrive unannounced or with short notice for most surveys. Please consult the Hospital 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 List for Hospitals 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 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.
- Persons to notify upon surveyor 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 if 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 activity description for these steps.)
- Readiness Guide and Accreditation Program-specific Document List: The Guide is created for you to use as a planning tool and can be included with your survey plan. Your organization should be prepared to have the requested documents available for review by 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 provide the Safety Briefing for the surveyors
  - The purpose of the Safety Briefing is for your organization to inform surveyors about any current safety or security concerns and how Joint Commission staff should respond if your safety plans are implemented while they are on site.
  - **The briefing is informal, five minutes or less**, and should take place once the surveyors are settled in the “base” location reserved for their use throughout the survey.

- Situations that should be covered include fire, smoke or other emergencies; workplace violence events (including active shooter scenarios); any contemporary issues the surveyors may experience during the time they are with you (for example, seasonal weather-related events, anticipated or current civil unrest, or labor action)
- 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 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

### Survey Planning and Readiness Notes:

1. Please review the Hospital 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. Make available as many of the materials noted on the Hospital Requested Documentation List as possible for the Surveyor Preliminary Planning Session.
3. 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

# Hospital Accreditation Program

## Requested Documentation List

Hospitals will need to have the following information and documents available for the surveyor(s) to begin reviewing during the Surveyor Arrival and Preliminary Planning activity. This review will continue 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
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. Environment of Care data (see [Life Safety & Environment of Care Document List and Review Tool](#))
23. Environment of Care Management Plans and annual evaluations
24. Environment of Care multidisciplinary team meeting minutes for the 12 months prior to survey
25. Emergency Management documentation for each of the following (each must be updated and reviewed at least every 2 years):

## Hospital Requested Documentation ...continued

- a. Emergency management program
  - b. Hazard vulnerability analysis
  - c. Emergency operation plan and policies and procedures
  - d. Communications plan
  - e. Continuity of operations & recovery plan
  - f. Education and training program
  - g. Exercises and testing program
  - h. Emergency management program evaluation (after-action/improvement plans)
  - i. Unified and integrated Emergency management program, plans, policies & procedures (if applicable)
  - j. Transplant program-specific protocols (if applicable)
26. Annual infection risk assessment (i.e., identified risks for infection, contamination, and exposure that pose a risk to patients and staff)
  27. Infection Control surveillance data from the past 12 months
  28. Medical Staff Bylaws and Rules and Regulations (**Please Note:** If your organization has had any changes or updates to your Medical Staff Bylaws and/or Medical Staff Rules and Regulations since your last full triennial survey, please have those sections flagged for your survey team to review.)
  29. Medical Executive Committee meeting minutes
  30. 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
  31. Governing Body minutes for the last 12 months
  32. Autopsy policy
  33. Blood transfusion policy
  34. Complaint/grievance policy
  35. Restraint and seclusion policy
  36. Waived testing policy and quality control plan
  37. ORYX data – an organization should be prepared to share ORYX Performance Measurement data and/or Accelerate PI Dashboard reports.
  38. Available regulatory reports (CMS, State)
  39. Medication management policy (*which defines what is a complete medication order and therapeutic duplication*)
  40. Abuse and neglect policy for inpatient, and ambulatory sites, if applicable
  41. Fall risk assessment and policy
  42. Organization approved antibiotic stewardship protocols (for example, policies, procedures, or order sets)
  43. Antibiotic stewardship data
  44. Antibiotic stewardship program reports to leadership and prescribers
  45. 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)
  46. Most recent culture of safety and quality evaluation data
  47. Environmental risk assessment identifying features in the physical environment that could be used to attempt suicide (*Applies to psychiatric hospitals and psychiatric units in general hospitals*)

## Hospital Requested Documentation ...continued

**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 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 (Includes the Safety Briefing)	30-60 minutes	1 <sup>st</sup> day, upon arrival	
Opening Conference and Orientation to the Organization	30-60 minutes	1 <sup>st</sup> 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 <b>OR</b> 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 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization May be conducted with Life Safety surveyor.	
<u>Organization Quality and Performance Improvement Session</u>	60-90 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization.	
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	
<b>Note: The following activities may be incorporated into the survey agenda as noted under the Suggested Scheduling of Activity column.</b>			
Interim Exit – w/ early departing surveyors and organization	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	
<b>Life Safety Code® Survey Activity</b>			
Life Safety Code Surveyor Arrival and Preliminary Planning Session	15 minutes	LSCS survey 1 <sup>st</sup> day, early	
Facility Orientation and Document Review	60 minutes 120-150 minutes	At a time negotiated with the organization	

## Hospital Accreditation Survey Activity List ...continued

<b>Survey Activity Name</b>	<b>Suggested Duration of Activity</b>	<b>Suggested Scheduling of Activity</b>	<b>Organization Participants (Refer to Survey Activity Guide for more info.)</b>
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	60 minutes	At a time negotiated with the organization. May be conducted with a Clinical surveyor.	
Report Preparation	60 minutes	Towards the end of last day of survey	
Interim Exit	30 minutes	Last activity on last day of survey	

# Surveyor Arrival

## Organization Participants

Suggested participants include the organization's accreditation contact or survey coordinator.

## Logistical Needs

- Identify a location where surveyors can wait for organization staff.
- Identify a location surveyors can consider as their "base" or work-area 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](http://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:
  - Confirmation of scheduled Joint Commission event authorizing the surveyor's presence for the unannounced survey
  - Surveyor name(s), picture, and biographical sketch
  - Survey agenda.
- 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 Hospital Requested Documentation list. Surveyors will start reviewing this information immediately.

# Surveyor Preliminary Planning Session

## Organization Participants

Suggested participants include the organization's accreditation contact or survey coordinator, individual or individuals that will provide the Safety Briefing to surveyors, if different than the accreditation contact or survey coordinator.

## Logistical Needs

- The suggested duration of this session is approximately 30 to 60 minutes, with only a few minutes of this time designated for the Safety Briefing.

Surveyors need:

- A work area they can use as their "base" for the duration of the survey with a desk or table, telephone, **internet access**, and access to an electrical outlet, if possible.
- A means to secure their belongings.
- The name and phone number of a key contact person to assist them in survey planning and tracer selection.
- As much information and material noted on the Hospital Requested Documentation list as possible.

## Objectives

Surveyors will:

- Learn about any current organization safety or security concerns and how they should respond if organization safety plans are implemented.
- Begin review of available documents to become acquainted with your organization.
- Plan for tracer activity.

## Overview

After surveyors arrive 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.

The organization is requested to provide surveyors with a Safety Briefing (informal, no more than five minutes) sometime during this activity. The purpose of this briefing is to inform the surveyors of any current organization safety or security concerns and how Joint Commission staff should respond if your safety plans are implemented while they are on site. Situations to cover include:

- Fire, smoke, or other emergencies
- Workplace violence events (including active shooter scenarios)
- Any contemporary issues the surveyor may experience during the time they are with you (for example, seasonal weather-related events, anticipated or current civil unrest, or labor action)



# Opening Conference

## Organization Participants

Suggested participants include members of the governing body and senior leadership representing the accredited program and services.

## Logistical Needs

The duration of this session is approximately 15 minutes. Inform surveyors at this time of any agenda considerations that may impact the activities for the day.

Immediately following this session is the Orientation to the Organization. If possible, designate a room or space that will hold all participants and will allow for an interactive discussion.

## 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. 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 review any updates to the accreditation process that may have been implemented since the organizations last full survey event.

## IMPORTANT

Your organization should ask questions and seek clarification from the surveyor(s) about anything that you do not understand throughout the onsite event. Depending on the question, issue, or concern, the surveyor may suggest addressing them during a Special Issue Resolution Session later in the day. It is important for you to request clarification at any time you do not understand surveyor questions, actions, or discussions.

# Orientation to the Organization

## Organization Participants

Attendees should be able to address leadership's responsibilities for:

- Strategic planning,
- Resource allocation,
- Management, oversight,
- Performance improvement, and
- Support in carrying out your organization's mission and strategic objectives

Consider including the following individuals

- Senior leadership representing the accredited program and services
- Member(s) of the governing body, or organization trustee
- Administrators
- Leader(s) of the medical staff
- Leader(s) of the nursing staff
- Accreditation contact

## Logistical Needs

- This activity is usually combined with the Opening Conference.
- Meeting space should allow for an interactive discussion.
- The suggested duration of this session is approximately 30-60 minutes.
- **Please do not prepare a formal presentation.**

## Objective

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

## Overview

During this activity 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
- Planning, resource allocation, and decision-making processes
- Information management, especially the format and maintenance of medical records
- Contracted services and performance monitoring, including telemedicine, telehealth services
- Health care errors reduction and patient safety initiatives
  - Processes in place for reporting "close calls" or "near misses"
  - Frequency with which this process is being used, analysis of data, including root cause analyses
- National Patient Safety Goal on suicide risk reduction (NPSG.15.01.01), including environmental risk assessments and mitigation plans
- The organization's patient population, including characteristics such as race, ethnicity, and language/communication needs
- Community involvement initiatives
- Leaders' roles and scope of responsibility in emergency management planning
- Utilization review process--if there is no agreement with a QIO (deemed hospitals only)

- Organization activities related to risk awareness, detection, and response as it relates to cyber emergencies
- Assessment of the organization's culture and attention to safety, including
  - Instrument being used
  - Scope of assessment
  - Response rate
  - Assessment results
  - Actions to improve results
- Organization's code of conduct and behavior for physicians and staff
- Infection prevention and control program
- Pain assessment, pain management including nonpharmacologic treatment modalities, and safe opioid prescribing, when applicable
- 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
- Organ, tissue, and eye donation and procurement processes; OPO identification
- Imaging services, scope, types, including fluoroscopy services, locations, safety

Additional discussion topics include:

- Leaders' ideas about the organization's potential risk areas
- Leaders' 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
- Physician and other licensed practitioner involvement in performance improvement projects and initiatives

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, physicians, other licensed practitioners, 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 patient 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 patient.

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 patient received services.

## Objective

The surveyor will evaluate your organization's compliance with standards as they relate to the care, treatment, and services provided to patients.

## Overview

Most survey activity occurs during individual tracers. The term "individual tracer" denotes the survey method used to evaluate the organization's compliance with standards related to the care, treatment, and services provided to a patient. 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 organization 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 patients with more complex situations whose care involves multiple services.

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

- Following the course of care, treatment, or services provided to the patient 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 during other survey activities such as Competence Assessment Organization Quality and Performance Improvement, 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 patients by physicians and other licensed practitioners.
- The medication process (e.g., preparation, dispensing, administration, storage, control of medications).
- Infection prevention and control practices For full details, refer to the Infection Prevention and Control Program Assessment Tool in this guide [Infection Prevention and Control Program Assessment Tool](#).
- The process for planning care, treatment, or services.
- The environment as it relates to the safety of patients and staff.

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, for example patient hand-offs.
- The use of data in the care of patients, and for improving organization performance; their awareness and involvement in performance improvement projects.
- Patient flow through the organization.
- National Patient Safety Goals for example, anticoagulant therapy (NPSG.03.05.01) and suicide risk reduction (NPSG.15.01.01).
- Patient education, availability of tools and resources to assist with communication.
- Obtaining of informed consent in accordance with hospital policy. This includes the following situations:
  - When practitioners other than the operating practitioner, including but not limited to other physicians, residents, advanced practice providers (such as NPs and PAs), and medical and other applicable students, will be participating in and/or performing for educational and training purposes an intimate/sensitive examination (such as breast, pelvic, prostate, and rectal exams) or invasive procedure when a patient is receiving sedation or anesthesia (included in the consent form)
  - When practitioners other than the operating practitioner, including but not limited to other physicians, residents, advanced practice providers (such as NPs and PAs), and medical and other applicable students, will be participating in and/or performing for educational and training purposes an intimate/sensitive examination (such as breast, pelvic, prostate, and rectal exams) or invasive procedure without sedation or anesthesia (documented in the record as determined by policy)
- Orientation, education, and competency of staff.
- The record-keeping systems in 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.
- The education staff have been provided on antibiotic resistance and the organization's antibiotic stewardship program.
- 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.
- Awareness of and participation in a safety culture assessment; awareness of assessment results.
- Reporting near misses/close calls as well as actual errors; awareness of any organization processes to look at these occurrences.
- Workload issues.
- Discharge planning.
- Organization's code of conduct/behavior; reporting intimidating behavior or perceived violations of such codes.
- 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.
- Roles and responsibilities related to the environment of care, for example preventing, responding to, and reporting incidents.
- Other topics, as applicable.

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

- Organization processes that support or may be a barrier to patient care, treatment, and services.
- Communications and coordination with other physicians and licensed 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.
- The education or information they have been provided on antibiotic resistance and the organization's antibiotic stewardship program.
- 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.
- Awareness of and participation in a safety culture assessment; awareness of assessment results.
- Reporting near misses/close calls as well as actual errors; awareness of any organization processes to look at these occurrences.
- Organization's code of conduct/behavior; reporting intimidating behavior or perceived violations of such codes.
- 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.
- Other topics, as applicable.

During the individual tracer, the surveyor interviews patients, 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 handwashing and verifying their identity.
- Understanding of instructions (for example, diet or movement restrictions, medications, discharge, and provider follow-up), as applicable.
- Involvement in decision-making.
- Informed consent prior to non-emergency procedures, as applicable. This includes patients (and/or family members) being informed if practitioners other than the operating practitioner, including but not limited to, other physicians, residents, advanced practice providers (such as NPs and PAs), and medical and other applicable students will be participating in and/or performing for educational and training purposes an intimate/sensitive examination (such as breast, pelvic, prostate, and rectal exams) or invasive procedure when a patient is receiving sedation or anesthesia.
- Informed consent prior to an intimate/sensitive examination (such as breast, pelvic, prostate, and rectal exams) or invasive procedure without sedation or anesthesia for educational and training purposes. This includes patients (and/or family members) being informed if practitioners other than the operating practitioner, including but not limited to, other physicians, residents, advanced practice providers (such as NPs and PAs), and medical and other applicable students, will be participating in and or performing for educational and training purposes an intimate/sensitive exam (such as breast, pelvic, prostate, and rectal exams) or invasive procedure without sedation or anesthesia.
- If 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).
- Discharge planning and instructions.
- Patient's rights, including those regarding visitation.
- Other topics, as applicable.

## Using individual tracers for continuous evaluation

Many organizations find tracer activity helpful in the continuous evaluation of their services. If your hospital chooses to practice individual tracer activity, in addition to clinical services, consider the following criteria in selecting patients.

### Selection Criteria

- Patients that allow for evaluating systems such as infection prevention and control, and safe medication practices
- Patients who move between programs/services (for example, patients scheduled for a follow-up in ambulatory care post discharge, hospital patient being discharged with home care, long term care residents transferred from the hospital, patients referred to another specialty practitioner within the same organization, patients who received radiology or laboratory services)
- Patients recently admitted

- Patients due for discharge or recently discharged
- Patients who cover multiple additional criteria listed below, such as:
  - Receiving care and treatment in the intensive care units (MICU, SICU, CVCU, etc.)
  - Admitted to the health care system through the emergency department
  - Diagnosed with cardiac arrest
  - Receiving labor and delivery services (including patients scheduled for C-section)
  - Receiving care and treatment that requires sedation and anesthesia (includes hand-off communication)
  - Receiving care and treatment on a skilled nursing or subacute care unit
  - A 23-hour admit
  - Receiving dialysis services
  - Diagnosed with a psychiatric condition, or identified as a high risk for suicide
  - Assigned to pediatric service
  - Receiving radiology or nuclear medicine services
  - Receiving rehabilitation services
  - A possible organ donor or transplant recipient
  - Receiving waived lab services
  - Discharged (or retrospective review and interview of recently discharged patient)
  - Receiving antibiotic medications
  - Receiving opioid medications
  - Diagnosed with a terminal illness
  - Discharged, deceased

## **Program Specific Tracer – Suicide Prevention, including Ligature and Other Self-Harm Risk Assessment**

### **Joint Commission Participants** Clinical and Life Safety Surveyors

Note: The surveyors will determine how to best meet the objectives for this activity, either as a team or by splitting up to perform individual tracers and continuing the building tour.

### **Organization Participants**

- Staff who have been involved in care, treatment, or services of a patient screened and considered high risk for suicide
- Facility manager(s)
- Safety Management Coordinator
- Nurse Leader or chief nursing officer
- Medical Director or chief medical officer

### **Logistical Needs**



This focused tracer occurs during time designated for Individual Tracer Activity and Life Safety building tour activity.

## Objectives

The surveyor will:

- Evaluate effectiveness of the organization's suicide prevention strategy
- Identify processes and system level issues contributing to suicide attempts
- Evaluate the effectiveness of the organization's processes for designing and maintaining buildings and the patient care environment in a manner to prevent suicides and self-harm behaviors.
- Evaluate the effectiveness of the organization's processes for identifying, assessing, and resolving ligature, suicide, and self-harm risks present in the environment.
- Assess the organization's ability to maintain activities to mitigate against environmental risks prior to resolving them, through clinical program activities such as suicide risk assessment, precautions, one-to-one monitoring when appropriate, contraband searches, patient observation checks, etc.

## Overview

Suicide ranks as the 10<sup>th</sup> most frequent cause of death (third most frequent in young people) in the United States. Suicide of a care recipient while in a staffed, round-the-clock care setting continues to be a 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 hospital psychiatric inpatient setting is an important first step in protecting and planning the care of these at-risk individuals.

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

- Crisis process
- Initial assessment process
- Reassessment process
- Environmental assessment for ligatures and other risks for self-harm and suicide
- Planning of care, treatment, or services
- Mitigation plans for patients at high-risk for suicide
- Continuum of care, treatment, or services
- Education provided to the patient and family
- Orientation, training, and competency of clinicians
- Staffing
- Information management, including timely and accessible information to staff who need to know

The Life Safety surveyor will:

- Interview staff such as security, counselors about training and processes related to the care of patients at risk for suicide
- Assess the environment for the presence or absence of items that would prevent suicide
- Assess ligature, suicide and other self-harm risks while moving throughout care, treatment, and service areas
- Assess plans and policies on mitigation of harm posed by environmental risks

# Program Specific Tracer – Special Psychiatric Hospital CoPs

## Applicability:

Psychiatric hospitals participating in Medicare and Medicaid with distinct part certified programs

## Joint Commission Participants

Psychiatrist and/or nurse surveyors with psychiatric experience

## Organization Participants

Staff who have been involved in care, treatment, or services of patients

## Logistical Needs

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

## Objectives

The surveyor will:

- Evaluate compliance with the special psychiatric hospital conditions of participation.
- Evaluate the degree and intensity of treatment and confirm documentation in the clinical record.
- Collect and document required information related to nurse staffing and physician coverage.
- Collect and document required information related to discharge planning and death record review.

## Overview

There are additional CMS Conditions of Participation details that must be evaluated for compliance during psychiatric hospital surveys. This activity describes the additional areas of focus that will be covered in the noted activities.

## Individual Tracer Activity

In addition to topics and areas addressed during individual tracer activity, surveyors will spend time conducting additional tracers to evaluate the degree and intensity of treatment provided through:

Interviewing patients to determine:

- If treatment plan goals are consistent with the psychiatric condition for which the patient is being treated.
- Participation in the discharge planning process
- Level of participation in the activities and services

Interviewing staff, and reviewing records to determine:

- If short-term and long-term goals along with projected outcomes are developed and documented
- The plan of care includes treatment team members' responsibilities
- How they assess the patient's response to treatment modalities
- The patient's contribution to formulation of the treatment plan and plan of care.

- Therapeutic activities and rehabilitative services are individualized based on the goals set in the patient’s treatment plan
- The patient’s level of participation in the activities and services
- Staff participation in the discharge planning process
- Physician availability, and participation in treatment planning

Surveyors will draw a representative sample number of patients from each distinct program area based on the size of the program. Each patient’s record in the selected sample will be reviewed for compliance with the condition of participation titled “Special Medical Record Requirements for Psychiatric Hospitals” (482.61).

### **Staffing Review**

Surveyors will spend some time speaking with care staff and managers about how units are staffed. Data will be collected during this time to allow for completion of required CMS forms.

### **Credentialing and Privileging**

During this scheduled activity, surveyors will focus on the qualifications of the clinical director and other physicians who provide psychiatric services through a review of credentials files

In addition to the discussion topics presented in the Credentialing and Privileging activity description, the following will also be covered:

- Physician coverage during evenings, nights, and weekends
- Roles and responsibilities of the clinical director
- Monitoring and evaluating the quality, safety, and appropriateness of the services and treatments provided by the medical staff
- Collection of information to complete required CMS form

### **Discharge Planning and Death Record Review**

Surveyors will:

- Spend time reviewing discharge records representative of the certified programs to evaluate compliance with the discharge planning requirements
- Request a list of all patient deaths that resulted from suicide, homicide, or other unexpected conditions since the last survey, and request all death records for review
- Collect information for completion of required CMS form

# Program Specific Tracer – Laboratory Integration

## 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, and licensed 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

## 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 licensed practitioners), 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.

# Organization Quality and Performance Improvement Session

## Organization Participants

Suggested participants include representatives from:

- Quality Assessment and Performance Improvement
- Staff involved in the selected performance improvement activities and projects
- Infection Prevention and Control program staff
- Leadership, (for example, hospital board members, senior leader(s), administrator(s))
- Pharmacy staff
- Medical Staff
- Nursing

## Logistical Needs

The suggested duration for this activity is approximately 60-minutes depending on the number of days surveyors spend on-site and the size and complexity of your organization.

Surveyors will inform your organization (prior to this activity) of the specific performance monitoring or distinct quality indicators, performance improvement project, and proactive risk assessment they would like to discuss.

A meeting space that can accommodate participants is recommended.

## Objectives

- Understand and assess the organization's performance improvement and patient safety strategy and processes.
- Understand how data is used to monitor performance and improve processes throughout the organization.
- Learn how the organization is using process and outcome data to evaluate the safety and quality of care being provided to patients.

## Overview

### Orientation to Organization Quality Improvement Program

Surveyors will review your organization's ongoing performance monitoring data, distinct quality indicators, and performance improvement projects during planning activity. This review will inform the questions and topics surveyors want to discuss related to:

- Program organization, structure, links to other departments and functions, and resources
- Scope of program (Is it organization-wide?)
- Chosen PI method(s) (for example, PDCA, Six Sigma)
- General approach to PI (data collection, aggregation, and analysis, monitoring, reporting, identifying opportunities to improve, and making improvements)
- Evaluate leaders', including governing body, involvement in the PI program
  - Leadership identification and prioritization of ongoing performance monitoring and performance improvement projects

- How data is being used to create a culture of safety.
- Evaluation of quality and performance improvement program effectiveness

### **Use of Data in Quality Assessment and Performance Improvement**

Using the surveyor selected performance monitoring data and quality indicators, the surveyors will trace the following:

- Data Collection
  - Quality Indicators related to improved health outcomes and patient care data.
  - Scope of data collection for each indicator is appropriate, that is, that data is being collected in all parts of the hospital where it applies.
  - Data is being collected at the appropriate frequency and according to the prescribed method; the process used to check collected data for accuracy, timeliness.
- Aggregation and analysis
  - If staffing adequacy is factored into analysis of undesirable performance.
- Use of data such as influence on decision-making; determining improvement and sustainability; reporting/sharing throughout organization to further influence performance.
  - Actions taken when quality indicator data analysis reveals a need for improvement, and the process for evaluating interventions for effectiveness and sustainability.

### **Patient Safety-Related Data Collection, Analysis, and Monitoring**

- Be prepared to discuss other patient safety-related data monitoring topics from the standards, including:
  - The process and methods used throughout the hospital to identify errors, close calls, and actual adverse events, including those related to medication management, (for example, incident reporting systems, claims data review, and retrospective medical record reviews).
  - Effectiveness of the hospital's suicide prevention program
  - National patient safety goals
  - Antibiotic use and improvement opportunities
  - Pain assessment, pain management, including non-pharmacologic approaches, and safe opioid use.
  - Patient flow throughout the hospital and specific areas of focus (for example, emergency department wait times, instances of patient boarding, bed availability, throughput in patient care areas.
  - Readmission rates and use of this data
  - Performance of contracted services
  - Safety culture surveys (for example, response rates, what data has revealed over time, and any improvements)
  - If and how data is helping to create a culture of safety and quality.
  - Active or recently completed **proactive risk assessment** activity (LD.03.09.01, EP 7) and identified potential process failures, and any process improvements implemented.
  - Patient perception of safety and quality of care.

- Infection prevention and control data integration into the quality and performance improvement program (for example, surveillance data collection, monitoring implementation of evidence-based practices related to CLABSI, CAUTI, MDROs, and prevention of surgical site infections).
- Medication safety and quality assurance data integration into the quality and performance improvement program (for example, drug reactions, adverse drug events, controlled substance monitoring, overrides of automated dispensing systems, medication administration errors, and near misses).
- Use of root cause analysis for all serious, preventable, adverse events.

### **Performance Improvement Project Tracer**

Using the surveyor selected performance improvement project, be prepared to discuss the following:

- How was the project need identified and by who? (quality indicators, dashboards)
- How did you get leadership to make this project a priority?
- What guidance and expectations did leadership establish for the project?
- The plan for the project (PI.02.01.01, EP 1)
  - Is the process needing improvement identified?
  - Are there any stakeholder requirements for the project?
  - Are there project goals?
  - What improvement activities are planned?
  - Is the method(s) for measuring performance of the process(es) needing improvement described?
  - What method(s) will be used to analyze performance measure data?
  - Is there a description of how the process(es) will be improved?
  - What method(s) will be used to determine if actions taken to improve the process(es) resulted in improved performance?
  - Are next steps identified in the plan if improvement is not achieved? (PI.04.01.01, EP 5)
  - Is there a plan to continue monitoring improved processes for sustainability, and for how long?



## Performance Improvement Evaluation Tool

Use this tool as a checklist to verify that data is being collected on the items below. This review should be performed prior to conducting the Organization Quality and Performance Improvement session. Surveyor(s) will inform the hospital staff of the specific PI activities, projects, and proactive monitoring activities that will be discussed during the session.

X	Assessment Item	Notes	Joint Commission Standard	HAP CoPs	CAH CoPs
	Data Collection, Analysis, and Improvement for Ongoing Performance Monitoring				
	<b>Operative/other procedures placing patient at risk</b>	- Verify data is collected - Ask hospital if any of these data collection topics have evolved into improvement projects  <b>***Use this information when selecting the performance monitoring data and improvement projects to trace. (See Performance Improvement Tracer guidance below)</b>	PI.01.01.01, EP 3	482.21(a)(2)	No CoP
	<b>Significant discrepancies between pre-op and post-op diagnosis</b>		PI.01.01.01, EP4	482.21(a)(2), (e)(1)	No CoP
	<b>Use of blood and blood components</b>		PI.01.01.01, EP6	482.21(a)(2)	No CoP
	<b>Resuscitation results</b>		PI.01.01.01, EP10	482.21(a)(2)	No CoP
	<b>Patient perception of safety and care</b>		PI.01.01.01, EP14	482.21(a)(2)	No CoP
	<b>Pain management assessment interventions and effectiveness</b>		PI.01.01.01, EP 40 PI.03.01.01, EP 18	No CoP	No CoP
	<b>Contract services</b>		LD.04.03.09, EPs 4, 6, 7	482.12(e) and (e)(1), 482.21	485.635(c)(4)(i) and (ii)
	<b>Patient flow process</b>		LD.04.03.11, EP 5 <b>NA for CAH</b>	No CoP	
	<b>Medication management system</b>		MM.08.01.01, EPs 1, 5, 6, 8	482.21(e)(1)	No CoP
	<b>Antibiotic stewardship/use</b>		MM.09.01.01, EPs 16, 19-21	482.42(b)(2)(iii), (b)(3), (c)(1)(i)	485.640 (b)(2)(iii), 485.640(b)(3), 485.640(c)(1)(i)
	<b>Hand hygiene</b>		NPSG.07.01.01, EPs 1-3	No CoP	No CoP
	<b>Safety Culture Evaluation</b>		LD.03.01.01, EP 1	No CoP	No CoP
	<b>Health care disparities</b>		NPSG.16.01.01, EPs 3, 4-6	No CoP	No CoP
	<b>Compounded sterile preparations quality assurance</b>		MM.05.01.07, EP 6	482.25(b)(1)	485.635 (a)(3)(iv) 485.635 (d)(3)
	Adverse Event, Incident Report Data – There may not be data available, but process must exist to collect, aggregate, analyze/study, and report undesirable event/incident data.				
	<b>Moderate or deep sedation adverse events</b>		PI.01.01.01, EP5	482.21(a)(2), (e)(1)	485.635(a)(3)(v)

X	Assessment Item	Notes	Joint Commission Standard	HAP CoPs	CAH CoPs
	Transfusion reactions (reported and confirmed)		PI.01.01.01, EP7	482.21(a)(2), (e)(1)	No CoP
	Significant medication errors		PI.01.01.01, EP12	482.21(a)(2), (e)(1)	485.635(a)(3)(v)
	Significant adverse drug reactions		PI.01.01.01, EP13	482.21(a)(2), (e)(1)	485.635(a)(3)(v)
	MRI thermal injuries		PI.01.01.01, EP 34	No CoP	No CoP
	Ferromagnetic object injuries (MRI room)		PI.01.01.01, EP 35	No CoP	No CoP
	Analysis of sentinel events		LD.03.09.01, EP 5	482.21(a)(2), (c)(2), (e)(1)	No CoP
	Proactive risk assessment (every 18 months)		LD.03.09.01, EP 7	482.21(e)(1)	No CoP
	Incident Reporting System		EC.04.01.01, EP 1	482.13(c)(2), 482.41(d)(2)	485.623(a)
	Radiation dose incidents		PI.03.01.01, EP 6	No CoP	No CoP
	Data Analyzed and Actions Taken				
	Deemed only: Medicare quality reporting data used in PI program		LD.03.02.01, EP 4 <b>LD.03.02.01, EP 5 CAH</b>	482.21(b)(1)	485.641(b)(5)
	Use of system/process failure and proactive risk assessment information		LD.03.09.01, EP 8	482.21(a)(1), (b)(2)(i), (c)(2), (e)(1)	No CoP
	Uses improvement tools or methodologies		PI.04.01.01, EP 3	No CoP	No CoP
	Analysis of data to identify patterns, trends, variation		PI.03.01.01, EP 4	482.21, 482.21(a)(2), (b)(2)(i), (e)(1)	485.641, 485.641(d)(2), 485.641(e)
	Use data to identify improvement opportunities		PI.03.01.01, EP 8	482.21, 482.21(a)(2), (b)(2)(ii), (c)(2), (e)(1)	485.641, 485.641(d)(2), 485.641(e)
	Acts on performance improvement priorities		PI.04.01.01, EP 2	482.21, (c)(3), (d)(4)	485.641(e)
	Improving Performance				
	Acts when does not achieve or sustain improvements		PI.04.01.01, EP 5	482.21, (c)(3), (d)(3)	485.641(e)
	Identifying, Prioritizing, and Planning Performance Improvement Projects				
	Deemed: PI reflects complexity of services		LD.01.03.01, EP 21	482.21	485.641(b)(1) through (b)(4), 485.641(c)
	PI is hospitalwide		LD.03.07.01, EP 1	482.21	485.641
	- Leaders set priorities for PI - Leaders give priority to high-risk, high- volume, or problem-prone processes - Leaders identify frequency of data collection		LD.03.07.01, EP 2	482.21, 482.21(c)(1)(i) – (iii)  482.21(b)(3)	485.641, 485.641(d)(1) and (d)(3)
	Leaders set expectations for using data and information to achieve PI goals		LD.03.02.01, EP 1	482.21, 482.21(a)(1), (b)(2)(i)	485.641, 485.641(e)
	Leaders review plan for addressing PI priorities annually and update		PI.02.01.01, EP 2	No CoP	No CoP
	Sharing of PI Data and Information (e.g., Governing Body, Medical Staff, Patient				

<b>X</b>	<b>Assessment Item</b>	<b>Notes</b>	<b>Joint Commission Standard</b>	<b>HAP CoPs</b>	<b>CAH CoPs</b>
	Safety, Performance Improvement Program)				
	<b>ICP communicates w/antibiotic stewardship and PI program</b>		<u>IC.04.01.01, EP 2</u>	482.42, 482.42(c)(1)(ii) 482.42(c)(2)(iii) 482.42(c)(2)(vi)	485.640(c)(1)(ii), 485.640(c)(2)(iii), 485.640(c)(2)(vi)
	<b>Antibiotic stewardship program communicates with ICP, leaders, and PI</b>		MM.09.01.01, EP 12	482.42, 482.42(c)(1)(ii), 482.42(c)(3)(iii)	485.640, 485.640(c)(1)(ii), 485.640(c)(3)(iii)
	<b>Annual reports to governance (deemed: includes PI improvement projects)</b>		LD.03.09.01, EP 10	482.21(c)(2), (d)(1), (d)(3), (e)(1), (e)(5)	No CoP

## **Performance Improvement (PI) Project Tracer Checklist**

Use this tool to trace the selected organization PI project related to improving patient outcomes.

### **PI Patient Outcomes Project**

#### **Discussion**

How was the project need identified and by who? (quality indicators, dashboards)

How did you get leadership to make this project a priority?

What guidance and expectations did leadership establish for the project?

Review the written plan for the project  
**(PI.02.01.01, EP 1)**

- Is the process needing improvement identified?
- Are there any stakeholder requirements for the project?
- Are there project goals?
- What improvement activities are planned?
- Is the method(s) for measuring performance of the process(es) needing improvement described?
- What method(s) will be used to analyze performance measure data?
- Is there a description of how the process(es) will be improved?
- What method(s) will be used to determine if actions taken to improve the process(es) resulted in improved performance?
- Are next steps identified in the plan if improvement is not achieved?  
**(PI.04.01.01, EP 5)**
- Is there a plan to continue monitoring improved processes for sustainability, and for how long?

## **Performance Monitoring and Distinct Quality Indicator Checklist**

Use this tool to trace the selected organization performance monitoring and distinct quality indicators related to the following:

- **Infection prevention and control data** (for example, surveillance, CLABSI, CAUTI, hand hygiene, C-diff., other)
- **Medication management data** (for example, antibiotic stewardship, medication error reduction, adverse drug reactions)
- **Other performance monitoring activity** (for example, stroke measures, maternal health measures)

### **Performance Monitoring and Distinct Quality Indicators**

	<b>IC PI Activity</b>	<b>MM PI Activity</b>	<b>Other Performance Monitoring Activity</b>
<b>Discussion</b>			
Is the scope of data collection appropriate to the indicator (e.g., indicators related to hand hygiene would require data from multiple units/areas)? <b>PI.02.01.01, EP 1</b>			
Is the method and frequency of data collection specified? <b>PI.02.01.01, EP 1</b>			
Is there evidence that the data are collected in the manner and frequency specified? <b>PI.02.01.01, EP 1</b>			
Are data collected aggregated in accordance with the hospital's methodology specified? <b>PI.03.01.01, EP 3</b>			
Are the collected data analyzed? <b>PI.03.01.01, EP 4</b>			
If the activity/indicator is the type that measures a rate, are rates calculated for points in time and over time, and are comparisons made to performance benchmarks when available? <b>PI.02.01.01, EP 1, PI.03.01.01, EP 4</b>			
When appropriate, are aggregated data broken down into subsets that allow comparison of performance among units/areas of the hospital? <b>PI.03.01.01, EP 3</b>			
If data analysis identified opportunities for improvement, is there evidence of actions taken to address them? <b>PI.03.01.01, EP 8</b>			
Are actions taken evaluated for success? <b>PI.04.01.01, EP 5</b>			
If actions taken were not successful, were new actions identified? <b>PI.04.01.01, EP 5</b>			
If actions taken were successful, did evaluation continue to assess sustained compliance? <b>PI.02.01.01, EP 1</b>			

# Special Issue Resolution

## 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 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

## 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 need to have any information available.

## Overview

Surveyors use this session to debrief on the day's observations and findings 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

## 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 Session

## 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.

## Logistical Needs

The suggested duration for this session is 30-60 minutes. 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 antibiotic resistance and antibiotic stewardship (Note: surveyors will not review human resource records or medical staff records related to antibiotic 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

# Medical Staff Credentialing and Privileging

## 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 physicians and other licensed 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 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 physicians and licensed 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 physicians and licensed 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 practitioners who are privileged through the medical staff process
- Processes for granting privileges and the delineation of privileges
- Whether physicians and other licensed 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 antibiotic resistance and antibiotic stewardship (Note: surveyors will not review medical staff records related to antibiotic stewardship)

# Facility Orientation and Document Review – Life Safety Surveyor

## 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 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 the Orientation activity include:
  - 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 protection and suppression equipment
  - Maintenance records for emergency power systems
  - Maintenance records for piped medical gas and vacuum systems
- A detailed list of documents along with 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:

- Become familiar with the building, including specific systems (for example, generator, fire pump) and plan an efficient survey of Life Safety Code® (NFPA 101-2012) and selected Environment of Care standards (NFPA 99-2012 Health Care Facilities Code)
- Review identified building systems, life safety drawings, and select policies to support the building tour activities.
- Review documentation related to other Environment of Care standards per the Life Safety and Environment of Care Document List and Review Tool

## Overview

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*<sup>®</sup> (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*<sup>®</sup> (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*<sup>®</sup> (NFPA 101-2012) or environment of care risks

Immediately following the Orientation activities, the surveyor will continue to review documentation required by the Environment of Care standards using the ***Life Safety and Environment of Care Document List and Review Tool***.

# Life Safety Code® Building Assessment

## Applicability

This activity 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 Surveyor, Clinical Surveyor in outpatient locations

## Organization Participants

Suggested participants include the individual who manages organization 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 Session

## Joint Commission Participants

Clinical surveyor and/or Life Safety surveyor

## Organization Participants

Participants include leaders and other individuals familiar with all aspects of the Emergency Management (EM) program within your hospital. Participants may include the following EM multidisciplinary team members (as available):

- EM program lead
- Senior leadership
- Nursing leadership
- Medical staff
- Pharmacy
- Infection prevention and control
- Facilities engineering
- Safety & security
- Ancillary staff
- Information technology

## Logistics

The suggested duration of the Emergency Management session is approximately 60 minutes. In preparation for the EM session, the surveyor will evaluate written documentation of the following and make certain that the documents have been updated and reviewed at least every two years:

- Emergency management program
- Hazard vulnerability analysis
- Emergency operation plan and policies and procedures
- Communications plan
- Continuity of operations & recovery plan
- Education and training program
- Testing program
- Program evaluation (after-action/improvement plans)
- Unified and integrated EM program (if applicable)
- Transplant program (if applicable)

## Objective

To provide consistent and systematic review of the hospital's emergency management program, the application and use of the emergency operations plan and policies and procedures during an emergency (real or simulated), and to assess the hospital's degree of compliance with relevant emergency management chapter standards and applicable law and regulation.

## Overview

The surveyor(s) initiates discussion about the hospital's recent emergency management activities that have occurred in the past 12–36 months that is inclusive of all the hospital settings, services, and programs. The EM session begins with introductions of leadership and other EM multidisciplinary team members and the surveyor will ask that those attending briefly describe their role(s) in the emergency management program. The EM session is broken into four distinct discussion topics and the hospital should be prepared to discuss the following topics.

## Part 1: “Actual” emergencies or disaster incidents

The hospital describes what “real” events impacted them and how they utilized their risk assessment, emergency operations plan, policies and procedures, and the six critical areas to prepare for these events.

Be prepared to discuss:

- Recent emergencies or disaster incidents that have occurred in the past 12/24/36 months in which the emergency operations plan was activated
- The impacts the recent events had on the hospital
- How the recent events were identified, and risk prioritized as part of the hazard vulnerability analysis
- The communication methods that were used to notify staff, relevant authorities, and community partners of the recent events
- How the hospital collaborated with their community partners during the recent events
- How communications were maintained, including alternative communication methods used during recent events
- How staffing was managed to meet patient care needs and if any additional staffing (such as volunteers, etc.) was used during the recent events
- How patient care was impacted and how the hospital continued to provide services to meet those needs during the recent events, including at-risk patients
- Implementation of any safety and security measures that were required during the recent events
- How resources and supplies were managed during the recent events and how additional supplies were obtained.
- How the hospital can sustain operations up to 96-hours based on-hand resources
- If any of the hospital’s utility systems were impacted and how they were maintained or provided for during the recent events. What alternative means have been established to continue to provide for essential or critical utility systems (water, power, etc.)

**Note:** Review of emergency and standby power systems are evaluated by the LSC surveyor during documentation review and building tour.

## **Part 2: Emergency exercises**

As part of planning and preparedness, the hospital describes what emergency exercises they recently conducted and should be based on past experiences, known risks/hazards, recent changes to their emergency operations plan, policies or procedures. These exercises should have included evaluation of one or more of the six critical areas that were used to assess responses.

Be prepared to discuss:

- One annual operations-based exercise (either a full-scale, community-based or a functional, facility-based exercise) that was conducted (or participated in), **and**
- One other annual exercise of choice, either an operations-based *or* discussion-based exercise (tabletop, seminar, etc.) that was conducted (or participated in)
- Why these exercises were selected and how these exercises stressed (or fully tested) the emergency operations plan and response procedures and how staff and management were involved
- The exercises that were conducted at the off-site facility locations

## **Part 3: Training and education**



The hospital describes what education and training they provided to their staff, volunteers, physicians, etc. in the past 12–36 months.

Be prepared to discuss:

- The types of emergency preparedness training that the hospital provided (for example, classes, webinars, self-study modules, conferences) and how you validated staff knowledge of emergency response procedures
- If the hospital has determined a need for any additional staff education or training because of recent emergency event or exercises. If so, what education or training was or will be provided
- Education and training that was provided to staff at off-site facility locations

#### **Part 4: Evaluation, After-action and improvement plans, and review**

The hospital describes the evaluation process, lessons learned, and actions taken to improve the program.

Be prepared to discuss:

- The after-action reports (AARs) include evaluations that include any gaps in the plan that were identified
- The lessons learned and what was identified as opportunities for improvement as a result of recent events and/or exercises
- The multidisciplinary team's efforts to incorporate lessons learned to review, revise, or update the EM program, including HVA, EOP, policies and procedures, communications plan, etc.
- Senior leaders' involvement in the EM program and their support for needed changes and program improvements

#### **For hospitals that participate in their health care system's unified and integrated emergency management program**

In addition to the above, be prepared to discuss:

- The hospital's participation in the development of the unified and integrated emergency management program, emergency operations plan, policies and procedures, communication plan, education, training, emergency exercises
- How your hospital considers its unique circumstances, patient population, and services offered
- Your hospital's capabilities to actively use the unified and integrated emergency management program and its compliance with the program
- The hospital-specific community-based and facility-based risk assessments

#### **For hospitals only that use Joint Commission accreditation for deemed status purposes and has one or more transplant programs**

Be prepared to discuss:

- Involvement of the transplant program representative in the development and maintenance of the hospital's EM program
- How the hospital develops and maintains mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant program, and the organ procurement organization (OPO) for the designated service area where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency

**After the EM session has concluded the surveyor(s) will continue relevant discussions and review of emergency management-related activities that include the following:**

- During tracer activity, asking staff about any orientation or training they have received in emergency preparedness roles or responsibilities, and their involvement in emergency management exercises, and/or responses to recent actual emergencies or disaster incidents
- During the competency and credentialing/privileging activities, reviewing staff files to verify completion of initial and ongoing EM-related education and training

# Emergency Management Documentation Review Tool

## Hospital and Critical Access Hospital

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
<b>Emergency Management Program</b>				
<input type="checkbox"/> Written emergency management program	All hospitals and CAHs	EM.09.01.01, EPs 1 & 3	HAP 482.15 CAH 485.625	<input type="checkbox"/> Reviewed and updated every 2 years <input type="checkbox"/> Not reviewed and updated every 2 years
<b>Hazard Vulnerability Analysis (HVA)</b>				
<input type="checkbox"/> Written all-hazards HVA that include: <input type="checkbox"/> Facility-based and community-based risk assessment <input type="checkbox"/> Strategies for addressing events identified by the risks <input type="checkbox"/> HVA includes All-hazards: <ul style="list-style-type: none"> <li>• Natural hazards</li> <li>• Human-caused hazards</li> <li>• Technological hazards</li> <li>• Hazardous materials</li> <li>• Emerging infectious diseases</li> </ul>	All hospitals and CAHs	EM.11.01.01, EPs 1-4 EM.17.01.01, EP 3	HAP 482.15 (a)-(a)(2) CAH 485.625 (a)-(a)(2)	<input type="checkbox"/> Reviewed and updated every 2 years <input type="checkbox"/> Not reviewed and updated every 2 years
<b>Emergency Operations Plan (EOP)</b>				
<input type="checkbox"/> Written EOP that include: <ul style="list-style-type: none"> <li>• Addresses patient population &amp; persons at risk</li> <li>• Type of services provided in an emergency</li> <li>• Continuity of operations</li> <li>• Delegation of authority</li> <li>• Leadership succession</li> <li>• Cooperation and collaboration with external authorities</li> </ul>	All hospitals and CAHs	EM.12.01.01, EP 1 & EP 2 EM.13.01.01, EPs 1-4 EM.17.01.01, EP 3	HAP 482.15 (a), (a)(3) to (a)(4) CAH 485.625 (a), (a)(3) to (a)(4)	<input type="checkbox"/> Reviewed and updated every 2 years <input type="checkbox"/> Not reviewed and updated every 2 years
<b>Policies and Procedures</b>				
<input type="checkbox"/> Written Policies & Procedures that include: <ul style="list-style-type: none"> <li><input type="checkbox"/> Provision of subsistence needs for staff and patients               <ul style="list-style-type: none"> <li>• food, water, medical and pharmaceutical supplies</li> </ul> </li> <li><input type="checkbox"/> Alternate sources of energy to maintain:               <ul style="list-style-type: none"> <li>• temperatures to protect patient health &amp; safety &amp; safe and sanitary storage of provisions</li> <li>• emergency lighting,</li> <li>• fire detection, extinguishing and alarm systems</li> </ul> </li> <li><input type="checkbox"/> Sewage and waste disposal</li> <li><input type="checkbox"/> System to track location of on-duty staff and sheltered patients</li> <li><input type="checkbox"/> Safe evacuation from the hospital (needs of evacuees, staff responsibilities, transportation, evacuation location(s))</li> <li><input type="checkbox"/> Means to shelter in place</li> <li><input type="checkbox"/> System of medical documentation to preserve PHI</li> </ul>	All hospitals and CAHs	EM.12.01.01, EPs 1, 3, 4 & 9 EM.12.02.11, EP 4 EM.17.01.01, EP 3 EM.12.02.07, EP 2 EM.12.02.01, EP 6 EM.12.02.03, EPs 1 & 2 EM.12.02.05, EP 1  IM.01.01.03, EPs 1 & 2 IM.02.01.01, EPs 1 & 4 IM.02.01.03 EPs 1 & 5	HAP 482.15 (b) to (b)(8) CAH 485.625 (b) to (b)(8)	<input type="checkbox"/> Reviewed and updated every 2 years <input type="checkbox"/> Not reviewed and updated every 2 years

Emergency Management Documentation Review Tool--Hospital and Critical Access Hospital

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
<ul style="list-style-type: none"> <li><input type="checkbox"/> Use of volunteers and other staffing strategies</li> <li><input type="checkbox"/> Arrangements and/or agreements with other hospitals and providers to receive patients if needed</li> <li><input type="checkbox"/> Role of the hospital in providing care and treatment at alternate care sites under an 1135 waiver</li> </ul>				
<b>Communications plan</b>				
<ul style="list-style-type: none"> <li><input type="checkbox"/> Written communication plan that includes:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Names &amp; contact information for:                                     <ul style="list-style-type: none"> <li>• Staff</li> <li>• Entities providing services under arrangement</li> <li>• Patient physicians</li> <li>• Other hospitals</li> <li>• Volunteers</li> </ul> </li> <li><input type="checkbox"/> Contact information for:                                     <ul style="list-style-type: none"> <li>• Federal, state, tribal agencies</li> <li>• Other sources of assistance</li> </ul> </li> <li><input type="checkbox"/> Primary and alternate means for communicating with:                                     <ul style="list-style-type: none"> <li>• Hospital staff</li> <li>• Federal, state, tribal agencies</li> </ul> </li> <li><input type="checkbox"/> Method for sharing information &amp; medical documentation with other healthcare providers</li> <li><input type="checkbox"/> Means of providing/releasing information under 45 CFR 164.510(b)(1)(ii)</li> <li><input type="checkbox"/> Means of providing information about occupancy needs and ability to provide assistance</li> </ul> </li> </ul>	All hospitals and CAHs	EM.09.01.01, EP 3 EM.12.01.01, EP 1 EM.17.01.01, EP 3 EM.12.02.01, EPs 1, 3, 5 & 6 EM.12.02.05, EP 1	HAP 482.15 (c) to (c)(7)  CAH 485.625 (c) to (c)(7)	<ul style="list-style-type: none"> <li><input type="checkbox"/> Reviewed and updated every 2 years</li> <li><input type="checkbox"/> Not reviewed and updated every 2 year</li> </ul>
<b>Education and Training Program</b>				
<ul style="list-style-type: none"> <li><input type="checkbox"/> Written education and training program</li> <li>Documented education &amp; training occurs:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Initially to all new/existing staff, those providing services under contract, volunteers</li> <li><input type="checkbox"/> At least every 2 years</li> <li><input type="checkbox"/> Staff demonstrate knowledge in EM procedures</li> <li><input type="checkbox"/> Conduct training when:                                     <ul style="list-style-type: none"> <li>• When roles &amp; responsibilities change</li> <li>• When significant revisions are made to P&amp;Ps</li> <li>• When procedural changes are made during an event</li> </ul> </li> </ul> </li> </ul>	All hospitals and CAHs	EM.15.01.01, EPs 1, 2, 3 EM.16.01.01, EP 1 EM.17.01.01, EP 3	HAP482.15 (d) to (d)(1)(v)  CAH 485.625 (d) to (d)(1)(v)	<ul style="list-style-type: none"> <li><input type="checkbox"/> Reviewed and updated every 2 years</li> <li><input type="checkbox"/> Not reviewed and updated every 2 years</li> </ul>
<b>Testing Program</b>				

## Emergency Management Documentation Review Tool--Hospital and Critical Access Hospital

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
<input type="checkbox"/> Two annual emergency exercises are documented and conducted as follows: <ul style="list-style-type: none"> <li><input type="checkbox"/> Participation in one operational-based exercise (full-scale community (if avail) or a functional facility-based) <b>and</b></li> <li><input type="checkbox"/> One additional exercise of choice operations-based or discussion-based</li> <li><input type="checkbox"/> Has exemption from conducting its next operations-based exercise due to a real event in which the EOP was activated</li> </ul>	Applies to all hospitals and CAHs	EM.16.01.01, EP 2	HAP 482.15 (d)(2) to (d)(2)(ii)(C)  CAH 485.625 (d)(2) to (d)(2)(ii)(C)	
<b>Evaluation Program</b>				
<input type="checkbox"/> Documents and reviews all emergency exercises, emergency or disaster incidents (After-action reports) <input type="checkbox"/> Documentation, review, & update of improvement plans, actions taken, and any revisions made to plans/policies and procedures	Applies to all hospitals and CAHs	EM.17.01.01, EPs 1 & 3	HAP 482.15 (d) (2)(iii)  CAH 485.625 (d)(2)(iii)	<input type="checkbox"/> Plans/policies are reviewed and updated every 2 years <input type="checkbox"/> Plans/policies not reviewed and updated every 2 years
<b>Emergency and standby power systems (may part of LS document review/LS building tour)</b>				
<input type="checkbox"/> Written plan for managing essential or critical utilities during an emergency that includes: <ul style="list-style-type: none"> <li>• Emergency &amp; standby power systems</li> <li>• Emergency generator location</li> <li>• Emergency generator inspection &amp; testing</li> <li>• Emergency generator fuel source</li> </ul>	Applies to all hospitals and CAHs	EM.12.02.11, EPs 1-3 EM.12.02.09, EPs 1 & 2  EC.02.06.05, EP 1 EC.02.05.07, EPs 3-11	HAP 482.15 (e) to (f)  CAH 485.625 (e) to (f)	
<b>Unified and Integrated EM Program (if applicable)</b>				
If hospital is part of health care system and participates in a unified and integrated emergency management program: <ul style="list-style-type: none"> <li><input type="checkbox"/> Program accounts for the hospital's unique circumstances, patient population, and services offered</li> <li><input type="checkbox"/> Documented community-based &amp; individual facility-based risk assessment</li> <li><input type="checkbox"/> Unified and integrated EOP</li> <li><input type="checkbox"/> Integrated P&amp;Ps</li> <li><input type="checkbox"/> Coordinated communication plan</li> <li><input type="checkbox"/> Training and testing program</li> <li><input type="checkbox"/> Reviews and evaluates exercises and emergency events</li> <li><input type="checkbox"/> Documentation of improvement plans, actions taken, revisions to plans/policies and procedures</li> </ul>	Applies to Hospitals and CAHs that are part of a system that has a unified and integrated EM program	EM.09.01.01 EM.11.01.01 EM.12.01.01 EM.13.01.01 EM.15.01.01 EM.16.01.01 EM.17.01.01 (every 2 years)	HAP 482.15 (f) to (f)(5)  CAH 485.625 (f) to (f)(5)	<input type="checkbox"/> Written documentation <input type="checkbox"/> No written documentation <input type="checkbox"/> Reviewed and updated every 2 years <input type="checkbox"/> Not reviewed and updated every 2 years
<b>Transplant Program (if applicable)</b>				
<input type="checkbox"/> Written protocols addressing duties and responsibilities of the hospital, transplant program(s), and OPO	Deemed Hospitals only	EM.09.01.01, EP 3	HAP 482.15 (g) to (g)(2)	

# Leadership Session

## 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.

## Logistical Needs

The suggested duration of this session is approximately 60 minutes.

## Objective

Surveyors will explore leadership's responsibility for creating and maintaining the 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 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 workflow
- 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 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:

- Antibiotic stewardship program, including who leads the program, leadership support of the program, and committee that oversees the program.
- Pain assessment, management, and safe opioid prescribing
- 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
- Code of conduct and 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
- Managing near misses, close calls, actual errors
  - What is the process for staff 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?
- Health care equity and the organization's efforts to reduce health care disparities, including
  - Identification of an individual to lead activities.
  - Identification of health-related social needs for the patient population served by the organization.
  - Processes to assess patients' health-related social needs, including collection of data.
  - Information the organization has gathered about community resources and support services available to the patient population being served.
  - Work planned or underway to identify health care disparities in the patient population being served.
  - Patient population health care disparities identified for initial focus and status of efforts.
  - Key stakeholders that will be receiving reports and monitoring organization progress to improve health care equity.

# Surveyor Report Preparation

## 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

## 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

## 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. If follow-up is required in the form of an Evidence of Standard Compliance (ESC) the surveyors explain the ESC submission process. Surveyors will direct you to information on your extranet site that explains “What Happens after Your Survey.”

For 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 they may provide your organization with a brief report of their findings and respond to questions.

*For Hospital Deemed Status surveys, 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 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: 3/1/2024

The following pages present documentation required by the Hospital and Critical Access Hospital Accreditation Programs Life Safety (LS), and 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	C	NC	NA	IOU	Document / Requirement	Yes	No	
<b>LS.01.01.01</b>					<b>Buildings serving patients comply w/ NFPA 101 (2012)</b>			
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"> <li>a. Areas of building fully sprinklered (if building only partially sprinklered)</li> <li>b. Locations of all hazardous storage areas</li> <li>c. Locations of all fire-rated barriers</li> <li>d. Locations of all smoke-rated barriers</li> <li>e. Sleeping and non-sleeping suite boundaries, including size of identified suites</li> <li>f. Locations of designated smoke compartments</li> <li>g. Locations of chutes and shafts</li> <li>h. Any approved equivalencies or waivers</li> </ul>	<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	C	NC	NA	IOU	Document / Requirement	Yes	No	
<b>EC.02.03.01</b>					<b>Hospital Manages Fire Risk – Fire Response Plan</b>			
EP 9					The written fire response plan describes the specific roles of staff at and away from fire including: <ul style="list-style-type: none"> <li>• When and how to sound and report fire alarms</li> <li>• How to contain smoke and fire</li> <li>• How to use a fire extinguisher</li> <li>• How to assist and relocate patients</li> <li>• How to evacuate to areas of refuge</li> <li>• <u>How staff will cooperate with firefighting authorities</u></li> </ul> <p>Staff periodically instructed on/kept informed of duties under plan</p> <p>Copy of plan readily available with telephone operator or security</p> <p>NFPA 101-2012: 18/19.7.1; 7.2</p>	<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"/>	

COMMENTS:

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
<b>EC.02.03.05</b>					<b>Fire Protection and Suppression Testing and Inspection</b>					
EP 1					Testing for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices NFPA 72-2010: Table 14.4.5	Quarterly				
EP 1					Testing for valve supervisory switches NFPA 72-2010: Table 14.4.5	Semiannual				
EP 1					Testing for other supervisory initiating devices NFPA 72-2010: Table 14.4.5	Annually				
EP 2					Water flow devices NFPA 72-2010: Table 14.4.5 NFPA 25-2011: Table 5.1.1.2	Semiannual				
EP 2					Tamper switches NFPA 72-2010: Table 14.4.5	Semiannual				
EP 3					Duct, heat, smoke detectors, and manual fire alarm boxes NFPA 72-2010: Table 14.4.5; 17.14	Annually				
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				
EP 6					Diesel-engine-driven fire pumps tested under no-flow conditions NFPA 25-2011: 8.3.1; 8.3.2	Weekly				
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	Annually				

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
<b>EC.02.03.05</b>					<b>Fire Protection and Suppression Testing and Inspection</b>					
					Fire pump supervisory signals for pump running and pump power loss tested NFPA 25-2011: 8.3.3; 8.3.3.4					
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 NFPA 96-2011: 11.2	Semiannual				
EP 14					Carbon dioxide systems tested NFPA 12-2011:4.8.3.2	Annually				
EP 14					Halon systems NFPA 12A-2009: 6.1	Semiannual				
EP14					Other special systems per National Fire Protection Association standards and manufacturers' recommendations NFPA 11-2010; NFPA 16-2011; NFPA 17-2009; NFPA 17A-2009					
EP 15					Portable fire extinguishers inspected monthly NFPA 10-2010: 7.2.2; 7.2.4	Monthly				
EP 16					Portable fire extinguishers maintained annually NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1	Annually				
EP 17					Fire hoses hydro tested 5 years after install; every 3 years thereafter NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6	5 years / 3 years				
EP 18					Smoke and fire dampers tested to verify full closure NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5	1 year after install. At least every 6 years thereafter.				
EP 19					Smoke detection shutdown devices for HVAC tested NFPA 90A-2012: 6.4.1	Annually				
EP 20					All horizontal and vertical roller and slider doors tested NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2	Annually				



STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
<b>EC.02.03.05</b>					<b>Fire Protection and Suppression Testing and Inspection</b>					
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. NFPA101-2012: 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	Annually				
EP 27					Elevators with firefighters' emergency operations NFPA 101-2012: 9.4.3; 9.4.6	Monthly				
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 NFPA 25-2011: 4.3; 4.4; NFPA 72-2010: 14.2.1; 14.2.2; 14.2.3; 14.2.4					

**COMMENTS:**

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
<b>EC.02.05.07</b>					<b>Emergency Power Systems are Maintained and Tested</b>			
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 NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5	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	Annually		

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
<b>EC.02.05.07</b>					<b>Emergency Power Systems are Maintained and Tested</b>			
					for 30 minutes with test results and completion dates documented NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5			
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		
EP 3					<i>Note 1: Non-SEPSS tested per manufacturer's specifications</i>	Per Mfr.		
EP 3					<i>Note 2: Level 1 SEPSS defined for critical areas and equipment</i>			
EP 3					<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; <b>OR</b>	Monthly		
EP 6					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	36 Months		

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

**COMMENTS:**

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD	Yes	No	Testing Dates
<b>EC.02.05.09</b>					<b>Medical Gas and Vacuum Systems are Inspected and Tested</b>				
EP 7					<p><b>Test, inspect and</b> 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 &lt; annual NFPA 99-2012: 5.1.14.2; 5.1.15; 5.2.14; 5.3.13</p>	Per policy			
EP 8					Location of and signage for bulk oxygen systems NFPA 99-2012: 5.1.3.5.12	On Bldg. Tour			
EP 9					Emergency oxygen supply connection NFPA 99-2012: 5.1.3.5.13	On Bldg. Tour			
EP 10					Review medical gas installation/modification/breech certification results for cross connection, purity, correct gas, and pressure NFPA 99-2012: 5.1.2; 5.1.4; 5.1.14.4.1; 5.1.14.4.6; 5.2.13	As applicable			
EP 11					Medical gas supply and zone valves are accessible and clearly labeled NFPA 99-2012: Table 5.1.11	On Bldg. Tour			

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD	Yes	No	Testing Dates
<b>EC.02.05.09</b>					<b>Medical Gas and Vacuum Systems are Inspected and Tested</b>				
					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				
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	C	NC	NA	IOU	Document / Requirement	Frequency	Q1	Q2	Q3	Q4 Annual
<b>EC.02.03.03</b>					<b>Fire Drills</b>					
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) NFPA 101-2012: 18/19: 7.1.7	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"> <li>• Drills held at unexpected times and under varying conditions – at least one hour apart for each shift from quarter to quarter through four consecutive quarters</li> <li>• Drills include transmission of fire alarm signal and simulation of emergency fire conditions</li> </ul> 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					Critiques include fire safety equipment and building features, and staff response	YES	NO			

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Frequency	Q1	Q2	Q3	Q4 Annual
<b>EC.02.03.03</b>					<b>Fire Drills</b>					
EP 7					Fire exit drills for operating rooms/surgical suites. NFPA 99-2012: 15.13.3.10.3	Annually				
EP 8					Annual emergency procedures and fire training drills for hyperbaric facilities that include recording of time to evacuate all persons from area, involves applicable staff, and focuses on prevention and simulated extinguishment and evacuation. NFPA 99-2012: 14.2.4.5.4; 14.3.1.4.5 NFPA 99-2012: B.14.2 and B.14.3	Annually				

COMMENTS:

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
<b>EC.02.05.01</b>					<b>Manages risks associated with utility systems</b>			
EP 15					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>  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).			

COMMENTS:

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Yes	No
<b>EC.02.05.02</b>					<b>Manages risks associated with utility systems – Water Management Program</b>		
EP 1					Verify individual or team responsible for oversight and implementation of the water management program		
EP 2					Review water management program to verify the following components are included: <ul style="list-style-type: none"> <li>• Diagram of water supply sources, treatment systems, processing steps, control measures, and end-use points</li> <li>• Water risk management plan identifies areas where potentially hazardous conditions may occur <ul style="list-style-type: none"> <li>○ Note: Refer to the Centers for Disease Control and Prevention’s “Water Infection Control Risk Assessment (WICRA) for Healthcare Settings” tool as an example for conducting a water-related risk assessment.</li> </ul> </li> <li>• Plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time</li> <li>• Evaluation of immunocompromised patients</li> <li>• Monitoring protocols and acceptable ranges for control measures</li> </ul>		
EP 3					Verify that the water management program includes documentation of the following: <ul style="list-style-type: none"> <li>• Results of all monitoring activities</li> <li>• Corrective actions and procedures to follow if test results are outside of acceptable limits</li> <li>• Corrective actions taken when control limits are not maintained</li> </ul>		
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	C	NC	NA	IOU	Document / Requirement	Yes	No
<b>EC.02.04.01</b>					<b>Management of Medical Equipment Risks</b>		
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.		

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Yes	No
<b>EC.02.04.01</b>					<b>Management of Medical Equipment Risks</b>		
					<b>OR</b>		
					Deemed status requirement: Maintains a written inventory of <b>all</b> 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.		

**COMMENTS:**

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
<b>EC.02.04.03</b>					<b>Medical equipment inspection, testing and maintenance</b>			
EP 2					All high-risk equipment.  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.  Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of medical equipment must have a 100% completion rate.			
EP 3					Non-high-risk equipment identified on the medical equipment inventory			
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:** Refer to the Guidance on Use of Alternate Maintenance Activities and/or Schedules section when hospitals choose to employ alternate maintenance activities and/or schedules.

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
<b>EC.02.05.05</b>					<b>Utility system Inspection, testing and maintenance</b>			
EP 4					High-risk utility system components on the inventory with completion date and results of activities documented  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.  Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components 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 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			
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.  NFPA 99-2012: 6.3.2; 6.3.3; 6.3.3.3.2; 6.3.4			

**COMMENTS:** Refer to the Guidance on Use of Alternate Maintenance Activities and/or Schedules section when hospitals choose to employ alternate maintenance activities and/or schedules.

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
<b>EC.02.01.01</b>					<b>The hospital manages safety and security risks.</b>			
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.  Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk			



STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
<b>EC.02.01.01</b>					<b>The hospital manages safety and security risks.</b>			
					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.			
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.			
<b>Note: EP's 14 and 16 are covered by the clinical imaging tracer.</b>								
EP 17					The hospital conducts an annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the analysis. 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	C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
<b>EC.01.01.01</b>					<b>The hospital plans activities to minimize risks in the environment of care.</b>			
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>In circumstances where the program or service is located in a business occupancy not owned by the accredited organization, the plan may only need to address how routine service and maintenance for their utility systems are obtained.</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 <a href="https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/life-safety-code-information-and-resources/">https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/life-safety-code-information-and-resources/</a> and NFPA 99-2012: 1.4.</p>			

**COMMENTS:**

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
<b>EC.04.01.01</b>					<b>The hospital collects information to monitor conditions in the environment.</b>			
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	C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
<b>EC.04.01.03</b>					<b>The hospital plans activities to minimize risks in the environment of care.</b>			
EP 2					The hospital uses the results of data analysis to identify opportunities to resolve environmental safety issues.			

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

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Addressed in policy?	Addressed in policy?	Implemented as required?	Implemented as required?
<b>LS.01.02.01</b>					<b>Interim Life Safety Measures (ILSM)</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
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				
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				

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Addressed in policy?	Addressed in policy?	Implemented as required?	Implemented as required?
<b>LS.01.02.01</b>					<b>Interim Life Safety Measures (ILSM)</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
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:

STANDARD - EPs	C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
<b>EC.02.02.01</b>					<b>The hospital manages risks related to hazardous materials and waste.</b>			
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 MM.01.01.03, EPs 1 and 2)			
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.			
<b>Note EP's 6, 7, 8, 17, and 18 are covered under clinical tracers.</b>								

COMMENTS:

# Guidance on Use of Alternate Maintenance Activities and/or Schedules

Although AEM references have been removed from the standards/EPs, organizations can continue to use AEM activities and/or schedules if they choose to do so. If AEM strategies are used, organizations need to comply with the following requirements. If any issues are identified, score the issue at the appropriate EPs located at EC.02.04.01, EC.02.04.03, EC.02.05.01, or EC.02.05.05.

In order to ensure all essential mechanical, electrical and patient-care equipment is maintained in safe operating condition, the hospital must identify the essential equipment required to meet its patients' needs for both day-to-day operations and in a likely emergency/disaster situation, such as mass casualty events resulting from natural disasters, mass trauma, disease outbreaks, internal disasters, etc. In addition, the hospital must make adequate provisions to ensure the availability and reliability of equipment needed for its operations and services. Equipment includes both facility equipment, which supports the physical environment of the hospital (e.g., elevators, generators, air handlers, medical gas systems, air compressors and vacuum systems, electrical systems, etc.) and medical equipment, which are devices intended to be used for diagnostic, therapeutic or monitoring care provided to a patient by the hospital (e.g., IV infusion equipment, ventilators, laboratory equipment, surgical devices, etc.).

All equipment must be inspected and tested for performance and safety before initial use and after major repairs or upgrades. Equipment to be used for the first time should be inspected and tested for performance and safety in accordance with manufacturer recommendations, unless a sufficient amount of maintenance history has been acquired, either based on its contractor's records or available publicly from nationally recognized sources, to determine whether the alteration of initial inspection and testing activities and frequencies would be safe.

All equipment must be inspected, tested, and maintained to ensure their safety, availability, and reliability. Equipment maintenance activities may be conducted using hospital personnel, contracted services, or through a combination of hospital personnel and contracted services. Individual(s) responsible for overseeing the development, implementation, and management of equipment maintenance programs and activities must be qualified. The hospital maintains records of hospital personnel qualifications and is able to demonstrate how it assures all personnel, including contracted personnel, are qualified.

All equipment maintenance policies, procedures, and programs, as well as specific equipment maintenance inventories, activities and schedules fall under the purview of the hospital's clinical maintenance personnel, safety department personnel or other personnel who have been assigned responsibility for equipment maintenance by hospital leadership.

Hospitals comply with this regulation when they follow the manufacturer-recommended maintenance activities and schedule. Hospitals may choose to perform maintenance more frequently than the manufacturer recommends but must use the manufacturer-recommended maintenance activities in such cases. When equipment is maintained in accordance with the manufacturer's recommendations, the hospital must maintain documentation of those recommendations and the hospital's associated maintenance activity for the affected equipment.

## **Alternate Equipment Management (AEM) Program (Refer to EC.02.04.01, EP 4; EC.02.05.01, EP 5)**

A hospital may, under certain conditions, use equipment maintenance activities and frequencies that differ from those recommended by the manufacturer. Hospitals that choose to employ alternate maintenance activities and/or schedules must develop, implement, and maintain a documented AEM program to minimize risks to patients and others in the hospital associated with the use of facility or medical equipment. The AEM program must be based on generally accepted standards of practice for facility or medical equipment maintenance. An example of guidelines for a medical equipment medical equipment maintenance program may be found in the American National Standards Institute/ Association

for the Advancement of Medical Instrumentation document: ANSI/AAMI EQ 56:1999/ (R) 2013, Recommended Practice for a Medical Equipment Management Program. Likewise, an example of guidelines for physical plant equipment may be found in the American Society for Healthcare Engineering (ASHE) 2009 document: Maintenance Management for Health Care Facilities. There may be similar documents issued by other nationally recognized organizations which HOSPITALS might choose to reference.

**Decision to Place Equipment in an AEM Program (Refer to EC.02.04.01, EPs 2, 3, 4; EC.02.05.01, EPs 3, 4)**

The determination of whether it is safe to perform facility or medical equipment maintenance without following the equipment manufacturer recommendations must be made by qualified personnel, regardless of whether they are hospital employees or contractors. Hospitals must be able to verify that qualified personnel, employees, or contractors, are making the decisions to place equipment in the AEM program, performing the risk-based assessments, establishing the alternate equipment maintenance requirements, managing the AEM program, and performing the maintenance in accordance with the AEM policies and procedures.

In the case of medical equipment, a clinical or biomedical technician or engineer would be considered qualified. Highly specialized or complex equipment may require specialized knowledge or training in order for personnel to be considered qualified to make a decision to place such equipment in an AEM program.

In the case of facility equipment, a Healthcare Facility Management professional (e.g., facility manager, director of facilities, vice president of facilities) would be considered qualified.

The hospital must maintain records of the qualifications of hospital personnel who make decisions on placing equipment in an AEM program and must be able to demonstrate how they assure contracted personnel making such decisions are qualified.

In determining whether or not to include equipment in an AEM program, and which maintenance strategies to use in developing maintenance activities and frequencies for particular equipment, the hospital must take into account the typical health and safety risks associated with the equipment's use. Note that the risk may vary for the same type of equipment, depending on the patient care setting within the hospital where it is used.

A hospital is expected to identify any equipment in its AEM program which is critical equipment, i.e., biomedical, or physical plant equipment for which there is a risk of serious injury or death to a patient or staff person should the equipment fail. Surveyors must focus their review of a hospital's AEM program on critical equipment in that program and the hospital's documentation of the factors and evidence it considered in developing an AEM strategy for that equipment.

Factors for a hospital to consider when evaluating the risks associated with a particular type of equipment include, but are not limited to:

- How the equipment is used and the likely consequences of equipment failure or malfunction: would failure or malfunction of the equipment hospital-wide or in a particular setting be likely to cause harm to a patient or a staff person?
  - How serious is the harm likely to be? For example, a slightly miscalibrated scale in an adult internal medicine outpatient clinic might not present significant risk of harm. However, a miscalibrated scale in a neonatal intensive care unit could have very serious consequences for patient care.
  - How widespread is the harm likely to be? For example, are many patients exposed to the equipment, resulting in harm due to failure impacting more patients or staff? If harm would be widespread, even if the harm to each affected individual is not serious, this would be a cause for concern.

- Information, if available, on the manufacturer's equipment maintenance recommendations, including the rationale for the manufacturer's recommendations.
- Maintenance requirements of the equipment:
  - Are they simple or complex?
  - Are the manufacturer's instructions and procedures available in the hospital, and if so can the hospital explain how and why it is modifying the manufacturer's instructions?
  - If the manufacturer's instructions are not available in the hospital, how does the hospital assess whether the AEM uses appropriate maintenance strategies?
  - How readily can the hospital validate the effectiveness of AEM methods for particular equipment? For example, can the hospital explain how it ensures there is no reduction in the quality of the performance of biomedical equipment subjected to alternate maintenance methods?
- The timely availability of alternate devices or backup systems in the event of equipment failure or malfunction; and
- Incident history of identical or very similar equipment – is there documented evidence, based on the experience of the hospital (or its third party contractor), or on evidence publicly reported by credible sources outside the hospital, which:
  - Provides the number, frequency and nature of previous failures and service requests?
  - Indicates use of an AEM strategy does not result in degraded performance of the equipment?

Generally multiple factors must be considered, since different types of equipment present different combinations of severity of potential harm and likelihood of failure. The hospital is expected to be able to demonstrate to a surveyor the factors it considered in its risk assessment for equipment placed in its AEM program.

**Equipment not Eligible for Placement in the AEM Program (Refer to EC.02.04.01, EP 4; EC.02.05.01, EP 5)**

Some equipment may not be eligible for placement in the AEM program, for one or more of the following reasons:

- Other Federal law (for example, regulations promulgated by another Federal agency) or State law may require that facility or medical equipment maintenance, inspection and testing be performed strictly in accordance with the manufacturer's recommendations, or may establish other, more stringent maintenance requirements. In these instances, the hospital must comply with these other Federal or State requirements, but State Surveyors conducting Federal surveys assess compliance only with the hospital Conditions of Participation (CoPs).
- Other CoPs require adherence to manufacturer's recommendations and/or set specific standards which preclude their inclusion in an AEM program. For example:
  - The National Fire Protection Association Life Safety Code (LSC) requirements incorporated by reference at 42 CFR 485.623(d) have provisions that are pertinent to equipment maintenance, and compliance with these requirements are assessed on Federal surveys. Further, §485.623(d)(7)(v) requires hospitals to adhere to the manufacturer's maintenance guidelines for alcohol-based hand-rub dispensers. Compliance with these requirements is assessed on Federal surveys.
- Imaging/radiologic equipment, whether used for diagnostic or therapeutic purposes, must be maintained per manufacturer's recommendations.
- The equipment is a medical laser device. It should be noted that for medical lasers the U.S. Food and Drug Administration requires manufacturers to provide a schedule of maintenance and adequate instructions for service adjustments and service procedures to purchasers and, at cost, to any other parties requesting them.

- New equipment for which sufficient maintenance history, either based on the hospital's own or its contractor's records, or available publicly from nationally recognized sources, is not available to support a risk-based determination must not be immediately included in the AEM program. New equipment must be maintained in accordance with manufacturer recommendations until a sufficient amount of maintenance history has been acquired to determine whether the alteration of maintenance activities or frequencies would be safe. If a hospital later transitions the equipment to a risk-based maintenance regimen different than the manufacturers' recommendations, the hospital must maintain evidence that it has first evaluated the maintenance track record, risks, and tested the alternate regimen.

**Alternative Maintenance Frequencies or Activities (Refer to EC.02.04.01, EP 4; EC.02.04.03, EPs 2, 3; EC.02.05.01 EPs 4, 5; EC.02.05.05, EPs 4-6)**

Maintenance strategies are various methodologies used for determining the most efficient and effective maintenance activities and frequencies. Manufacturers' recommendations may be based on one or more such strategies. A hospital may also use one or more maintenance strategies for its AEM program in order to determine the appropriate maintenance, inspection, and testing activities and frequencies, based upon the nature of the equipment and the level of risk it presents to patient or staff health and safety. The risk to patient health and safety that is considered in developing alternative maintenance strategies must be explained and documented in the AEM program.

In developing AEM maintenance strategies, hospitals may rely upon information from a variety of sources, including, but not limited to manufacturer recommendations and other materials, nationally recognized expert associations, and/or the hospital's (or its third party contractor's) own experience. Maintenance strategies may be applied to groups or to individual pieces of equipment.

The hospital is expected to adhere strictly to the AEM activities or strategies it has developed.

**Background Information on Types of Maintenance Strategies**

- Preventive Maintenance (Time-based Maintenance) – a maintenance strategy where maintenance activities are performed at scheduled time intervals to minimize equipment degradation and reduce instances where there is a loss of performance. Most preventive maintenance is “interval-based maintenance” performed at fixed time intervals (e.g., annual or semi-annual), but may also be “metered maintenance” performed according to metered usage of the equipment (e.g., hours of operation). In either case, the primary focus of preventive maintenance is reliability, not optimization of cost-effectiveness. Maintenance is performed systematically, regardless of whether or not it is needed at the time. Example: Replacing a battery every year, after a set number of uses or after running for a set number of hours, regardless.
- Predictive Maintenance (Condition-based Maintenance) – a maintenance strategy that involves periodic or continuous equipment condition monitoring to detect the onset of equipment degradation. This information is used to predict future maintenance requirements and to schedule maintenance at a time just before equipment experiences a loss of performance. Example: Replacing a battery one year after the manufacturer's recommended replacement interval, based on historical monitoring that has determined the battery capacity does not tend to fall below the required performance threshold before this extended time.
- Reactive Maintenance (Corrective, Breakdown or Run-to-Failure Maintenance) – a maintenance strategy based upon a “run it until it breaks” philosophy, where maintenance or replacement is performed only after equipment fails or experiences a problem. This strategy may be acceptable for equipment that is disposable or low cost and presents little or no risk to health and safety if it fails. Example: Replacing a battery after equipment failure when the equipment has little negative health and safety consequences associated with a failure and there is a replacement readily available in supply.
- Reliability-Centered Maintenance – a maintenance strategy that not only considers equipment condition, but also considers other factors unique to individual pieces of equipment, such as equipment function, consequences of equipment failure, and the operational environment.



Maintenance is performed to optimize reliability and cost effectiveness. Example: Replacing a battery in an ambulance defibrillator more frequently than the same model used at a nursing station, since the one in the ambulance is used more frequently and is charged by an unstable power supply.

### **Maintenance Tools**

Tools (e.g., hand tools, test equipment, software, etc.) necessary for performing equipment maintenance must be available and maintained to ensure that measurements are reliable. Tools used for maintenance are not required to be those specifically recommended by the manufacturer, but tools utilized must be capable of providing results equivalent to those required by the equipment manufacturer.

### **AEM Program Documentation (Refer to EC.02.04.01, EPs 3, 4; EC.02.04.03, EPs 2, 3; EC.02.05.01, EPs 4, 5; EC.02.05.05, EPs 4-6)**

For each type of equipment subject to the AEM program, there must be documentation indicating:

- The pertinent types and level of risks to patient or staff health and safety.
- Alternate maintenance activities, and the maintenance strategy and any other rationale used to determine those activities; the differences from the manufacturer's recommended maintenance activities are made explicit, unless the hospital is unable to obtain the manufacturer's maintenance recommendations, due to the age of the equipment or the manufacturer's restricting the availability of its recommendations.
- Alternate maintenance frequencies to be used, if any, and the maintenance strategy and any other rationale used to determine those frequencies. For equipment identified as presenting a very low risk to patient or staff safety, it could be acceptable to not set a particular frequency but instead indicate a less specific approach, for example, an interval range, such as "every 12 – 24 months." It could also be acceptable to employ periodic "departmental sweeps" for such very low risk equipment, where equipment functioning is sampled and operators are polled about its functionality.
- The date when AEM program maintenance activities were performed and, if applicable, further actions required/taken; and
- Documentation of any equipment failures (not including failures due to operator error), including whether there was resulting harm to an individual. (Note: equipment failure that is due to operator error and which results in an adverse event or near miss must be documented in accordance with the QAPI CoP, as part of the hospital's required tracking of patient safety-related incidents. However, there is no requirement to include operator failures in equipment maintenance documentation.) When the hospital has multiple identical equipment items, the documentation may be generic to that type of equipment, except that documentation of maintenance activities performed must be specific to each item of equipment.

### **Evaluating Safety and Effectiveness of the AEM Program (Refer to EC.02.04.01, EP 9; EC.02.05.01, EPs 10, 11, 13)**

The hospital must have policies and procedures which address the effectiveness of its AEM program. In evaluating the effectiveness of the AEM program, the hospital is expected to address factors including, but not limited to:

- How equipment is evaluated to ensure there is no degradation of performance, particularly for equipment where such degradation may not be readily apparent to staff using the equipment, e.g., miscalibration.
- How incidents of equipment malfunction are investigated, including:
  - whether or not the malfunction could have been prevented, and what steps will be taken to prevent future malfunctions; and
  - how a determination is made whether or not the malfunction resulted from the use of an AEM strategy.

- The process for the removal from service of equipment determined to be unsafe or no longer suitable for its intended application; and
- The use of performance data to determine if modifications in the AEM program procedures are required.

**Equipment Inventory (Refer to EC.02.04.01, EPs 2, 3; EC.02.04.03, EPs 2, 3; EC.02.05.01, EPs 3, 4, 5; EC.02.05.05 EPs 2-6)**

- All hospital facility and medical equipment essential to the operation of the hospital, regardless of whether it is leased or owned, and regardless of whether it is maintained according to manufacturer recommendations or is in an AEM program, is expected to be listed in an inventory which includes a record of maintenance activities. For low cost/low risk essential equipment, such as housekeeping cleaning equipment, it is acceptable for the inventory to indicate under one item the number of such pieces of equipment in the hospital, e.g., “15 vacuum cleaners for cleaning patient rooms and common areas.”
- If the hospital is using an AEM program, the equipment managed through that program must be readily separately identifiable as subject to AEM. Critical equipment, whether in an AEM program or not, must also be readily identified as such.
- To facilitate effective management, a well-designed equipment inventory contains the following information for all equipment included. However, hospitals have the flexibility to demonstrate how alternative means they use are effective in enabling them to manage their equipment.
  - A unique identification number;
  - The equipment manufacturer;
  - The equipment model number;
  - The equipment serial number;
  - A description of the equipment;
  - The location of the equipment (for equipment generally kept in a fixed location);
  - The identity of the department considered to “own” the equipment;
  - Identification of the service provider;
  - The acceptance date; and
  - Any additional information the hospital believes may be useful for proper management of the equipment.

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

Medical Record Review Components	TJC Standard	A Tag/CoP
<b>Admitting diagnosis</b>	RC 02.01.01 EP 2	A0463 – 482.24(c)(4) (ii)
<b>H&amp;P</b> 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)
<b>H&amp;P Update</b>	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)
<b>All orders</b> , 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 <b>information necessary to monitor the patient's condition</b>	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 <b>evaluates nursing care</b> 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)
<b>Inform patient of rights</b>	RI 01.01.01 EP 2	A0117 – 482.13(a)(1)
<b>Informed consent</b>	RC 02.01.01 EP 4 RI 01.03.01 EP 1, 2	A0466 – 482.24(c)(4)(v) A0955 – 482.51(b)(2)
<b>Advanced directives</b> – 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)
<b>Patient asked about notifying</b> family and physician about inpatient admission	RI 01.02.01 EP 1	A0133 – 482.13(b)(4)
Patient informed of <b>visitation rights</b>	RI 01.01.01 EP 2	A0216 – 482.13(h)(1) &(2)
<b>Medication administration</b> 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)
<b>Medical record information</b> 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)
<b>Nutritional needs</b>	PC 01.02.01 EP 3 PC 01.03.01 EP 1 PC 02.02.03 EP7	A0629 – 482.28(b)(1), (b)(2)
<b>Discharge planning</b> in early stage of hospitalization	PC 04.01.03 EP 1	A0800 – 482.43(a)
<b>Discharge planning evaluation</b> – 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)
<b>Discharge plan</b> – 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)

<b>Medical Record Review Components</b>	<b>TJC Standard</b>	<b>A Tag/CoP</b>
<b>Discharge planning</b> – pt and family counseled to prepare them for discharge	PC 04.01.05 EP 1, 2, 7	A0820 – 482.43(c)(5)
<b>Reassess discharge plan</b>	PC 01.02.03 EP 3	A0821 – 482.43(c)(4)
<b>Discharge summary</b> with outcome of hospitalization, disposition, and f/u care	RC 02.04.01 EP 3	A0468 – 482.24(c)(4)(vii)
<b>List of HHAs or SNFs</b> was presented to the patient	PC 04.01.01 EP 22-25	A0823 – 482.43(c)(6), (c)(7),(c)(8)
Necessary <b>medical information is forwarded</b> to next provider(s) of care	PC 04.02.01 EP 1	A0837 – 482.43(d)
<b>Final diagnosis</b> 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 <b>self-administration of medication</b> 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 <b>consultative evaluations</b>	RC 02.01.01 EP 2	A0464 – 482.24(c)(4)(iii)
Results of <b>consultative evaluations</b>	RC 02.01.01 EP 2 RC 02.01.03 EP 8	A0465 – 482.24(c)(4)(iv)
<b>Complications</b> , 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)
<b>Pre-anesthesia</b> eval within 48 hours prior to surgery or anesthesia	PC 03.01.03 EP 18	A1003 – 482.52(b)(1)
<b>Intraoperative anesthesia</b> record or report	PC 03.01.05 EP1 RC 02.01.03 EP 1	A1004 – 482.52(b)(2)
<b>Post anesthesia</b> eval no later than 48 hours after surgery or anesthesia	PC 03.01.07 EP 7, 8	A1005 – 482.52(b)(3)
Conduct <b>suicide risk assessment</b> 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 <b>resolution of complaint</b>	RI 01.07.01 EP 18	A0123 – 482.13(a)(2)(iii)
Documentation of justification of simultaneous use or <b>restraints and seclusion</b>	PC 03.05.13 EP 1	A0183 – 482.13(e)(15)(ii)
Documentation of the use of <b>restraint or seclusion</b> 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 -any injuries -any deaths -Identity of physician or other licensed practitioner who ordered 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)

<b>Medical Record Review Components</b>	<b>TJC Standard</b>	<b>A Tag/CoP</b>
-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))		
<b>Restraints</b> properly and safely applied	PC 03.05.03 EP 1	A0167 – 482.13(e)(4)(ii)
Medical record includes date and time <b>death associated with use of restraint/seclusion</b> 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 <b>death</b> -include patient’s name, date of birth, date of death, name of the physician or other licensed 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 <b>notify patient of potentially infectious blood</b>	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 <b>notification to exceed 12 weeks.</b>	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** accreditation program. 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

	<b>MS.01.01.01 - Medical Staff Bylaws address self-governance and accountability to the governing body.</b>
<b>EP</b>	<b>DESCRIPTION</b>
<b>1</b>	Medical Staff Develops Medical Bylaws, rules and regulations and policies.
<b>2</b>	Medical Staff adopts and amends Medical Staff Bylaws. Bylaws become effective only upon governing body approval.
<b>12</b>	The structure of the medical staff
<b>13</b>	Qualifications for appointment to the medical staff
<b>14</b>	Process for privileging and re-privileging physicians and other licensed practitioners*
<b>15</b>	Duties and privileges (prerogatives) related to each category of the med staff
<b>16</b>	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.
<b>17</b>	Description of those members of the medical staff eligible to vote
<b>18</b>	Process by which org MS selects or elects and removes MS officers*
<b>19</b>	List of all the officer positions for the medical staff
<b>20</b>	The MEC's function, size, and composition; authority delegated to MEC to act on MS behalf; how such is delegated or removed
<b>21</b>	Process for selecting or electing and removing MEC members*
<b>23</b>	That the MEC acts on behalf of MS between meetings as defined by MS
<b>24</b>	Process for adopting and amending the medical staff bylaws*
<b>25</b>	Process for adopting/amending the MS rules and regulations, and policies*
<b>26</b>	Process for credentialing/re-credentialing physicians and other licensed practitioners*
<b>27</b>	Process for appointment/re-appt to membership on the med staff*
<b>28</b>	Indications for automatic suspension of MS membership or clinical privileges
<b>29</b>	Indications for summary suspension of MS membership or clinical privileges
<b>30</b>	Indications for termination or suspension of MS membership and/or termination, suspension, or reduction of privileges
<b>31</b>	Process for automatic suspension of MS membership or clinical privileges*
<b>32</b>	Process for summary suspension of MS membership or clinical privileges*
<b>33</b>	Process for recommending termination or suspension of MS membership and/or termination, suspension or reduction of clinical privileges*
<b>34</b>	The fair hearing and appeal process*
<b>35</b>	Composition of the fair hearing committee
<b>36</b>	<b>If departments of MS exist</b> , 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"> <li>• Clinically related activities of the department</li> <li>• Administrative activities of dept, unless provided by hospital</li> <li>• Continuing surveillance of prof perf of all in dept with privileges</li> <li>• Recommending to the med staff the criteria for departmental clinical privileges</li> <li>• Recommending clinical privileges for each member of dept</li> <li>• Assessing and recommending to hospital authority off-site sources of care</li> <li>• Integration of dept or service into primary functions of org</li> <li>• Coordination and integration of inter- and intra-departmental services</li> <li>• Development and implementation of policies and procedures</li> <li>• Recommendations for sufficient number of qualified and competent persons to provide care, treatment, and services</li> <li>• Determination of qualifications and competence of dept or service licensed practitioners that cannot practice independently</li> <li>• Continuous assessment and quality improvement</li> <li>• Maintenance of quality control programs, as appropriate</li> <li>• Orientation and continuing education of persons in dept or svc</li> <li>• Recommending space and resources needed by the dept or service</li> </ul>
37	<ul style="list-style-type: none"> <li>• Process by which med staff at each hospital are advised of their right to opt out of unified &amp; integrated medical staff structure after a majority vote to maintain a separate medical staff for their hospital. <b><i>N.B.: Applies to multihospital systems with unified/integrated medical staff and deemed status*</i></b></li> </ul>
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		
Standard	EP	DESCRIPTION
EM.12.02.03	5	Individuals responsible for granting disaster privileges to volunteer physicians and other licensed practitioners are identified in Medical Staff bylaws, rules and regulations, or policies and procedures.
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 physician and other licensed 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.



<b>Other Medical Staff and Related Standards</b>		
<b>Standard</b>	<b>EP</b>	<b>DESCRIPTION</b>
MS.06.01.13	<b>1</b>	Temporary privileges are granted to meet an important patient care need for the time period defined in the medical staff bylaws.
MS.10.01.01	<b>5</b>	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 Rules and Regulations or policies, as applicable.

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: 7/1/23*

## Medical Staff and Related Standards Compliance Evaluation Guide

		1- Credentialing Process Discussion	
YES	NO	<b>Credentialing Discussion – If no issues found in document review, begin meeting with the discussion of the credentialing process.</b>	
<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 ( <b>See also: MS Bylaws Checklist for relevant EPs of MS.01.01.01</b> ) Privileges are granted for a period not to <b>exceed 3 years</b> . Physician or other licensed practitioner is notified in writing of the decision Re: appointment, reappointment, privileges.	<b>MS.02.01.01 EP8, 11 MS.06.01.03 EP4 MS.06.01.07 EP9 MS 06.01.09 EP1</b>
<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.	<b>MS.06.01.03 EP6</b>
<input type="checkbox"/>	<input type="checkbox"/>	Evidence of Physician and Other Licensed Practitioner ID verification (Hospital or government-issued picture ID) DEA Registration, when required by MS, hospital, or state.	<b>MS.06.01.03 EP5 LD.04.01.01 EP2 Scored only if DEA has expired</b>
<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 physician or other licensed practitioner?"	<b>MS.07.01.03 EP1-4</b>
<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 practitioner's health and ability to perform the requested procedures?	<b>MS.06.01.05 EP7 MS.06.01.05 EP6</b>
<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.	<b>MS.06.01.05 EP9</b>
<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?	<b>MS.06.01.11 EP1 MS.06.01.11 EP2</b>
<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?	<b>MS.06.01.05 EP2</b>
<input type="checkbox"/>	<input type="checkbox"/>	Temporary privileges: Time periods must be defined in bylaw <b>Must be no more than 120 Days.</b> ( <b>See also box 3 below - file review</b> )	<b>MS.06.01.13 EP1</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Telemedicine:</b> How are these credentialed? They should all be granted privileges by the originating site but may do so in the usual way <b>-OR-</b> By contractual arrangement to accept the credentialing information from a Joint Commission Accredited or CMS certified Organization <b>-OR-</b> Joint Commission accredited or CMS Certified accept the privilege decision of distant site if all of these are met by the distant site	<b>MS.13.01.01 EP1</b>

		<ul style="list-style-type: none"> <li>and the privileges to be exercised are granted: List of privileges at distant site is provided</li> <li>FPPE, OPPE information is shared</li> <li>Physician or other licensed practitioner is licensed in the originating site's state</li> </ul>	
<input type="checkbox"/>	<input type="checkbox"/>	<p><b>CME:</b> Requires that the MS sets priorities for CME topics</p> <p><b>EP2</b> Requires CME resources are related to the scope of services of the organization</p> <p><b>EP3</b> State CME should be related to outcomes of PI activities</p> <p><b>EP4</b> Requires documentation of CME; and</p> <p><b>EP5</b> Requires CME to be considered in the credentialing process</p>	<b>MS.12.01.01 EP2-5</b>
<b>2- FPPE/OPPE</b>			
<b>YES</b>	<b>NO</b>		
<input type="checkbox"/>	<input type="checkbox"/>	<p><b>FPPE for all initial or New Privileges</b></p> <p><b>EP1</b> Implemented for all practitioners in all clinical sites and privilege specific (includes Physicians, PAs, APRNs, CRNAs, Dietitians granted privileges to write orders, pharmacists with prescriptive authority, telemedicine practitioner, 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><b>EP2</b> The process including criteria is approved by the MS (evaluation should be qualitative and not just quantitative)</p> <p><b>EP3</b> 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><b>EP4</b> Applied consistently (<i>follow the same process step and documentation requirements for all evaluations</i>)</p>	<b>FPPE: MS.08.01.01</b>
<input type="checkbox"/>	<input type="checkbox"/>	<p><b>FPPE for Cause</b></p> <p><b>EP5</b> Triggers should be defined clearly (<i>i.e. in policy</i>)</p> <p><b>EP6</b> Decisions to initiate FPPE for cause should be based upon objective measures of current performance reflective of quality and/or safety concerns.</p> <p><b>EP7</b> Criteria are developed for type of monitoring to be conducted</p> <p><b>EP8</b> Measures/actions to address performance issues are defined</p> <p><b>EP9</b> These measures/actions are consistently implemented</p>	<b>MS.08.01.01</b>
<input type="checkbox"/>	<input type="checkbox"/>	<p><b>OPPE:</b></p> <p><b>EP1</b> There is a clearly defined process: For example, a written policy, bylaw, or Rules and Regulations. <u>The organization determines the frequency of the data collection and review, but this may not exceed 12 months.</u> Process includes all physicians and other licensed practitioners in all clinical sites and includes methodology of data collection and who/how the data is reviewed and acted upon.</p> <p><b>EP2</b> 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"> <li>Aggregate (quantitative) or trended quality metrics are encouraged - e.g., SSI rates, complications, BUT:</li> <li>Qualitative or chart review data may be used</li> <li>The data must be RELEVANT to the specialty or privileges granted</li> <li>Review of data that occurs only when triggered by an incident is NOT acceptable</li> <li>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 physicians or other licensed practitioners</i>)</li> <li>Data must be from the organization except for low volume physicians or other licensed practitioners who have available data from other</li> </ul>	<b>MS.08.01.03</b>

		<p>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</p> <ul style="list-style-type: none"> <li>• Use of quantitative (raw) data may be used, however, it cannot be the only type of data used to evaluate performance</li> </ul> <p><b>EP3</b> 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 physician's or other licensed practitioner'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 3-year reappointment.</p>	
<b>Other items to review/confirm related to the medical staff.</b>			
<b>YES</b> <input type="checkbox"/>	<b>NO</b> <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.	<b>PC.02.02.03, EP22</b>
<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	<b>MS.03.01.01 EP 16,17</b>
<input type="checkbox"/>	<input type="checkbox"/>	Is there a process for education of licensed practitioners in antibiotic stewardship? Is there a process for education of licensed practitioners 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>	<b>MM.09.01.01 EP2 LD.04.03.13 NPSG.06.01.01 EP4</b>
<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, rules and regulations or policy and procedures.	<b>EM.12.02.03 (see also MS.01.01.01 EP14)</b>

Updated 7/1/24

## Professional Graduate Medical Education Program Standard Compliance Evaluation Guide

Response	Response (if “no” score standard and EP)	Standard, EP, and Compliance Criteria
<b>YES</b>	<b>NO</b>	<b>MS.04.01.01 All EPs (1-9)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<p>MS.04.01.01 EP1 <i>This EP has a documentation requirement</i></p> <p>Does the organized medical staff have a document that defines a process for supervision by a physician 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 <i>This EP has a documentation requirement</i></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 <i>This EP has a documentation requirement.</i></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, and what entries, if any, must be countersigned by a supervising physician.</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 hospital. Affiliated hospitals often have only a coordinator and not a full GMEC, in</p>

		<p>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>If the hospital surveyed has a professional GMEC, how does it communicate to the medical staff and governing body information about:</p> <ul style="list-style-type: none"> <li>• safety and quality of patient care, treatment and services by the training program</li> <li>• related educational and supervisory needs of the training program</li> </ul> <p>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:</p> <ul style="list-style-type: none"> <li>• patient care, treatment, and services provided by the training program</li> <li>• related educational and supervisory needs of its participants in the GME programs.</li> </ul> <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

Practitioner info				PSV Documents									Peer Recommendations					FPPE	OPPE	Administration	
Practitioner	Specialty	Application Type	Valid Picture ID (file copy not required)	Current License	Relevant Training	Current Competence	NPDB Review	Health Status	DEA Current? (if required by medical staff)	Medical/Clinical Knowledge	Technical/Clinical Skills	Interpersonal Skills	Communication Skills	Professionalism	Was FPPE process used for new applicant or new privileges?	Was OPPE data used for recredentialing decision?	Timeliness of decision and < 2 yr term	Board approval and letter to applicant			
Other Medical Staff Standards to Review																					
																	Yes	No			
Confirm qualifications of key department leaders—name, license and board certification:																					
Respiratory																					
Radiology																					
Nuclear Medicine																					
Emergency Department																					
Psychiatry (Inpatient)																					
Anesthesia																					
<i>(Refer to the Medical Staff chapter for relevant standards and EPs.)</i>																					

Updated: 12.2.20

# Kitchen Tracer Survey Guide – Hospital and Critical Access Hospital

This tool is used by surveyors when performing the evaluation of dietary services and kitchen area.  
Updated: 6/9/24

YES	NO		YES	NO	
		<b>Do the organization’s practices address the following: CMS 482.28</b>	<input type="checkbox"/>	<input type="checkbox"/>	Does staff have appropriate <b>competencies/skill sets</b> for food/nutrition services? <i>Consider patient assessments, care plans, etc.</i> <b>HR.01.06.01 EP 5 and HR.01.06.01 EP 6</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Meal frequency?</b> and <b>PC.02.02.03 EP 7</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<b>Diet ordering/patient tray delivery system?</b> <b>PC.02.02.03 EP 7 and PC.02.01.03 EP 1 for diet ordering</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Diet Manual;</b> approved by medical staff/dietitian & current? <b>PC.02.02.03 EP 22 (CAH DPU only)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Non-routine occurrences?</b> <i>e.g., parenteral nutrition, change in diet orders, early/late trays</i> <b>PC.01.02.01 EP 3</b>	<input type="checkbox"/>	<input type="checkbox"/>	Do <b>menu options</b> meet patient needs? <b>PC.02.02.03 EP 7</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>QAPI</b> integration of food/dietetic service? <b>LD.01.03.01 EP 21</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Does the organization have a full-time qualified dietitian or other qualified professional?</b> <i>If a dietitian or other qualified professional is not full-time, interview staff to determine adequacy of the dietary director’s qualifications.</i> <b>HR.01.02.05 EP 2 (CAH DPU only)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Hygiene Practices</b> for food service personnel? <b>IC.06.01.01, EP 3</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<b>Kitchen sanitation?</b> <b>IC.06.01.01, EP 3, Applies to sanitation of surfaces.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Food safety certification/license;</b> if required, do the appropriate staff members have this? <b>HR.01.01.01 EP 2</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Safe food handling?</b> <b>PC.02.02.03 EP 6</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<b>Emergency food supplies?</b> <b>EM.12.02.09 EP 3</b>			
<input type="checkbox"/>	<input type="checkbox"/>	Orientation, assignments, supervision & personnel performance? <b>HR.01.04.01, HR.01.05.03 HR.01.07.01</b>			<b>Advanced: You can ask for recent health department inspection to provide baseline for whether issues are ongoing or isolated.</b>

		<b>PHYSICAL ENVIRONMENT</b>			
YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Are areas kept clean? <b>EC.02.06.01 EP 20</b>	<input type="checkbox"/>	<input type="checkbox"/>	Is the area free of any signs of <b>pests</b> ? If there are pests, has the organization taken steps to address the issue? <b>EC.02.06.01 EP 20</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Kitchen equipment;</b> 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> <b>EC.02.06.01 EP 26</b>	<input type="checkbox"/>	<input type="checkbox"/>	Are <b>cookware/dishware/Dishes/Utensils</b> stored in a clean, dry location? <i>There is no requirement for a solid bottom shelf for storage of food or cooking equipment. Use of solid bottom shelving is an example of a strategy that would be used.</i> Clean items are managed as per local/state food code, e.g., protected from contamination, such as splash, dust or other contaminants. The HCO determines how items will be protected in accordance with food code. <b>IC.06.01.01, EP 3</b>
<input type="checkbox"/>	<input type="checkbox"/>	Is <b>garbage/refuse</b> properly disposed of? <b>EC.02.02.01 EP 19</b>	<input type="checkbox"/>	<input type="checkbox"/>	Are <b>wet wiping cloths</b> stored in an approved sanitizing solution & washed daily? <b>IC.06.01.01, EP 3</b>
<input type="checkbox"/>	<input type="checkbox"/>	Are sinks clear from items that can be contaminated from splashes? <i>e.g., paper-wrapped straws</i> <b>IC.06.01.01, EP 3</b>	<input type="checkbox"/>	<input type="checkbox"/>	Are <b>food carts</b> cleaned & sanitized <i>after every meal.</i> <b>IC.06.01.01, EP 3</b>



					Advanced: You can ask a question regarding pest control services that have been accomplished.
--	--	--	--	--	---

		<b>REFRIGERATOR</b>				
YES	NO			YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Refrigerator temps:</b> have they been monitored? PC.02.02.03 EP11		<input type="checkbox"/>	<input type="checkbox"/>	Is <b>uncooked food</b> (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 EP 11
<input type="checkbox"/>	<input type="checkbox"/>	Is frequency of <b>temp checks &amp; limits</b> (41° or lower) maintained as per policy? PC.02.02.03 EP11		<input type="checkbox"/>	<input type="checkbox"/>	Is <b>prepared food</b> covered & labeled with expiration date? PC.02.02.03 EP 11
<input type="checkbox"/>	<input type="checkbox"/>	Is there a process if the temp is inadequate? <i>If possible, PC.02.02.03 EP 11 validate the process was followed.</i>		<input type="checkbox"/>	<input type="checkbox"/>	Are <b>open containers</b> labeled with expiration date? PC.02.02.03 EP 11
<input type="checkbox"/>	<input type="checkbox"/>	Is <b>food stored</b> away from soiled areas & rust? PC.02.02.03 EP 11		<input type="checkbox"/>	<input type="checkbox"/>	Are there any <b>expired items</b> ? PC.02.02.03 EP 11
				<input type="checkbox"/>	<input type="checkbox"/>	Is the <b>locking mechanism</b> on the door in proper working condition? EC.02.06.01 EP 26
<input type="checkbox"/>	<input type="checkbox"/>	Is <b>food stored</b> to allow for ventilation? PC.02.02.03 EP 11		<input type="checkbox"/>	<input type="checkbox"/>	Is staff aware of how to use <b>safety process/mechanisms</b> in an emergency? EC.03.01.01 EP 2

		<b>DRY STORAGE</b>				
YES	NO			YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Are there any <b>expired items</b> ? PC.02.02.03 EP 11		<input type="checkbox"/>	<input type="checkbox"/>	Is the <b>area</b> clean, dry, & well ventilated? <i>This will help with humidity &amp; prevent growth of mold/bacteria.</i> PC.02.02.03 EP 11
<input type="checkbox"/>	<input type="checkbox"/>	Are <b>canned goods</b> properly sealed? PC.02.02.03 EP 11		<input type="checkbox"/>	<input type="checkbox"/>	Is <b>food stored</b> away from sources of heat/light? <i>This helps preserve shelf life.</i> PC.02.02.03 EP 11
<input type="checkbox"/>	<input type="checkbox"/>	Does the kitchen have food storage items/plans for <b>disaster preparedness</b> ? <i>A 96-hour stockpile isn't required for emergency operations. The kitchen should have a role in response to an event, &amp; it should correspond with the organization's Emergency Operations Plan.</i> EM.12.02.09 EP 3		<input type="checkbox"/>	<input type="checkbox"/>	Are <b>food containers</b> 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 EP 11

		<b>FOOD PREP ASSESSMENT - Interview</b>			
YES	NO				
<input type="checkbox"/>	<input type="checkbox"/>	<b>Foodborne illness:</b> does the organization take prevention measures? Question if cases have occurred/been resolved. IC.06.01.01, EP 4		Advanced: Ask about ladle size & how to determine appropriate proportions.	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Sick employees or those with open wounds;</b> is there a procedure for them? PC.02.02.03 EP6 or IC.06.01.01, EP 5		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"/>	<b>Thawing food;</b> is there a process? <i>Validate the staff is following the process during observation. Food should not be thawing at room temperature &amp; can be thawed under cold running water or the refrigerator.</i> PC.02.02.03 EP 6		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.	

		<b>FOOD PREP ASSESSMENT - Observation</b>				
YES	NO			YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Hand hygiene during food prep</b> ; is staff using proper practices to prevent contamination of food and food surfaces, e.g., <i>washing after touching face or hair</i> <b>PC.02.02.03 EP 6</b>		<input type="checkbox"/>	<input type="checkbox"/>	<b>Monitor food temp checks for hot, cold and pre-cooked items undergoing the cooling process.</b> <i>Food should be cooled to 70° within 2 hours &amp; to 41° within 4 &amp; total cooling time should not exceed 6 hours.</i> <b>PC.02.02.03 EP 6</b>
<input type="checkbox"/>	<input type="checkbox"/>	Is <b>hand washing facilities</b> separate from ones used for food prep? <b>EC.02.06.01 EP 1</b>		<input type="checkbox"/>	<input type="checkbox"/>	Review <b>temp logs</b> – did staff maintain logs for each service during food prep? Is the process for monitoring temps in alignment with food code? <i>Temps are usually logged at start, midpoint &amp; end if meal service is extended. Ensure adequate process for Potentially Hazardous Foods (PHF) and Time/Temp Controlled for Safety (TCS) Foods</i> <b>PC.02.02.03 EP 6.</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Gloves</b> : do staff use when appropriate to prevent contamination? e.g., <i>handling raw meat or ready-to-eat foods</i> <b>PC.02.02.03 EP 6</b>				
<input type="checkbox"/>	<input type="checkbox"/>	<b>Hair nets</b> ; are all staff members wearing? <b>PC.02.02.03 EP 6</b>				<b>Final cooking temps</b> should be as follows: <b>PC.02.02.03 EP 6</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Cutting boards/prep surfaces</b> ; are they cleaned and sanitized properly to avoid contamination? E.g., one for meat, one for veggies & sanitized between uses <b>IC.06.01.01, EP 3</b> Does the staff use <b>clean utensils</b> with bulk foods/ice? <b>PC.02.02.03 EP 6</b>		<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"/>	Cold food hold temp - 41° or below
<input type="checkbox"/>	<input type="checkbox"/>	<b>Evaluate dishwasher temps/chemical monitoring processes</b> <b>EC.02.05.05 EP 5</b>				

		<b>FREEZER</b> <b>PC.02.02.03 EP 11 for food storage</b>				
YES	NO			YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Freezer temps</b> : have they been monitored?		<input type="checkbox"/>	<input type="checkbox"/>	Is the freezer free of any ice buildup? <b>EC 02.06.01 EP 26</b>
<input type="checkbox"/>	<input type="checkbox"/>	Is 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 <b>expiration dates</b> ? <i>There should be no expired items</i> <b>PC 02.02.03 EP 11</b>
<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 <b>pre-cooked food</b> , is the cooling process sufficient? <i>See refrigerator note above</i> <b>PC 02.02.03 EP 11</b>
<input type="checkbox"/>	<input type="checkbox"/>	Is food stored away from soiled areas & rust?		<input type="checkbox"/>	<input type="checkbox"/>	Is the <b>locking mechanism</b> on the door in proper working condition? <b>EC.02.06.01 EP 26</b>
<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, and 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 <b>freezer burn/food discoloration</b> ?				
<input type="checkbox"/>	<input type="checkbox"/>	Are <b>raw foods</b> stored properly? <i>There should be no signs of them dripping on other foods.</i>		<input type="checkbox"/>	<input type="checkbox"/>	Is staff aware of how to use safety process/mechanism in emergency? <b>EC.03.01.01 EP 2</b>

		<b>LIFE SAFETY</b>				
YES	NO			YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Is the kitchen in good repair? e.g., lack of broken floor tiles, delamination, flaking walls, etc. <b>EC.02.06.01 EP 1</b>		<input type="checkbox"/>	<input type="checkbox"/>	Can staff <b>access eyewash station</b> within 10 seconds of hazardous material storage/usage area? <b>EC 02.02.01 EP 5</b>
<input type="checkbox"/>	<input type="checkbox"/>	Do <b>sprinkler heads</b> have adequate <b>18"</b> clearance? <i>Ensure racks perpendicular to walls do not encroach 18" open space for sprinklers.</i> <i>NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1;</i> <i>NFPA 13-2010: 8.5.5.2; 8.5.5.2.1; 8.5.5.3</i> <b>LS.02.01.35 EP 6</b>		<input type="checkbox"/>	<input type="checkbox"/>	Has the <b>eyewash inspection log</b> been kept up to date? <b>EC 02.02.01 EP 5</b>
		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"/>	<b>Natural gas:</b> does the organization use this?
<input type="checkbox"/>	<input type="checkbox"/>	<b>Soda fountain machine:</b> is the CO2 secured? <b>EC 02.05.09 EP 12</b>		<input type="checkbox"/>	<input type="checkbox"/>	Is a <b>gas valve</b> accessible for emergency shutoff & do staff know its location/operation? <b>EC.02.05.05 EP 6/ EC 03.01.01 EP 2</b>
<input type="checkbox"/>	<input type="checkbox"/>	Are <b>sewage/pipelines</b> free from signs of water damage? <b>EC 02.06.01 EP 1</b>		<input type="checkbox"/>	<input type="checkbox"/>	Is <b>emergency shutoff valve</b> properly labeled? <b>EC.02.05.01 EP 9</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Deep fat fryer;</b> is there a <b>K fire extinguisher</b> within 30'? <i>NFPA 96-2011 10.10.1; NFPA 10-2010, 6.6.1; 6.6.2</i> <b>LS.02.01.35 EP 11</b>		<input type="checkbox"/>	<input type="checkbox"/>	<b>Tethering</b> – Kitchen appliances are required to have restraints or tethering. <i>NFPA 54-2012, 9.6.1.2, LS.02.01.50 EP 1</i>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Deep fat fryer:</b> 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> <b>LS.02.01.30 EP 26</b>				<b>Evaluate the hood system</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>K fire extinguisher placard</b> identifying need to activate the fixed suppression (ansul) system before using the extinguisher? <i>NFPA 96-2011 10.2.2</i> <b>LS.02.01.35 EP 11</b>		<input type="checkbox"/>	<input type="checkbox"/>	Is the <b>hood clean</b> with no grease buildup? <i>NFPA 96-2011 11.6.2</i> <b>LS.2.01.30 EP 26</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Suppression system:</b> does staff know how to use it? <i>Instructions for manual operations should be conspicuously posted &amp; reviewed by staff.</i> <i>NFPA 96-2011 11.1.4</i> <b>EC.03.01.01 EP 1</b>		<input type="checkbox"/>	<input type="checkbox"/>	Are the <b>steel filter baffles</b> all installed with no gaps & are they in the proper direction? <i>NFPA 96-2011 6.2.3.1; 6.2.3.5</i> <b>LS.02.01.35 EP 12</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Compressed gas cylinders:</b> are they properly secured? <i>NFPA 99-2012 11.3; 11.6.2.3</i> <b>EC.02.05.09 EP 12</b>		<input type="checkbox"/>	<input type="checkbox"/>	Is <b>grease producing equipment</b> located properly under the hood? <i>NFPA 96-2011 5.2</i> <b>LS.02.01.35 EP 12</b>
<input type="checkbox"/>	<input type="checkbox"/>	Are the <b>gaskets</b> intact for kitchen entry/delivery doors to prevent entry from pests? <b>EC.02.06.01 EP 1</b>		<input type="checkbox"/>	<input type="checkbox"/>	Are <b>extinguishing heads</b> pointed properly toward the cooking surface? <b>LS 02.01.35 EP 12</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Eyewash/shower station;</b> if required, is it in good working order & located away from hazards? <b>EC.02.02.01 EP 5</b>		<input type="checkbox"/>	<input type="checkbox"/>	<b>Electrical panels;</b> are they clear from obstruction? <i>There should be 36"</i> <b>EC.02.05.05 EP 6</b>
				<input type="checkbox"/>	<input type="checkbox"/>	<b>Fire Evacuation &amp; Relocation Plan;</b> is the staff knowledgeable? <i>NFPA 101-2012: 18/19.7.1; 7.2</i> <b>EC.03.01.01 EP 2</b>

Creation Date: 2016  
Last Review Date: 12/12/2023  
Revision Date: 6/9/2024  
Reviewed by: PES, DSSM, FDs

# 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 physician or other licensed practitioner in direct supervision of contrast administration, including timely intervention in the event of patient emergency. Either a pharmacist reviews orders for contrast OR a physician or other licensed practitioner 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.03.01.01, 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

# Infection Prevention and Control Program Assessment Tool

## Hospital and Critical Access Hospital

### Required Documents and Data

- Assessment of infection risks  
Note: Performed at least annually, the format is determined by the hospital.
- Results of infection control surveillance  
Note: Infection control surveillance includes surveillance of healthcare-associated infections (HAIs), such as data submitted to the National Healthcare Safety Network (NHSN) for Centers for Medicare & Medicaid (CMS) or State requirements, and data on any epidemiologically important organisms or infectious diseases that have impacted the hospital during the preceding 12 months.
- Infection prevention and control policies and procedures that guide program activities and methods (in electronic or paper form)
- Documentation of completed job-specific staff education, training, and competencies on infection control and prevention
- Program documents demonstrating that the problems identified by the infection prevention and control program have been reviewed and addressed in collaboration with the hospital's quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders).  
Note: The format of this documentation is determined by the hospital. Examples may include relevant committee meeting agendas and minutes, presentations, reports, planning documents.
- Documentation demonstrating the governing body's oversight of the program implementation and performance (for example, governing body minutes)

**Table: Elements of Compliance and Scoring Guidance**

Elements of Compliance	Standard(s)/EP(s)
<b>Infection Prevention and Control Program &amp; Leader(s)</b>	
1. An infection preventionist(s) or infection control professional(s) has been appointed by the hospital governing body, based on the recommendation of the medical staff and nursing leaders, and is qualified through education, training, experience, or certification.	IC.04.01.01 EP 1
2. The hospital defines the qualifications for the infection preventionist(s) or infection control professional(s), which may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).	HR.01.01.01 EP 1
3. The infection preventionist(s)/infection control professional(s) perform the following activities in collaboration with all departments, programs, and areas involved in infection prevention and control activities: <ol style="list-style-type: none"> <li>Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines</li> <li>Documentation of the infection prevention and control program and its surveillance, prevention, and control activities</li> <li>Competency-based training and education of hospital staff on infection prevention and control policies and procedures and their application</li> </ol> Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection (HLD). (For more information on competency requirements, refer to HR.01.06.01 EPs 1, 3, 5, 6)	IC.04.01.01 EP 2

## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

<ul style="list-style-type: none"> <li>d. The prevention and control of healthcare-associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures Note: Auditing tasks may be delegated to the appropriate staff (for example, unit-based liaisons or leaders); however, if delegation occurs, the infection preventionist(s) or infection control professional(s) must be updated on the results of auditing activities</li> <li>e. Communication and collaboration with all components of the hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and the water management program</li> <li>f. Communication and collaboration with the hospital's quality assessment and performance improvement program to address infection prevention and control issues.</li> </ul>	
<ul style="list-style-type: none"> <li>4. The infection prevention and control program reflects the scope and complexity of the hospital's services as evidenced by the following: <ul style="list-style-type: none"> <li>a. The program's policies and procedures; prevention, control, and auditing activities; and job-specific competency-based training activities apply to all staff providing patient care, treatment, or services.</li> <li>b. The program's policies and procedures; prevention, control, and auditing activities; and job-specific competency-based training activities apply to all inpatient and outpatient care locations.</li> <li>c. The program's policies and procedures; prevention, control, and auditing activities; and job-specific competency-based training activities apply to all care, treatment, and services (for example, hemodialysis, HLD/sterilization, respiratory therapy, wound care, dietary services, and laundry services).</li> <li>d. The scope of surveillance is consistent with infection control standards of practice and the scope and complexity of the hospital's services.</li> <li>e. Policies and procedures address the special populations served by the hospital (for example, pediatric patients, patients undergoing bone marrow transplant, hemodialysis, etc.)</li> <li>f. New hospital locations, services, and areas (for example, new ambulatory sites) are incorporated into the infection prevention and control program activities.</li> </ul> </li> </ul>	IC.04.01.01 EP 5
<b>Hospital Leadership Responsibility and Program Resources</b>	
<ul style="list-style-type: none"> <li>1. The governing body ensures that the infection prevention and control program is operational and resourced to carry out and track its activities through the following: <ul style="list-style-type: none"> <li>a. Resources must be adequate to accomplish the tasks required for the infection prevention and control program. This includes the following: <ul style="list-style-type: none"> <li>i. Allocating human resources to mitigate infection risks and prevent transmission of infections (for example, nursing and environmental services staffing must be adequate to carry out infection prevention and control activities).</li> <li>ii. Allocating material resources to mitigate infection risks and prevent transmission of infections, such as information technology, laboratory services, equipment, and supplies.</li> <li>iii. Allocating sufficient information resources to guide program activities, such as access to local, state, and federal public health authorities' advisories and alerts (for example, the CDC's Health Alert Network [HAN]; FDA alerts); access to manufacturers' instructions for use; access to any standards and guidelines required by applicable regulation and the guidelines and consensus standards chosen by the hospital to inform policies and procedures (for example, guidelines and standards from ASHRAE, FGI, SHEA, AAMI, AORN, APIC Text, etc.)</li> </ul> </li> <li>b. The governing body is ultimately accountable for the implementation, success, and sustainability of the program activities, while the medical director, nurse executive, and administrative leaders provide additional leadership support for the program.</li> <li>c. Hospital policies address the roles and responsibilities for infection prevention and control program within the hospital and how the various hospital committees and departments interface with the infection prevention and control program (for example, how to report infectious/communicable disease issues to the infection prevention and control program).</li> </ul> </li> </ul>	IC.05.01.01 EP 1
<ul style="list-style-type: none"> <li>2. The hospital's governing body ensures that the problems identified by the infection prevention and control program are addressed in collaboration with the hospital's quality assessment and performance improvement (QAPI) leaders, and other leaders (for example, the medical director, nurse executive, and administrative leaders) as evidenced by the following:</li> </ul>	IC.05.01.01 EP 2



## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

<ul style="list-style-type: none"> <li>a. The hospital's QAPI program addresses problems identified by the infection control leader(s).</li> <li>b. The hospital leaders, including the CEO, the medical staff leader, and the nurse executive, monitor adherence to corrective action plans, assess the effectiveness of actions taken, and verify the implementation of revised corrective actions as needed.</li> <li>c. The hospital's governing body, the medical staff leader, the nurse executive, and administrative leaders must ensure that staff in-service training programs address problems identified through the infection prevention and control program.</li> </ul>	
<p>3. <b>For hospitals that use Joint Commission accreditation for deemed status purposes:</b> If a hospital is part of a hospital system consisting of separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member hospitals after determining that such a decision is in accordance with applicable law and regulation. The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meet all of the requirements at 42 CFR 482.42(d).</p> <p>Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program have the following characteristics:</p> <ul style="list-style-type: none"> <li>- Structured in a manner that accounts for each member hospital's unique circumstances and any significant differences in patient populations and services offered at each hospital</li> <li>- Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified hospital, regardless of practice or location, are given due consideration</li> <li>- Have mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed</li> <li>- A qualified individual(s) with expertise in infection prevention and control and in antibiotic stewardship has been designated at the hospital as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to hospital staff.</li> </ul>	LD.01.03.01 EP 27
<p><b>Program Policies and Procedures</b></p>	
<p>1. The hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings.</p> <p>The policies and procedures are in accordance with the following hierarchy of references:</p> <ul style="list-style-type: none"> <li>- Applicable law and regulation.</li> </ul> <p>Note: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare &amp; Medicaid Services Conditions of Participation, the Food and Drug Administration (FDA) regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators.</p> <ul style="list-style-type: none"> <li>- Manufacturers' instructions for use.</li> <li>- Nationally recognized evidence-based guidelines and standards of practice, including The Centers for Disease Control and Prevention (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures.</li> </ul> <p>Note 1: For full details on CDC Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to <a href="https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html">https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html</a>.</p>	IC.04.01.01 EP 3

## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

<p>Note 2: The hospital determines which evidence-based guidelines, expert recommendations, or best practices, or a combination thereof, it adopts in its policies and procedures.</p>	
<p>2. The hospital's policies and procedures for cleaning, disinfection, and sterilization of reusable medical and surgical devices and equipment address the following:</p> <ul style="list-style-type: none"> <li>- Cleaning, disinfection, and sterilization of reusable medical and surgical devices in accordance with the Spaulding classification system and manufacturers' instructions</li> </ul> <p>Note: The Spaulding classification system classifies medical and surgical devices as critical, semicritical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate and low-level disinfection) to be used for the three classes of devices.</p> <ul style="list-style-type: none"> <li>- The use of EPA-registered disinfectants for noncritical devices and equipment according to the directions on the product labeling, including, but not limited to, indication, specified use-dilution, contact time, and method of application</li> <li>- The use of FDA-approved liquid sterilants for the processing of critical devices and high-level disinfectants for the processing of semicritical devices in accordance with the FDA-cleared label and device manufacturers' instructions</li> <li>- Required documentation for device reprocessing cycles, including but not limited to sterilizer cycle logs, the frequency of chemical and biological testing, and the results of testing for appropriate concentration for chemicals used in high-level disinfection</li> <li>- Resolution of conflicts or discrepancies between a medical device manufacturer's instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment</li> <li>- Criteria and the process for the use of immediate-use steam sterilization</li> <li>- Actions to take in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use</li> </ul> <p>Note: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up.</p>	<p>IC.04.01.01 EP 4</p>
<p><b>Risk Assessment</b></p>	
<p>1. The hospital identifies risks for infection, contamination, and exposure that pose a risk to patients and staff to prioritize program activities, including the following:</p> <ol style="list-style-type: none"> <li>a. The hospital includes risks from organisms with a propensity for transmission within health care facilities based on published reports and the occurrence of clusters of patients (for example, norovirus, respiratory syncytial virus ([RSV]), influenza, measles, and organisms with antimicrobial resistance such as Carbapenem-resistant Enterobacterales ([CRE]), <i>Candida auris</i>).</li> <li>b. The hospital evaluates risk based on the geographical location and population it serves, for example, risk for exposure to tuberculosis (TB).</li> <li>c. The hospital includes community data in its risk assessment, for example, community-onset cases of multi-drug resistant organisms.</li> <li>d. The hospital evaluates risk based on the care, treatment, and services it provides, for example, the types of procedures, medical equipment, devices, and supplies used.</li> <li>e. The hospital examines the risk of potential exposure to infectious materials, blood, body fluids, secretions, or excretions to make sure PPE is appropriate and available based on the tasks performed.</li> <li>f. The hospital uses the information from local, state, and federal public health authorities' advisories and alerts, such as CDC' Health Alert Network (HAN) and FDA alerts, to identify infection control risks.</li> </ol> <p>Note: The hospital determines how it keeps current on epidemiological risks or changes.</p>	<p>IC.06.01.01 EP 1</p>
<p>2. As reflected in the water management program documentation, the hospital includes a hospital risk assessment to identify where</p>	<p>EC.02.05.02 EP 2</p>

## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

Legionella and other opportunistic waterborne pathogens (for example, Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the hospital water system.	
3. As part of its infection control policies and procedures relevant to construction, renovation, maintenance, demolition, and repair, the hospital requires an infection control risk assessment (ICRA) to define the scope of infection risk for the project and the need for barrier measures before a project gets underway.	EC.02.06.05 EP 2
4. The hospital reviews identified risks at least annually or whenever significant changes in risk occur.	IC.06.01.01 EP 2
<b>Surveillance</b>	
1. The hospital performs and documents surveillance activities to prevent and control healthcare-associated infections (HAIs). Note: The hospital conducts surveillance and reporting in accordance with law and regulation, its risk assessment, and in accordance with recognized surveillance practices, such as those set forth by the CDC's National Healthcare Safety Network (NHSN).	IC.06.01.01 EP 3
2. Surveillance of infections and infection prevention and control activities is conducted on a hospitalwide basis.  Note: This does not imply surveillance is always conducted in all areas and locations of the hospital. The expectation is that the hospital must have reliable sampling or other mechanisms in place to permit identifying and monitoring infections and communicable diseases occurring throughout the hospital's various locations or departments.	IC.06.01.01 EP 3
<b>Education, Training, and Competency Assessment</b>	
1. The hospital provides job-specific training and education on infection prevention and control. The staff's records confirm completion of education and training. Note 1: Job-specific means that education and training are consistent with or tailored to the performed roles and responsibilities. For example, environmental services staff must be trained in the methods and procedures for surface disinfection. Note 2: The training and education must include the practical applications of infection prevention and control guidelines, policies, and procedures.	HR.01.05.03 EP 1
2. The hospital provides training to staff expected to have contact with blood or other potentially infectious material on the blood borne pathogen standards upon hire, at regular intervals, and as needed.	HR.01.05.03 EP 1
3. The hospital staff receive training in the following: a. When personal protective equipment (PPE) is necessary. b. What PPE is necessary. c. How to properly don, doff, adjust, and wear PPE.	HR.01.05.03 EP 1
4. The hospital defines and assesses staff competency in infection prevention and control. Note: Competency-based training must be job-specific. For example, the staff in the sterile processing department must demonstrate competencies in the methods and procedures of sterilization, and the staff in areas that perform high-level disinfection must demonstrate competencies in the methods and procedures for high-level disinfection.	HR.01.06.01 EPs 1, 3, 5, 6
5. The hospital develops and implements education and training and assesses competencies for the staff who will implement protocols for high-consequence infectious diseases or special pathogens.	IC.07.01.01 EP 2

## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

<p>Note: IC.07.01.01 applies to acute hospitals; the requirements under IC.07.01.01 are not applicable to psychiatric, physical rehabilitation, surgical specialty, long term care acute hospitals or swing beds.</p>	
<p><b>Outbreak Management</b></p>	
<p>1. There is a process in place for reporting to public health authorities when the transmission of infection occurs; this process is consistent with state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks.</p>	<p>IC.06.01.01 EP 4</p>
<p>2. The hospital implements its policies and procedures for infectious disease outbreaks, including the following:</p> <ul style="list-style-type: none"> <li>- Implementing infection prevention and control activities when an outbreak is first recognized by internal surveillance or public health authorities</li> <li>- Reporting an outbreak in accordance with state and local public health authorities' requirements</li> <li>- Implementing outbreak investigation</li> <li>- Communicating information necessary to prevent further transmission of the infection among patients, visitors, and staff, as appropriate.</li> </ul>	<p>IC.06.01.01 EP 4</p>
<p><b>Standard Precautions: Hand Hygiene</b></p> <p>Note: The hospital policies and procedures on hand hygiene are in accordance with either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines, including the following:</p>	
<p>1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines.</p>	<p>NPSG.07.01.01</p>
<p>2. Set goals for improving compliance with hand hygiene guidelines.</p>	<p>NPSG.07.01.01</p>
<p>3. Improve compliance with hand hygiene guidelines based on established goals.</p>	<p>NPSG.07.01.01</p>
<p>4. Supplies necessary for adherence to hand hygiene (such as alcohol-based hand rub, soap, water, and a sink) are readily accessible in all areas where patient care is being delivered including but not limited to patient care areas and food and medication preparation areas.</p>	<p>IC.06.01.01 EP 3</p>
<p>5. Alcohol-based hand rub is readily accessible and placed in appropriate locations where it can be accessed by the staff, patients, and visitors. The locations may include the following:</p> <ol style="list-style-type: none"> <li>a. Entrances to patient rooms</li> <li>b. At the bedside</li> <li>c. Staff workstations</li> <li>d. Other convenient locations</li> </ol>	<p>IC.06.01.01 EP 3</p>
<p>6. Hospital staff use an alcohol-based hand rub or wash with soap and water for the following clinical indications:</p> <ol style="list-style-type: none"> <li>a. Immediately before touching a patient</li> <li>b. Before performing an aseptic task (for example, placing an indwelling device) or handling invasive medical devices</li> <li>c. Before moving from work on a soiled body site to a clean body site on the same patient</li> <li>d. After touching a patient or the patient's immediate environment</li> <li>e. After contact with blood, body fluids or contaminated surfaces</li> <li>f. Immediately after glove removal</li> </ol>	<p>IC.06.01.01 EP 3</p>
<p>7. Hospital staff perform hand hygiene using soap and water when hands are visibly soiled (for example, blood, body fluids) or after caring for a patient with known or suspected <i>C. difficile</i> or norovirus during an outbreak. Note: In all other situations, alcohol-based hand rub is preferred.</p>	<p>IC.06.01.01 EP 3</p>

## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

<p>8. Hospital staff do not wear artificial fingernails and/or extenders when having direct contact with patients in accordance with hospital policy.            Note: If following the <i>CDC Guideline for Hand Hygiene in Health-Care Settings</i>: when having direct contact with patients at high risk of infection (for example, those in intensive care units or ORs). If following the <i>WHO Guidelines on Hand Hygiene</i>: when having direct contact with patients.</p>	IC.06.01.01 EP 3
<p><b>Standard Precautions: Environmental Cleaning and Disinfection</b>            Note: Environmental cleaning and disinfection is performed in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:</p>	
<p>1. The hospital implements routine and targeted cleaning of environmental surfaces as indicated by the level of patient contact and degree of soiling, including the following:</p> <p>a. Surfaces in the patient care environment and areas are cleaned and disinfected on a regular basis, using an EPA- registered disinfectant.            Note: High-touch surfaces (for example, bed rails, over-bed table, bedside commode, lavatory surfaces in patient bathrooms) are cleaned and disinfected more frequently than minimal-touch surfaces.</p> <p>b. Spills of blood or other potentially infectious materials are promptly cleaned and decontaminated, using appropriate EPA-registered hospital disinfectants.</p>	IC.06.01.01 EP 3
<p>2. Cleaners and disinfectants, including disposable wipes, are used in accordance with manufacturers' instructions (for example, dilution, storage, shelf-life, contact time).</p>	IC.06.01.01 EP 3
<p>3. Mop heads and cleaning cloths are laundered at least daily using appropriate laundry techniques (for example, following manufacturers' instructions when laundering microfiber items).</p>	IC.06.01.01 EP 3
<p>4. The hospital has established and follows a schedule for areas/equipment (for example, refrigerators, ice machines, eye wash stations, scrub sinks) to be cleaned regularly.</p>	IC.06.01.01 EP 3
<p>5. After a patient vacates a room and before the bed linens and towels are replaced, all potentially contaminated surfaces in the room are thoroughly cleaned and disinfected.</p>	IC.06.01.01 EP 3
<p>6. Undamaged hospital bed mattress covers are cleaned and disinfected according to manufacturers' instructions.            Any damaged, worn, or visibly stained hospital bed mattress or mattress covers are removed from service and cleaned, disinfected, refurbished, or discarded in accordance with manufacturers' instructions and hospital procedures.</p>	IC.06.01.01 EP 3
<p><b>Standard Precautions: Injection and Sharps Safety</b>            Note: Injection practices and sharps safety and disposal are performed in accordance with The Centers for Disease Control and Prevention (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings and hospital policies and procedures to maximize prevention of infection and communicable disease including the following:</p>	
<p>1. Injections are prepared using aseptic technique in an area that has been cleaned and separated from potential sources of contamination (for example, visible blood, body fluids, sinks or other water sources).</p>	IC.06.01.01 EP 3
<p>2. Single-dose or single-use vials, ampules, bags or bottles of parenteral solution, fluid infusion or administration sets (for example, intravenous tubing) are used for one patient only.</p>	IC.06.01.01 EP 3
<p>3. Diaphragms of medication vials are disinfected before inserting a device into the vial.</p>	IC.06.01.01 EP 3

## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

4. Needles and syringes are used for one patient only (this includes manufactured prefilled syringes and cartridge devices such as insulin pens).	IC.06.01.01 EP 3
5. The same lancing/fingerstick device is <u>not</u> used for more than one individual, even if the lancet is changed.	IC.06.01.01 EP 3
6. If multidose vials are used for more than one patient, medication vials do not enter the immediate patient treatment area (for example, operating room, patient room, anesthesia carts). Note: If multi-dose vials enter the immediate patient treatment area, they must be dedicated for single patient use and discarded immediately after use.	IC.06.01.01 EP 3
7. Immediately or as soon as possible after use, contaminated sharps are discarded in puncture-resistant, leakproof (on the sides and bottom) sharps containers, and sharps containers are replaced when the fill line is reached.	IC.06.01.01 EP 3
<b>Standard Precautions: Risk Assessment with Appropriate Use of Personal Protective Equipment</b>	
Note: Appropriate personal protective equipment (PPE) is used in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. Staff have immediate access to PPE and are able to select, put on, remove, and dispose of PPE in a manner that protects themselves, the patient, and others.	IC.06.01.01 EP 3
2. Gloves are worn when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment could occur. The staff change gloves and perform hand hygiene before moving from a contaminated body site to a clean body site.	IC.06.01.01 EP 3
3. A gown is worn that is appropriate to the task to protect skin and prevent soiling of clothing during procedures and activities that could cause contact with blood, body fluids, secretions, or excretions.	IC.06.01.01 EP 3
4. Protective eyewear and a mask or a face shield are worn to protect the mucous membranes of the eyes, nose, and mouth during procedures and activities that could generate splashes or sprays of blood, body fluids, secretions, and excretions. Note: Masks, goggles, face shields, and combinations of each are selected according to the need anticipated by the task performed.	IC.06.01.01 EP 3
5. PPE removal and disposal: - PPE, other than respirators, are removed and discarded upon completing a task before leaving the patient's room or care area. - If a respirator is used, it should be removed and discarded (or reprocessed if reusable) after leaving the patient room or care area and closing the door. - Disposable gloves are removed and discarded upon completion of a task or when soiled during the process of care.	IC.06.01.01 EP 3
6. Face masks (procedure or surgical) are worn by staff who are placing a catheter or injecting materials into the epidural or subdural space (for example, during myelogram, epidural, or spinal anesthesia).	IC.06.01.01 EP 3
<b>Standard Precautions: Minimizing Potential Exposures Preparedness for High-Consequence Infectious Diseases or Special Pathogens</b>	
1. Respiratory hygiene and cough etiquette instructional signage or handouts are posted and tissues, masks, and hand hygiene supplies available at the points of entry to minimize potential exposures to or transmission of respiratory infection.	IC.06.01.01 EP 3

## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

<p>Note: Points of entry may include the emergency department, urgent care, and ambulatory clinics</p>	
<p>2. The hospital has developed and implemented protocols for high-consequence infectious diseases or special pathogens. The protocols are readily available for use at the point of care and address the following:</p> <ul style="list-style-type: none"> <li>- Identify: Procedures for screening at the points of entry to the hospital for respiratory symptoms, fever, rash, and travel history to identify or initiate evaluation for high-consequence infectious diseases or special pathogens</li> </ul> <p>Note: Points of entry may include the emergency department, urgent care, and ambulatory clinics.</p> <ul style="list-style-type: none"> <li>- Isolate: Procedures for transmission-based precautions</li> <li>- Inform: Procedures for informing public health authorities and key hospital staff</li> <li>- Required personal protective equipment and proper donning and doffing techniques</li> <li>- Infection control procedures to support continued and safe provision of care while the patient is in isolation and to reduce exposure among staff, patients, and visitors using the hierarchy of controls</li> </ul> <p>Note: See the Glossary for a definition of hierarchy of controls.</p> <ul style="list-style-type: none"> <li>- Procedures for waste management and cleaning and disinfecting patient care spaces, surfaces, and equipment</li> </ul> <p>Note: IC.07.01.01 applies to acute hospitals; the requirements under IC.07.01.01 are not applicable to psychiatric, physical rehabilitation, surgical specialty, long term care acute hospitals or swing beds.</p>	<p>IC. 07.01 01 EP 1</p>
<p><b>Standard Precautions: Reprocessing of Reusable Medical Equipment</b>            Note: Reprocessing of reusable medical equipment is performed in accordance with the Spaulding classification system, manufacturers' instructions, and hospital policies and procedures.</p>	
<p>1. Only devices labeled as reusable are reprocessed directly by the hospital onsite or offsite via a reprocessing vendor.            If the hospital elects to reuse any devices labeled for single use by the manufacturer, these devices are reprocessed by an entity that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question.            The hospital has documentation from the third-party reprocessor confirming this is the case.</p>	<p>IC.06.01.01 EP 3</p>
<p>2. Manufacturers' instructions for medical devices and equipment are available to the staff performing reprocessing. The hospital may use posters or other condensed methods to provide critical information to staff performing reprocessing to ensure reprocessing consistent with the instructions for use.</p>	<p>IC.05.01.01 EP 1</p>
<p>3. Reusable non-critical medical equipment (for example, blood glucose meters and other point-of-care devices, blood pressure cuffs, oximeter probes) are cleaned and disinfected according to manufacturers' instructions after each use or when visibly soiled.</p>	<p>IC.06.01.01 EP 3</p>
<p>4. Hydrotherapy equipment (for example, Hubbard tanks, tubs, whirlpools, spas, birthing tanks) are drained, cleaned, and disinfected using an EPA-registered disinfectant according to manufacturers' instructions after each patient use.</p>	<p>IC.06.01.01 EP 3</p>
<p>5. Responsibility for cleaning and disinfection of reusable noncritical patient-care equipment and devices is clearly designated.</p>	<p>IC.06.01.01 EP 3</p>
<p><b>High-level disinfection:</b></p>	
<p>6. All reusable semi-critical items receive at least high-level disinfection prior to reuse, in accordance with manufacturers' instructions.</p>	<p>IC.06.01.01 EP 3</p>
<p>7. Flexible endoscopes are inspected for damage and leak tested as part of each reprocessing cycle, in accordance with manufacturers'</p>	<p>IC.06.01.01 EP 3</p>

## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

instructions.	
8. Items are thoroughly pre-cleaned according to manufacturers' instructions and visually inspected for residual soil prior to high-level disinfection. For instruments with lumens (for example, endoscopes), pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	IC.06.01.01 EP 3
9. Manufacturers' instructions are followed for the following: a. Enzymatic cleaners or detergents b. Reusable cleaning brushes c. Chemicals used in high-level disinfection, including instructions for preparation, testing for appropriate concentration, and replacement (for example, prior to expiration) Note: The results of testing for appropriate concentration are documented to ensure minimal effective concentration of the active ingredient. d. Disinfection temperatures and length of time e. Device rinsing following high-level disinfection f. If automated reprocessing equipment is used, manufacturers' recommended connectors are used to assure that all endoscope channels are appropriately disinfected.	IC.06.01.01 EP 3
10. Devices are dried thoroughly prior to storage/reuse in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
11. After high-level disinfection, devices are stored in a manner that protects them from damage or contamination.	IC.06.01.01 EP 3
12. The hospital has a system in place to identify which endoscope was used on a patient for each procedure.	IC.06.01.01 EP 3
<b>Sterilization:</b>	
13. All reusable critical items are sterilized prior to reuse, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
14. Items are thoroughly pre-cleaned according to manufacturers' instructions and visually inspected for residual soil prior to sterilization. Note: For instruments with lumens, pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	IC.06.01.01 EP 3
15. Enzymatic cleaner or detergent is used and discarded according to manufacturers' instructions.	IC.06.01.01 EP 3
16. Cleaning brushes are single-use, disposable items or, if reusable, cleaned and either high-level disinfected or sterilized (per manufacturers' instructions) at least daily.	IC.06.01.01 EP 3
17. After pre-cleaning, items are appropriately wrapped-packaged for sterilization (for example, the package system selected is compatible with the sterilization process being performed, hinged instruments are open, and instruments are disassembled if indicated by the manufacturer).	IC.06.01.01 EP 3
18. The sterilization process is monitored by using a combination of mechanical, chemical, and biological indicators to ensure the effectiveness of the sterilization process. Indicators are used in accordance with the sterilizer or sterilizer accessory (pouch, casket, tray, etc.) manufacturers' instructions.	IC.06.01.01 EP 3
19. For dynamic air removal-type sterilizers (for example, prevacuum steam sterilizers), an air removal test (Bowie-Dick test) is performed each day the sterilizer is used to verify efficacy of air removal in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
20. Sterile packs are labeled with the sterilizer used, the cycle or load number, the date of sterilization, and, if applicable, the expiration date.	IC.06.01.01 EP 3



## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

<p>21. Logs for each sterilizer cycle are current and include results from each load, in accordance with the hospital policies and procedures. Note: For the absence of policies and procedures, score IC.04.01.01 EP 4</p>	IC.06.01.01 EP 3
<p>22. After sterilization, medical devices and instruments are stored so that sterility is not compromised.</p>	IC.06.01.01 EP 3
<p>23. Sterile packages are inspected for integrity and compromised packages are repackaged and reprocessed prior to use.</p>	IC.06.01.01 EP 3
<p>24. If immediate-use* steam sterilization (IUSS) is performed, all of the following criteria are met:</p> <ol style="list-style-type: none"> <li>Work practices ensure proper cleaning and decontamination, inspection, and arrangement of the instruments into the recommended sterilizing trays or other containment devices before sterilization.</li> <li>Once clean, the item is placed within a container intended for immediate use.</li> <li>The sterilizer cycle and parameters used are selected according to the manufacturers' instructions for use for the device, container, and sterilizer.</li> <li>The sterilizer function is monitored with mechanical monitors and chemical and biologic indicators that are validated for use with the sterilization cycle and in accordance with the device and sterilizer manufacturers' instructions.</li> <li>The processed item must be transferred immediately*, using aseptic technique, from the sterilizer to the actual point of use, the sterile field in an ongoing surgical procedure.</li> </ol> <p>**"Immediate use" is defined as the shortest possible time between a sterilized item's removal from the sterilizer and its aseptic transfer to the sterile field. A sterilized item intended for immediate use is not stored for future use, nor held from one case to another.</p>	IC.06.01.01 EP 3
<p>25. Immediate-use steam sterilization is not performed on the following devices:</p> <ol style="list-style-type: none"> <li>Implants (except in documented emergency situations when no other option is available) Note: If IUSS must be used for an implantable device, the name of the patient/patient's unique identifier and any other information needed to accurately link the instrument processed using IUSS back to the patient must be recorded.</li> <li>Post-procedure decontamination of instruments used on patients who may have Creutzfeldt-Jakob disease or similar disorders</li> <li>Devices that have not been validated with the specific cycle employed</li> <li>Single-use devices that are sold sterile</li> </ol>	IC.06.01.01 EP 3
<p>26. Staff follow hospital policies and procedures in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use.</p> <p>Note: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up.</p> <p>Note: For the absence of policies and procedures, score IC.04.01.01 EP 4.</p>	IC.06.01.01 EP 3
<p><b>Transmission-Based Precautions</b> Note: Transmission-based precautions are applied in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:</p>	
<p>1. The hospital implements transmission-based precautions based on the patient's clinical presentation and likely infection diagnoses (for example, syndromes suggestive of transmissible infections such as diarrhea, meningitis, fever and rash, respiratory infection) and adjusts or discontinues precaution per policies and procedures and clinical information.</p> <p>Note: Implementation of transmission-based precautions may differ based on the patient care settings (inpatient, outpatient, long-term care), facility design characteristics, and the type of patient interaction.</p>	IC.06.01.01 EP 3
<p>2. Personal protective equipment and supplies are available and located near point of use.</p>	IC.06.01.01 EP 3

## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

3. Personal protective equipment is put on/donned and removed/doffed properly.	IC.06.01.01 EP 3
4. Signs indicating that a patient is on transmission-based precautions are clear and visible.	IC.06.01.01 EP 3
5. If a patient is on transmission-based precautions and must leave their room for medically necessary purposes, there are methods and processes in place to communicate that patient's status and to prevent transmission of infectious disease.	IC.06.01.01 EP 3
6. A NIOSH-approved particulate respirator (N95 or higher) is worn by staff when entering the airborne infection isolation room (AIIR) for patients with confirmed or suspected TB. Hospital policies are followed for other pathogens requiring AIIR.	IC.06.01.01 EP 3
<b>Temporary Invasive Medical Devices for Clinical Management</b>	
1. Staff adhere to invasive medical devices insertion, maintenance, and discontinuation practices, in accordance with hospital policies and procedures. Note: Examples of invasive medical devices include vascular catheters, indwelling urinary catheter, ventilator.	IC.06.01.01 EP 3
2. The hospital follows its policies and procedures for appropriate indications for urinary catheters.	IC.06.01.01 EP 3
3. The hospital promptly removes any intravascular catheter that is no longer essential, in accordance with its policies and procedures. Note: For the absence of policies and procedures, score IC.04.01.01 EP 3.	IC.06.01.01 EP 3
<b>Occupational Health</b>	
1. The hospital implements policies and procedures to minimize the risk of communicable disease exposure and acquisition among its staff, in accordance with law and regulation. The policies and procedures address the following: - Screening and medical evaluations for infectious diseases - Immunizations - Staff education and training - Management of staff with potentially infectious exposures or communicable illnesses  Note: For the absence of policies and procedures, score IC.04.01.01 EP 3.	IC.06.01.01 EP 5
2. The hospital has a respiratory protection program that details required worksite-specific procedures and elements for required respirator use.	IC.06.01.01 EP 5
3. Fit testing is provided at regular intervals to staff at risk.	IC.06.01.01 EP 5
4. Following an exposure incident, post-exposure evaluation and follow-up, including prophylaxis as appropriate, is available to the individual and performed by or under the supervision of a practitioner.  Note: An exposure incident refers to a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that result from the performance of an individual's duties.	IC.06.01.01 EP 5
5. Hospital policies and procedures are followed for management of staff with potentially infectious exposures or communicable illnesses (for example, regarding contact with patients or food preparation and handling).	IC.06.01.01 EP 5

## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

<b>Hemodialysis</b>	
Note: Infection prevention practices during hemodialysis procedure are performed in accordance with hospital policies and procedures including the following:	
1. Staff wear appropriate PPE (gloves, gowns, face, and eye protection) and perform hand hygiene throughout the procedure.	IC.06.01.01 EP 3
2. Staff perform appropriate central line care, including preparing catheter hubs prior to accessing for hemodialysis, connecting, and disconnecting from bloodlines after the procedure.	IC.06.01.01 EP 3
3. During the priming process, blood lines do not come into contact with contaminated prime waste.	IC.06.01.01 EP 3
4. For tasks requiring aseptic technique, the staff avoid contamination of gloves and other clean/sterile items, for example avoiding touching contaminated surfaces.	IC.06.01.01 EP 3
5. Environmental surface disinfection is performed, when no patient is present, including the following: <ol style="list-style-type: none"> <li>The dialysis station</li> <li>Priming buckets</li> <li>Reusable equipment</li> </ol>	IC.06.01.01 EP 3
6. Disposable supplies are discarded after the patient has departed the dialysis station in accordance with the local regulated medical waste law and regulation.	IC.06.01.01 EP 3
7. The hospital adheres to the policies and procedures to determine and document the hepatitis status of a dialysis patient. Note: For the absence of policies and procedures, score IC.04.01.01 EP 3	IC.06.01.01 EP 3
8. The hospital adheres to manufacturers' instructions and hospital policies and procedures for cleaning and disinfection of the dialysis machine used for the treatment of a patient with hepatitis B. Note: For the absence of policies and procedures, score IC.04.01.01 EP 4	IC.06.01.01 EP 3
<b>Laundry &amp; Linen</b>	
Note: Laundry is processed in a manner consistent with law and regulation and hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. Soiled textiles/laundry are handled with minimum agitation to avoid contamination of air, surfaces, and persons.	IC.06.01.01 EP 3
2. Soiled laundry is contained in leak-proof bags or containers at the point of use. Note: Hamper covers are not required in patient care areas.	IC.06.01.01 EP 3
3. Healthcare textiles are protected from environmental contamination during transport and storage. Note: Textiles/linens are covered if stored in a clean area in the inpatient unit or may be uncovered if stored in a dedicated clean storage area.	IC.06.01.01 EP 3
4. The receiving area for contaminated textiles is clearly separated from clean laundry areas and is maintained at negative pressure compared with the clean areas of the laundry in accordance with FGI construction standards in effect during the time of facility construction.	EC.02.05.01 EP 16
<b>Dietary Services/Kitchen</b>	

## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

<p>Note: Practices for the prevention of foodborne infections and diseases are performed in accordance with the federal, state, and local codes, law and regulation on food operations, and hospital policies and procedures.</p>	
1. The hospital has written policies and procedures on sanitary and hand hygiene practices for its dietary services and kitchen staff.	IC.04.01.01 EP 3
<p>2. The hospital provides a clean and sanitary environment in food storage, preparation, serving, and dishware storage areas, consistent with law, regulation, and food sanitation code.</p> <p>Note: Examples may include:</p> <ol style="list-style-type: none"> <li>Cutting boards, prep surfaces, work areas, trays and equipment are cleaned properly to avoid contamination and sanitized between uses.</li> <li>Different cutting boards/prep surfaces are used for meat, vegetables, and other food items.</li> <li>Handwashing sinks are available.</li> <li>Sinks are clear of items that can be contaminated by splashes.</li> <li>Raw food and ingredients are prepared and stored in a manner that prevents cross contamination with other foods (for example, to avoid dripping, liquid pooling, splashing).</li> <li>Dishes and utensils are air dried and stored in a manner that prevents cross contamination.</li> <li>Food carts are sanitized after every meal.</li> <li>Wet wiping cloths are stored in an approved sanitizing solution and washed daily.</li> </ol>	IC.06.01.01 EP 3
3. The dietary services and kitchen staff comply with hand hygiene practices.	IC.06.01.01 EP 3
<p>4. The hospital prepares food and nutrition products using proper sanitation and temperature, including the following:</p> <ol style="list-style-type: none"> <li>Food service staff wear hair or beard coverings, in accordance with hospital policies and procedures.</li> <li>Food service staff adhere to hand hygiene in accordance with hospital policies and procedures.</li> <li>The hospital monitors the food's temperature for hot and cold items during meal service.</li> <li>The hospital maintains proper temperature of refrigerated or warmed foods during preparation.</li> <li>The hospital follows the proper process for thawing of foods.</li> <li>The hospital monitors final cooking temperatures.</li> </ol>	PC.02.02.03 EP 6
<p>5. The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation:</p> <ol style="list-style-type: none"> <li>Food is protected from contamination during storage.</li> <li>Food storage areas such as a refrigerator, cupboards, drawers, and bins are not soiled and protected from splashes and free of odors.</li> </ol>	PC.02.02.03 EP 11
6. The hospital manages foodborne outbreak(s) and reports outbreak(s) to public health authorities, in accordance with law and regulation and hospital policies and procedures.	IC.06.01.01 EP 4
<p><b>Surgical Services</b></p> <p>Note: Surgical services are performed in accordance with hospital policies and procedures including the following:</p>	
1. Staff perform a surgical scrub before donning sterile gloves for surgical procedures using either an antimicrobial surgical scrub agent or an FDA-approved alcohol-based antiseptic surgical hand rub. After surgical scrub, hands and arms are dried with sterile towel (if applicable), and sterile surgical gown and gloves are donned in the OR.	IC.06.01.01 EP 3
2. Staff in the surgical area adhere to aseptic and sterile technique.	IC.06.01.01 EP 3
3. Staff and visitors wear surgical attire (e.g., scrubs) and surgical caps/hoods covering all head and facial hair in semi restricted and restricted	IC.06.01.01 EP 3

## Infection Prevention and Control Program Assessment Tool for Hospitals and Critical Access Hospitals

<p>areas.</p> <p>Note: Restricted areas include ORs, procedure rooms, and the clean core (sterile supply) area. The semi restricted areas include the peripheral support areas of the surgical suite.</p>	
4. Surgical masks are worn fully covering the mouth and nose by all staff in restricted areas where open sterile supplies or scrubbed staff are located.	IC.06.01.01 EP 3
5. The sterile field is maintained, including the following: <ol style="list-style-type: none"> <li>a. Items used within the sterile field are sterile.</li> <li>b. Items introduced into the sterile field are opened, dispensed, and transferred in a manner to maintain sterility.</li> <li>c. The sterile field is prepared in the location where it will be used and as close as possible to time of use.</li> <li>d. Movement in or around sterile field is done in a manner to maintain sterility.</li> </ol>	IC.06.01.01 EP 3
6. Traffic in and out of the OR is kept to a minimum and limited to essential staff.	IC.06.01.01 EP 3
7. All horizontal surfaces (for example, furniture, surgical lights, booms, equipment) are damp dusted before the first procedure of the day using a clean, lint-free cloth and an EPA-registered hospital detergent/disinfectant.	IC.06.01.01 EP 3
8. High-touch environmental surfaces are cleaned and disinfected between patients.	IC.06.01.01 EP 3
9. ORs are terminally cleaned after the last procedure of the day (including weekends) and each 24-hour period during regular work week. Terminal cleaning includes wet-vacuuming or mopping the floor with an EPA-registered disinfectant.	IC.06.01.01 EP 3
10. Anesthesia equipment surfaces that are touched by staff while providing patient care or while handling contaminated items are cleaned and low-level disinfected between use on patients according to manufacturers' instructions.	IC.06.01.01 EP 3
11. Exterior surfaces of anesthesia equipment that are not knowingly contaminated during patient care are terminally low-level disinfected at the end of the day according to manufacturers' instructions.	IC.06.01.01 EP 3
12. Internal components of the anesthesia machine breathing circuit are cleaned per manufacturers' instructions and hospital policies and procedures.	IC.06.01.01 EP 3
13. Reusable noncritical items (for example, blood pressure cuffs, ECG leads, tourniquets, oximeter probes) are cleaned and disinfected between patients.	IC.06.01.01 EP 3

Page intentionally left blank.